Investigating the Islamic Perspective on Homosexuality

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Note: Our opinions do not necessarily reflect the opinions or policies of our respective institutions where we work.

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Abstract

In his 2006 article in the Journal of the Islamic Medical Association of North America (*JIMA)*, Dr. Ahmed qualified the predominant psychiatric view on "homosexuality" by recourse to opinions prevalent within reparative therapy circles. Conservative Muslim thinkers, online counselors and other professionals continue to hold opinions similar to those delineated by Dr. Ahmed in his journal article. We use his paper as a focal point to critique the general opinions upheld by conservative Muslim thinkers by alluding to the harms associated with reparative therapy and by rejecting the unreasonable prescription of permanent celibacy. We critique Dr. Ahmed's association of "homosexuality" with mental health issues, fatal diseases, alcoholism and illicit sexual intercourse. Investigating the Muslim tradition, we encourage conservative Muslim leaders to facilitate Muslim gays and lesbians in their legitimate human need for intimacy, affection and companionship.

Key words: Homosexuality; permanent celibacy; reparative therapy; Islam; Muslim same-sex unions, minority stress, internalized homophobia

Introduction and Motivation

Ahmed (2006) portrayed an Islamic perspective on "homosexuality" in the Journal of the Islamic Medical Association of North America (JIMA). We use quotation marks for the terms "homosexuality" and "lesbianism" to encompass both meanings of 'orientation' and 'conduct' that are interchangeably used based on the context. While, Dr. Ahmed accepts the predominant Islamic position of the prohibition of "homosexuality", he suggests medical professionals offer compassion in dealing with "sick homosexual patients". He acknowledges societal taboo that limits any meaningful discussion of the issue. Furthermore, he argues against hatred and rejection that might serve to drive homosexuals from the "right path" as shown by Islam. However, Dr. Ahmed biases his analysis with religious conviction and not scientific evidence and as such the approach that he has used to broach the issue of "homosexuality" amongst Muslim medical professionals merits a critique.

Dr. Ahmed draws from various studies to summarize the scientific position on "homosexuality". He qualifies the prevalent psychiatric view that sexual orientation is inherent by summarizing theories that are prevalent amongst reparative therapy groups. He also associates mental health issues and fatal diseases with "homosexuality" rather than societal prejudice. As such, he distinguishes between orientation and action and based on "Islamic values" he counsels permanent celibacy for homosexuals. He references two sets of Qur'anic verses and a Hadith

(saying attributed to the Prophet) to present the Islamic position. Eventually, he alludes to Spitzer's work on changing orientation, suggests that clinicians have experience for aversion therapy, and cautions against making "homosexuality" compatible with Islam.

Even though his paper was published in 2006, it is important to critique it as to our knowledge it is the only paper of its kind in an Islamic journal. Furthermore, not only has it not been effectively addressed but also because many conservative Muslim thinkers, online counselors and other professionals perpetuate opinions that are similar to those adopted by him. Conservative Muslim leaders continue to sideline the predominant position of mainstream psychiatry and medical professional organizations, including the Lebanese professional organizations, which have recently issued statements affirming the position on the innateness of the sexual orientation of gays and lesbians and on the dangers of conversion or reparative therapy (LebMASH, 2013).

The objective of this article is to use Ahmed (2006) as a focal point to critique several of the points raised by Dr. Ahmed, which are also upheld by conservative Muslim leaders, and briefly present an alternate Muslim discourse. As such, the intended audience for this critique is Muslim counselors, professionals and community leaders, who continue to ignore the predominant position amongst professional psychologists and psychiatrists on the acceptance of sexual orientation of gays and lesbians and on the harms of reparative therapy, and who persist in perpetuating the framework used by National Association for Research and Therapy of Homosexuality (NARTH) due to their religious convictions.

This article will comprise of four main sections. The first section will provide a critical summary of the views upheld by conservative Muslim leaders and their impact on Muslim gays and lesbians. The second section will contain a critique of reparative therapy as delineated in Dr. Ahmed's article. By elaborating how past Muslim jurists understood "homosexuality" the discourse will be shifted from the past to the present. The third section will examine Dr. Ahmed's analogy of "homosexuality" with alcoholism, association with illicit sexual intercourse, link with fatal diseases and the prescription of permanent celibacy. Finally, in the last section, the three sets of scriptural texts quoted by Dr. Ahmed will be briefly addressed followed by a brief outline of the case for Muslim same-sex unions.

Opinions of conservative Muslim leaders

Many conservative Muslim leaders continue to perpetuate positions espoused by NARTH. Krauss (2010) mentioned links from NARTH to argue that there is no evidence of people being born gay and underscore the need for having positive loving male figures to help with identity development. In another online response, the questioner is informed that "homosexuality" is a severe illness that must be treated, one which arises due to weakness of faith or failing to pray (Muslims of Calgary, 2011). He is counseled that through repentance the *haram* (prohibited) desires of many homosexuals have disappeared, and is therefore advised to get married (Muslims of Calgary, 2011).

However, sexual behavior has to be distinguished from sexual orientation. While, sexual orientation refers to physiological drives, beyond conscious choice and profound feelings (APA Task Force, 2009, p. 30), reparative therapists equate the suppression of behaviour with a change

in sexual orientation in the case of clients, who feign heterosexual desire to avoid Hell fire in the Hereafter (Grace, 2008). The APA Task Force Report (2009) also indicates that what seems to shift in some individuals is not sexual orientation but sexual orientation identity (APA Task Force, 2009, p. 4).

In 2013, a Muslim clinical psychologist mentioned on the popular onislam site that "homosexuality" is neither a mental disorder nor has any "cure", but then asserted that people get "caught up in a deviant lifestyle" that "includes drugs and deviant sexual practices" and which "provide an escape from the discomfort of childhood trauma" (Bachmeier, 2013). She also asserted, "many people, who call themselves homosexuals, were sexually abused when they were young … trying to fill an emotional void with a need for "father energy". Like Dr. Ahmed, ignoring stigma and prejudice within conservative Muslim spaces, she prescribed celibacy to remain compliant with morality.

Her comments on sexual orientation and sexual abuse are informed more by religious conviction than by scientific evidence, as the mainstream view among researchers and professionals who work in the area of child abuse reject the connection between a homosexual lifestyle and child molestation (Herek, n.d.). Causality claims are problematic due to the issue of reverse causality, as children who will later identify as LGBT are usually socially isolated and excluded, and therefore vulnerable to the perpetuation of abuse by those who prey on their uncertainties and insecurities (Katy, 2009). Furthermore, while sexual abuse may interfere with a survivor's sexual development and behaviour, it is highly unlikely that something as beautiful and wonderful as love and affection for another person could arise out of something as ugly and painful as sexual

abuse (Katy, 2009). Indeed, it seems rather strange to assert that a childhood rape programs the sexual orientation of the child so that all his future relationships built on love and affection are defined by childhood rape.

Kutty (2015) equated those who indulge in "homosexual behavior" with those who have been conditioned to fornicate, commit theft, murder or those who have become addicted to pornography. The tips he offers in the struggle to overcome "homosexuality" include elements of aversion therapy by associating the suffering of Hell with same-sex behavior or reading Qur'anic verses depicting Hell fire along with advising to pray for Allah's help, cut off relations with those involved in a gay lifestyle and to get married after repentance.

Kutty's juxtaposing of pornography, in the context of gays and lesbians, allows some conservative Muslims to establish causality between pornography and sexual orientation. However, confessions on a site on asexuality reveal how some heterosexuals and asexuals occasionally watch homosexual pornography despite having no desire in masturbation or establishing a sexual relationship with members of the same gender (Asexual Q&A, 2013). This only confirms that sexual practices have to be distinguished from the constitutional sexual orientation of an individual.

It seems that conservative Muslim leaders are stuck on the old models of "homosexuality" from the middle of the 19th century when "homosexuality" was viewed through the lens of psychological immaturity, pathology, excessive parental control, insufficient parenting, hostile parenting, seduction, molestation, or decadent lifestyles (APA Task Force, 2009, p. 21). While studies have failed to support factors such as family dynamics or trauma in the development of

sexual orientation (APA Task Force, 2009, p. 23), religious convictions prevent conservative Muslims from changing their viewpoints.

In the context of British Muslim heterosexuals, Siraj (2009) points out that religiosity is the most influential variable directly associated with intolerance and opposition to "homosexuality" and that having a higher level of education did not have an influence on such attitudes. Many conservative Muslim leaders, like Dr. Ahmed, bias their analysis with religious conviction rather than scientific evidence. They view the human need of gays and lesbians for intimacy, affection and companionship through the lens of "bad impulses" and "urges" and dehumanize them by reducing their life to the specific act of anal intercourse (Kesvani, 2015). Sidelining works like Kugle (2010) and Menyawi (2012), that present a reasonable case for Muslim same-sex unions, conservative Muslim leaders prescribe life-long celibacy (Ahmed, 2006) , encourage a false marriage (Qadhi, 2009) or perpetuate the status of gays and lesbians as sinners (Jackson, 2013).

The impact of conservative Muslim positions on Muslim gays and lesbians

While not all conservative Muslim opinions are homophobic, all traditional Muslim opinions are heterosexist (Eidhamar, 2014). Community leaders promote heterosexism within the Muslim community, which includes the refusal to engage with LGBT organizations and publicly tackle homophobia within the Muslim community (Siraj, 2012). Continued public declarations of Muslim community leaders that homosexuality is an abnormality and a disease exposes Muslim gays and lesbians to discrimination (Siraj, 2012). Other consequences of the heterosexism

instigated by Muslim community leaders include severe cognitive dissonance, as witnessed in online forums, in terms of the ability to harmonize faith and sexuality.

In one post from 2012, the author states that that while he feels disgusting and unclean, he cannot stop meeting guys in secret and that fasting has not helped in controlling his desires (Malik7, 2012). In 2014, an online post titled 'OCD about my sexuality is driving me mad' was posted by a 19 year old who stated that she has become sick to the point that she can't eat or sleep (Salmah123, 2014). The same year a post titled 'I hate myself for being homosexual' was posted by a 16 year old, who stated that he is so sick of himself that he wants to commit suicide (Feraligator619, 2014). The online posts from 2015 include one titled 'It's *haram* [prohibited], but I can't help it' by a 15 year old boy who states that he has always prayed and fasted but is beginning to develop strange feelings towards his roommate (Kertenkale, 2015). Such posts continue to be churned out online.

These online posts indicate the concern many religious youth have regarding their sexuality, and how praying and fasting does not alleviate their concerns. Such posts also suggest that Muslim leaders and professionals have failed to take a reasonable position on the human need for intimacy and affection, which at times contributes to a wide array of problems including alcohol abuse, suicide ideation, and unsafe sexual encounters (Depressedd, 2012).

Reparative Therapy

Dr. Ahmed presents the prevalent view within mainstream medical and psychiatry professions that sexual orientation is an outcome of both genetic and environmental factors. He peppers this

viewpoint by drawing out the limitations of the studies that indicate the innateness of sexual orientation. He alludes to theories paraphrased as 'distant father domineering mother' that are generally prevalent amongst reparative therapy professionals. While, Dr. Ahmed questions the stronger peer reviewed studies that support the innateness of sexual orientation, he does not critique the much weaker studies conducted in dubious settings.

Dr. Ahmed alludes to a "recent" study that indicates the influence of teachers in promoting "homosexuality" amongst students. The reference actually mentions Hatterer (1970) that delineates conversion therapy for male homosexuals. Given the dubious techniques (APA task Force, 2009) used by reparative therapists that include suggesting that fathers expose their penis to their young sons (Dobson, 2002) and given that the book was published in a time of immense prejudice against sexual minorities, the study cannot be taken seriously. According to a 1970 national survey more than 70% agreed that "homosexuals are dangerous as teachers because they try to get sexually involved with children", a number that has come down drastically over the years, as there is no scientific evidence that suggests that homosexuals are less likely than heterosexuals in controlling their sexual urges, refraining from the abuse of power, and exercising good judgment in their employment settings (Herek, n.d.).

Dr. Ahmed also alludes to Spitzer's work on successfully changing the sexual orientation of homosexuals. Spitzer (2003) had concluded that reparative therapy could reorient a predominantly homosexual orientation to a predominantly heterosexual one and therefore such therapies should not be banned. However, Grace (2008) summarized the criticisms levelled against Spitzer's controversial study, of which the salient ones are as follows. Spitzer's sample

suffered from the self-selection bias, as religion was important for a majority who were not only associated with reparative therapy but also spoke publicly in its favour. The results of the study were based on self-reporting and hence marred with the associated issues of self-deception, exaggeration and even lying. Moreover, the issues of imperfect recall or poor memory tainted the results as participants were trying to recall events from about 12 years. Above all, Spitzer did not establish a cause effect relationship between changes in sexual orientation and prayer or therapy, a point that has been used by reparative therapy proponents against studies that aim to show the constitutionality of a homosexual orientation.

Spitzer (2003) himself conceded that scientific evidence on the efficacy of reparative therapy based on randomized assignment of individuals to a treatment condition, and valid assessment of target symptoms before and after treatment is not available. In later interviews, Spitzer mentioned that not only was his sample self-selected but he suspected that the vast majority of gay people would be unable to change their orientation. He further opined that perhaps only '3% might have a malleable orientation' and that his study results were being 'twisted by the Christian right' (Robinson, 2002). Given the backdrop of such criticisms, in 2012, Spitzer apologized for his study by stating, 'I owe the gay community an apology … As I read these commentaries [criticisms of the Spitzer study], I knew this was a problem, a big problem, and one I couldn't answer … it's the only regret I have, the only professional one' (Carey, 2012).

There is no scientific evidence for any long-term success of sexual reorientation therapy. There are serious methodological issues in peer reviewed journal articles from 1960-2007 and none of the more recent research from 1999 – 2007 allows to draw any conclusions on the efficacy or

safety of sexual orientation change efforts (SOCE) (APA Task Force, 2009, p. 2). Even Charles Socarides (d. 2005) and Joseph Nicolosi, who helped found NARTH, respectively acknowledge the impossibility of the client giving up the "homosexual need" and that reparative therapy is not for all homosexuals (Grace, 2008). NARTH governing board member, Julie C. Harren (2004) mentioned at the 2004 NARTH Conference that, "attractions and desires are like feelings; they come from deep within us and are not a conscious choice on our part". Freud (d. 1939), whose idea that 'people are born bisexual and can move along the sexuality continuum' forms the foundation of reparative therapy (Carey, 2012), and who viewed "homosexuality" as a developmental arrest, concluded that changing a homosexual orientation was unlikely to be successful (APA Task Force, 2009, p. 21).

According to Dr. Nicolosi, one-third of patients at the Thomas Aquinas Psychological Clinic fail to change, one-third engage in occasional same-sex behavior, whereas the remaining one-third have desires but choose to remain celibate. Essentially, Dr. Nicolosi has admitted to a 100% failure rate of reparative therapy (Robinson, 2006). Jack Drescher, who has treated men who have undergone conversion therapy, actually states:

Many people who try this treatment tend to be desperate, very unhappy and don't know other gay people. I see people who've been very hurt by this. They spend years trying to change and are told they aren't trying hard enough (Robinson, 2006).

Grace (2008) indicates that all major U.S. mental health associations have issued statements warning against the potential harmful effects of reparative therapies on clients. The negative impact of SOCE include depression, hopelessness, loss of faith, deteriorated relationships with

family, poor self-image, social isolation, intimacy difficulties, self-hatred, sexual dysfunction, suicidal ideation, feelings of being dehumanized, increase in substance abuse and high-risk sexual behaviours (APA Task Force, 2009, p. 42, 50). Grace (2008) mentions that both the American Psychological Association in 1997 and the American Psychiatric Association in 1998 have rejected therapies based on the assertion that homosexuality is a mental illness. Excerpts from statements of both organizations on reparative therapy are as follows (Human Rights Campaign, n.d.).

In the last four decades, "reparative" therapists have not produced any rigorous scientific research to substantiate their claims of cure. … The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. … Therefore, the American Psychiatric Association opposes any psychiatric treatment, such as reparative or conversion therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual homosexual orientation. (American Psychiatric Association, 2000)

The American Psychological Association reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation; … concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation; … encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by

promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation… (Anton, 2010)

Despite all the harms alluded to by mainstream psychiatrists that includes suicide (Farley, n.d.), Ahmed (2006) indicates that a clinician must have experience in aversion therapy. Aversion treatments have included shame aversion, systematic desensitization, orgasmic reconditioning and satiation therapy, through methods that include inducing nausea, vomiting, providing electric shocks, having the client snap an elastic band around the wrist upon arousal, prayer, support groups and psychotherapy (APA Task Force, 2009, p. 22, 31). Negative effects of aversive forms of SOCE have included loss of sexual feeling, depression, suicidality and anxiety (APA Task Force, 2009, p. 3).

Indeed, SOCE, whether in the form or reparative therapy or aversion therapy goes against the medical professional's oath of doing no harm as well as the Prophet's teaching paraphrased as 'Do not harm and accept no harm.'

The shift from *liwat* to sexual orientation

Conservative Muslim scholars dehumanize gay men when they view "homosexuality" through the lens of a singular sexual act. Muslim scholar Muhammad Salih Al-Munajjid defines "homosexuality" as follows.

Homosexuality means having intercourse with males in the back passage. This was the action of the accursed people of the Prophet Lot. In Shariah terminology it refers to inserting the tip of the penis into the anus of a male (Munajjid, n.d.).

However, past exegetes and jurists viewed sexual activity between males as based on age and status stratified asymmetrical relationships (Ali, 2006, p. 84). They viewed "homosexuality" through the lens of *liwat,* defined as anal penetration of beardless youth, male slaves (Ali, 2010, p. 11) or those suffering from *ubnah* – an incurable disease that afflicted the anus. In contrast to anal intercourse, *liwat* was viewed as an action that inflicted subordination and humiliation on the receptive partner who submitted for reasons other than pleasure. The insertive partner's desire was viewed as the same which was directed toward women and therefore could be sated with lawful female partners (Ali, 2006, p. 88). Scholars like Zaylai (d. 1342-43) and Sarakshi (d. 1096) stated respectively that people of sound reason coveted both the vagina and anus (Lange, 2008, p. 211). Likewise, Al Nawawi (d. 1278) stated that the male youth is like a woman as his beauty is similar to a woman's beauty and that he is desired as she is desired (Rouayheb, 2005, p. 114).

Past Muslim scholars viewed "homosexuality" based on socio-cultural norms and medical knowledge of their times. They viewed *liwat* and *sihaq* (rubbing of vulvae) as diseases to be cured, based on the medical knowledge of their times as shaped by the Greek physician Galen (d. 200). While the physician Ibn Sina (d. 1037) denied a genetic cause for the disease, which he blamed on imagination (Rosenthal, 1978), Al Razi (d. 925) considered *ubnah* to be genetic in that it was a result of the contest between the female sperm and the male sperm (Zeevi, 2006, p. 38). He prescribed enemas and sensual massages of the private parts, seemingly based on the Galenic model of humoral effect (Zeevi, 2006, p. 38), asserting that the disease if prolonged would be incurable (Rosenthal, 1978). Dawud Al Antaki (d. 1599) explained *ubnah,* through the presence of a boric substance in the veins of the rectum that caused an itch in the anus

(Rouayheb, 2005, p. 19, 20). Jafar Sadiq (d. 765) is reported to have suggested that a person suffering from *ubnah* sit on a chopped off hump of a camel (Juma, n.d.). The physician Al Kindi (d. 873) deemed that *sihaq* was explained by an itch in the labia and Yuhanna Ibn Masawayh (d. 857) indicated that *sihaq* was a consequence of a nursing woman eating celery, rocket, melilot leaves and flowers of a bitter orange tree (Amer, 2009). Likewise, Al Samawuli Ibn Yahya (d. 1180), wrote of the physiological causes of *sihaq* through rationales of coldness, shortness, deficiencies or illnesses of wombs (Habib, 2009, p. 84, 85).

Islamicate medical tracts also indicate that the human body would have a feminine or masculine, active or passive and penetrating or penetrated type of sexuality (Zeevi, 2006, p. 22). As such, past jurists operated with the model that men were the insertive partners, whereas women were the receptive partners. Any deviation from this model was viewed as "unnatural". The religious scholar Al Raghib (d. 1108-09) described a woman sodomizing an effeminate man with a dildo as an ultimate sexual irregularity and explained *sihaq* through the aversion to phallic objects and penetration (Rowson, 1991, p. 68). Daniel Boyarin argues that the word *neqeba* for females in Talmudic Hebrew and Aramaic referred to orifice bearer and that gender was constructed on the basis of penetration and being penetrated (Najmabadi, 2008, p. 292). Likewise, the Qur'an uses the words *dhakr* (active and non-receptive) and *untha* (receptive) for men and women respectively.

The above indicates that it does not seem reasonable to superimpose the framework of *liwat* to understand the concerns of Muslim gays and lesbians. In the absence of developments in psychology, past jurists could not account for sexual orientation. Amidi (d. 1233) stated that

jurists based their opinions on the apparent, as hidden things were left to God (Lange, 2008, p. 193). While they ruled on the issue of *liwat*, they did not consider the issue of same-sex unions, which would have been anachronistically absurd for them.

Muslim scholar Muhammad Shahrur (b. 1938) indicated that the jurists were simply articulating the Weltanschauung or worldview of their times and that therefore, doctrines of the traditional schools of jurisprudence as well as the traditional interpretations of the Qur'an are not binding on modern Muslims as these interpretations and doctrines were based on assumptions based on the knowledge base of their times (Hallaq, 1999, p. 246-251). Thus, the discourse on "homosexuality" has to be shifted from that of *liwat* perpetrated in the context of exploitation and disease to one based on the sexual orientation of a minority with a constitution for the same gender. While some may argue that an identity based on sexual orientation be eschewed, yet identity comprises a coherent sense of spirituality, sexuality, ethnicity, disability, gender and other socio-economic variables (APA Task Force, 2009, p. 60). Moreover, an identity that includes sexual orientation provides self-esteem, belonging and meaning (APA Task Force, 2009, p. 62).

In this context, Dr. Qazi Rahman, a Lecturer at the University of London and co-author of the book *Born Gay: the Psychobiology of Sex Orientation* (Wilson and Rahman, 2005) can be quoted as follows.

As far as I'm concerned there is no argument any more - if you are gay, you are born gay (BBC News, 2008, June 16).

Likewise, Dr. Hashim Kamali from the International Institute of Advanced Islamic Studies in Malaysia has asserted that sexual orientation is increasingly considered inherent by not only science but also *fiqh* (Islamic jurisprudence).

Fiqh and science both confirm that sexual orientation is latent within each individual, emerging in complex interactions between one's biological make-up and early childhood. Current research is pushing slowly but steadily towards the conclusion that sexual orientation is largely inherent (Kamali, 2011, August 11).

The constitutionality of the sexual orientation of gays and lesbians can also be supported on the basis of Ghazali's (d. 1111) assertion that Allah's creations are not subject to the arrows of accident (Kugle, 2003, p. 198). The Qur'an can also be read to note that Allah creates whatsoever He wills and that includes, according to verses 17:84 and 30:22 (Bucar and Shirazi, 2012), those with alternative inner dispositions, as captured by the words *shakila* (manner) and *lawn* (colour).

The connection of "homosexuality" with mental health issues and fatal diseases

Unlike many conservative Muslims, Dr. Ahmed does not appear to invoke conspiracy theories to explain why "homosexuality" was declassified as a mental disorder. Grace (2008) references Friedman (1988) and Drescher (1999) who maintain that the American Psychiatric Association removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM) III for scientific reasons as there was inadequate research to support the pathologization of

homosexuality. Grace (2008) even mentions Nicolosi, who maintains that the declassification of homosexuality as a disorder was driven by the objective of ending social discrimination and based on the recognition that there has never been a guarantee on the treatment of homosexuality.

Over the years, major health and mental health professions (Just the Facts Coalition, 2008) including the American Academy of Pediatrics, have stated that "homosexuality" is not a choice and that it cannot be changed (Healthy Children, 2008). In 2013, the Lebanese Psychological Association affirmed that, "homosexuality is not a mental illness and thus requires no treatment" (Abdesammad, 2013, July 18), and the Lebanese Psychiatric Association strongly opposed SOCE and declared the following.

Homosexuality is not a mental disorder and does not need to be treated ... in itself does not cause any defect in judgment, stability, reliability or social and professional abilities. The assumption that homosexuality is a result of disturbances in the family dynamic or unbalanced psychological development is based on wrong information (Abdesammad, 2013, July 12).

In 2013, the Lebanese Medical Association for Sexual Health released a position statement on SOCE, which included the following excerpt.

Efforts to change sexual orientation are not based on any sound scientific evidence. On the contrary, this practice has been abandoned due to proven failure and serious harmful effects. Dr Spitzer, the father of reparative therapy recanted his position on reparative therapy in 2012. … Based on the above, the Lebanese Medical Association for Sexual Health (LebMASH) urges

healthcare providers in Lebanon to refrain from this unethical and potentially harmful practice. We also urge health care organizations to take a strong position against such practices (Abdesammad, 2013, May 17).

However, Dr. Ahmed associates "homosexuality" with mental health problems and alludes to a "consensus" on this issue based on the articles released in the October 1999 issue of the *Archives of General Psychiatry*. He specifically mentions three references – Remafedi (1999), Herrell et al. (1999) and Fergusson et al. (1999). Herrell et al. (1999) clearly concludes that "the underlying causes of the suicidal behaviors remain unclear…" Moreover, it is not clear whether any of these studies accounted for societal prejudice in their studies. In subsequent studies, societal prejudice is specifically pinpointed as the factor contributing to suicidal behavior. While, Bagley and D'Augelli (2000) associate suicidal behavior with homophobic legislation, Mathy (2002) indicates that changing cultural attitudes appears to be more effective in curbing suicidal behavior.

While enablers of homophobia argue that being gay causes health and social problems (Banks, 2003, p. 11), research indicates that gays, lesbians and bisexuals (GLB) and heterosexuals are equivalent in psychological and psychosocial functioning but that GLB individuals had shorter life expectancy, faced higher health risks and social problems primarily due to the chronic stress of dealing with stigmatization and societal hatred due to homophobia (Bux, 1996; Greene, 1994; Ross, 1978; Cochran & Mays, 1994; Gillow & Davis, 1987; Savin-Williams, 1994; Ungvarski & Grossman, 1999 as cited in Banks, 2003). While being GLB is not harmful to one's physical or psychological health (O'Hanlan, 1995; Remafedi, French, Story, Resnick & Blum, 1998; Ross,

Paulsen & Stalstrom, 1988; Wayment & Peplau, 1995 as cited in Banks, 2003), GLB suffer problems associated with homophobia, which include higher rates of depression, anxiety, substance abuse, loneliness and other psychological distress (Morrow, 1993; Rudolph, 1988; Rudolph, 1989; Ungvarski & Grossman, 1999; Ziebold & Mongeon, 1982; Kehoe, 1990 as cited in Banks, 2003).

The stress caused by homophobia may be worse than other stressors because of the loss of family and friend support systems (Bradford, Ryan & Rothblum, 1994; DiPlacido, 1994; Brooks, 1981; Larson & Chastain, 1990 as cited in Banks, 2003). Among other problems, internalized homophobia results in lower self-esteem, increased feelings of guilt, demoralization, alienation, and isolation (Bux, 1996; Meyer & Dean, 1996; McGregor et al., 2001; Flowers & Buston, 2001 as cited in Banks, 2003). Indeed, repressing feelings and concealing one's homosexuality cause not only unusual stress (Roberts & Sorenson, 1995; D' Augelli, Hershberger & Pilkington, 1998; Ungvarski & Grossman, 1999; Herek, 1991; Sewell et al., 2000; Mays & Cochran, 2001 as cited in Banks, 2003) but also negatively impact physical health (Larson & Chastain, 1990). On the other hand, openness about sexual orientation is associated with better psychological adjustment (Bradford, Ryan & Rothblum, 1994) and self-acceptance has been found to be the largest predictor of mental health (Hershberger & D'Augelli, 1995).

According to the APA (2000), stress related to stigmatization of homosexual orientation explains the differences in the psychological functioning between heterosexual and homosexual individuals (Grace, 2008). A growing body of evidence concludes that prejudice and discrimination are a major source of stress for sexual minorities, known as minority stress, which

is a factor in mental health disparities in some sexual minorities (APA Task Force, 2009, p. 1). Indeed, social stigma and prejudice are main reasons why sexual minorities seek to change their sexual orientation (APA Task Force, 2009, p. 68).

Ahmed (2006) asserts that "young people who are engaged in homosexual behavior are at an increased risk of mental health problems and suicidal behavior." He goes on to list problems that include rejection by family, friends and society, and academic and job related problems. While he states that "hate and rejection will not show anybody the right path," he attributes mental health problems to homosexual behavior instead of societal prejudice. It is important to underscore that "association is not causation" and that it is more reasonable to state that societal prejudice leads to many of the problems observed among gay youth.

A 2008 study prepared for the U.S. Department of Health and Human Services on the prevention of suicide rates amongst LGBT youth directly indicates "stigma and discrimination" as risk factors for suicide (Suicide Prevention Resource Center, 2008). Waldo (1999) indicates that GLB individuals who experience greater heterosexism exhibit greater job withdrawal suicide. High school dropout rates exacerbate employability issues for GLB individuals, who drop out due to verbal and physical harassment (Roberts & Sorenson, 1995) and feelings of isolation (Rivers, 2000). Indeed, sexual minority youth in schools with support groups have reported lower rates of suicide attempts and victimization than those without such groups and such support groups were associated with improved academic performance, safety of sexual minority youth and college attendance (APA Task Force, 2009, p. 78).

Michael Benibgui's (2011) doctoral thesis, as cited by Concordia News (2011, February 2), indicates that compared to their heterosexual peers, suicide rates are 14 times higher among GLB high school and college students and also establishes the link between the stress of being rejected or victimized due to sexual orientation with physiological response through abnormal cortisol activity. Hatzenbuehler (2011) found that GLB youth in the last 12 months were more likely to have attempted suicide compared to heterosexuals (21.5% vs 4.2%) and that their risk of attempting suicide was 20% higher in unsupportive environments compared to supportive ones. Hatzenbuehler and Keyes (2013) found that lesbian and gay youth living in counties with fewer school districts with anti-bullying policies were 2.25 times more likely to have attempted suicide in the past year compared to those living in counties where more districts had these policies.

Dr. Ahmed also associates "homosexuality" with fatal diseases such as AIDS. Specifically, he lumps "homosexuality" with promiscuous heterosexual relationships and drug abuse and states that they lead to fatal illnesses like Hepatitis B and C, AIDS and other STIs. He does not provide a reference for statistics that he provides, which indicate that 60% of new HIV infections occur amongst homosexuals. Two potential issues can be highlighted with regard to these connections.

First, it would be erroneous to equate "homosexuality" with promiscuity. It would be more appropriate to distinguish between monogamous relationships and promiscuity regardless of orientation. There are promiscuous heterosexuals just as there are monogamous homosexuals. In fact much of Islamic law deals with promiscuity amongst heterosexuals under the label of *zina* (illicit sexual intercourse). Furthermore, in the context of Sub Saharan Africa, we would not erroneously associate AIDS with heterosexuals but rather with unsafe sexual encounters. As

such, the association between gay men and HIV infections is irrelevant, specifically, in the context where the risky activity of unprotected anal sex is absent. Not all gay men indulge in anal sex just as several heterosexuals indulge in anal sex. In fact, according to Shii jurisprudence, anal sex is permissible with one's wife with her approval albeit it is strongly disliked (Lankarani, n.d.). While anal sex is deemed forbidden in Sunni jurisprudence, queries on various online Islam Q&A websites indicate how husbands pressure wives for anal sex (Islamweb, n.d.), and threaten them with divorce for not complying with their demand (Fathimath, 2013). A sex columnist writes on the distinction between anal sex and being gay as follows.

Many gay men do not have anal sex. In fact, oral sex and mutual masturbation are more common than anal stimulation among gay men in long-term relationships. … Studies indicate that about 25 percent of heterosexual couples have had anal sex at least once, and 10 percent regularly have anal penetration (Alice! Health Promotion, 1996, May 10).

Second, a distinction needs to be made between gay men and "men who have sex with men" (*MSM)*, as the statistics for gay men with HIV infections might be conflated due to the failure to distinguish between. This is an important point as usually MSM are not necessarily gay. Such people indulge in homosexual acts for a wide variety of reasons that could include making quick money (Kort, 2014), or perhaps drugs. Furthermore, they might indulge in homosexual acts in the absence of access to women in prisons or in heavily gender segregated cultures. Alhamad (2013) has reported that in a closed culture as Saudi Arabia, childhood sexual abuse, especially by relatives, is prevalent and which potentially affects sexual behavior to the extent that some victims engage in anal intercourse with their wives or other males, as a form of misdirected

revenge. Nadya Labi (2007) evokes this point through the experience of a Filipino expatriate in Saudi Arabia as follows.

Francis … reported that he's had sex with Saudi men whose wives were pregnant or menstruating; when those circumstances changed, most of the men stopped calling. "If they can't use their wives," Francis said, "they have this option with gays."

HIV and other diseases cannot be associated with sexual orientation. Several reasons explain the increased rates of HIV and AIDS in GLB individuals. First, given that GLB individuals resort to illicit drug and alcohol use due to societal rejection and since illicit drug and alcohol users often engage in unsafe sex, GLB individuals contract HIV/AIDS (Ostrow, 2000; Rosenberg et al., 2001 as cited in Banks, 2003). Second, GLB individuals with higher internalized homophobia engage in risky sexual behaviour at a greater rate than GLB individuals with lower internalized homophobia (Meyer and Dean, 1996; O'Hanlan et al., 1996 as cited in Banks, 2003), as they were less affiliated with the GLB community and therefore had less access to safer sex information and resources (Williamson, 2000). Third, GLB who live at the margins of society are more vulnerable to HIV/AIDS (Peersman, Sogolow and Harden, 2000) and finally, negative life events, depression and anxiety have been found to be predictors of risky sexual behaviours (Graham, Kirscht, Kessler and Graham, 1998; Lesserman et al., 2000 as cited in Banks, 2003).

According to groups that work on HIV prevention, it is stigma and discrimination that drives sexual activity underground thereby increasing the probability of HIV infections (Global Health Council, n.d., Avert, n.d.). Research conducted at San Francisco State University found that compared with LGBT young people who were not rejected by their parents, highly rejected

LGBT young people were 8 times more likely to attempt suicide, 6 times more likely to report high levels of depression, 3 times more likely to indulge in substance abuse and 3 times more likely to be at high risk for HIV and STIs (Human Rights Campaign, n.d.). Likewise, Cole, Kemeny, Taylor and Visscher (1996), as cited in Banks (2003), found for their sample that incidence of cancer and moderately serious infectious diseases increased in direct proportion to the extent to which homosexual identity is concealed.

The equation of "homosexuality" with alcoholism, illicit sexual intercourse and the prescription of life-long celibacy

Dr. Ahmed states that even if it is argued that alcoholism and obesity are genetically determined the posited solution is that of self-control. In a similar vein he prescribes restraint for gays and lesbians. He further states that people who indulge in homosexual conduct are committing a sin analogous to illicit sexual intercourse. Thereafter, he states that an individual can live a normal life without marriage or without any sexual conduct. Essentially, by comparing homosexual conduct with alcoholism and illicit sexual intercourse, he is prescribing celibacy to gays and lesbians. However, there are problems with these analogies.

Based on analogical reasoning, jurists like Abu Hanifa (d. 767) and Ibn Hazm (d. 1064) rejected the analogy of *liwat* with *zina*. Abu Hanifa reasoned that the anus was not a *faraj* - (sexual organ) and that in *liwaṭ* the attraction is one sided in contrast to *zina*. Ibn Taymiyyah (d. 1328) reasoned that in the absence of *ubnah* or financial reasons, the receptive partner did not desire *liwat* (Ibn Taymiyyah, n.d.). Razi (d. 1209) reasoned that *liwat* led to hatred and humiliation and

might lead the passive partner to kill the active partner (Razi, n.d.). Past jurists emphasized that, in contrast to *liwat*, *zina* included the danger of procreation for a child born outside a legally sanctioned relationship and whose pedigree would be eternally disputed, may grow up without a father (Lange, 2008, p. 210). Furthermore, they argued that *liwat* was half as less widespread than *zina* for there was only one solicitor in the act, as they assumed that males generally do not desire to be penetrated (Lange, 2008, p. 212).

According to Ibn Hazm (d. 1064) Allah has not forbidden anything without providing better lawful substitutes (Ibn Hazm. n.d.). Ibn Qutayba (d. 884) indicated that while God prohibited fornication, usury, wine, gambling and swine, He respectively allowed marriage, trade, many beverages, competitive sport, and the flesh of non-predatory beasts and birds (Mahfazah, 2012). This suggests that if marriage has been allowed in lieu of fornication, then the prescription of permanent celibacy not only imposes undue hardship but also binds gay Muslims without a reasonable alternative, which violates the Islamic ethos of human dignity and justice. While some may argue that marriage to an opposite gender spouse could be the alternative that the Sharia offers gay Muslims, such a false marriage violates the Islamic ethos of justice for both the gay and the straight spouse.

Likewise, the comparison of "homosexuality" with alcoholism does not seem reasonable as a basic intimacy need for which there exist no alternatives cannot be compared to an addiction. Furthermore, while the harms of alcoholism may be compared with those of heterosexual or homosexual unsafe sexual encounters, such an equation fails with monogamous long-term same-

sex relationships. Indeed, in contrast to depression and alcohol dependence, homosexuality does not cause marked distress or impairment (Carey, 2012, May 18).

Moreover, it is minority stress of dealing with stigmatization and societal hatred that drives GLB individuals to alcoholism and substance abuse. According to Alderson (2001), as cited in Banks (2003), not accepting one's sexuality due to homophobia may be causally related to higher incidence of alcohol abuse in the gay community. Likewise, Williamson (2000) asserted that internalized homophobia in GLB individuals results in alcohol abuse. Based on seventeen studies, Banks (2003) indicates that the percentage of GLB individuals who indulged in alcohol abuse ranged from 7% to 59% with 18% as the mean. GLB individuals were found to be 0.94 times to 7 times as likely as the heterosexual control sample to abuse alcohol. The median in this regard was found to be 1.7 times. Likewise, based on meta-analyses, King et al (2008) found that compared to heterosexuals, GLB individuals were twice as likely to attempt suicide, 1.5 times more likely to have depression and anxiety disorders, and 1.5 times more likely to indulge in alcohol and substance abuse. It is therefore not surprising that a poster at an online Islamic site indicated that struggling with his sexuality he tied a noose around his neck, indulged in alcohol, acquired an STI, fasted every day, deleted his music collection, distanced himself from friends, went back and forth and ended up being quite depressed (Depressedd, 2012).

Finally, the prescription of celibacy does not seem reasonable as Islam recognizes basic human sexual need and provides the legitimate avenue of marriage to satisfy emotional and physical needs. No Qur'anic verse indicates that procreation is the teleology of marriage for the purpose of marriage, based on verse 30:21, is rather tranquility, compassion and *mawaddah* (affection)

between spouses (Menyawi, 2012). Many jurists defined the purpose of marriage not through procreation but through sexual enjoyment (Ali, 2003, p. 179). In fact, in the Prophetic tradition, sex within wedlock that leads to tenderness and care is also viewed as a form of charity.

An excerpt from a popular Islamic site in the context of widows and divorced women is quite relevant to the case of Muslim gays and lesbians.

Do we really imagine that by providing only food, clothing, and shelter to widows and divorced women that all their needs in life are met, and they can live locked away from intimate interaction with the opposite sex - forever? … How could a human being, let alone a Muslim, suggest such a lifestyle for a fellow human being - especially when it's a lifestyle they don't accept for themselves? (Umm Zakiyyah, 2014).

For many people permanent celibacy is not feasible, therefore, by asking gays and lesbians to remain abstinent for their whole lives we are essentially ensuring that they either fail to live up to that standard or suffer the mental consequences of such a prescription. The spiritual struggles of those dealing with homosexual orientation include coping with intense guilt due to the inability to stop committing unforgivable sins (APA Task Force, 2009, p. 46-47). Such spiritual struggles have been associated with anxiety, panic disorders, depression, suicidality and while a minority of research participants have been willing to make sexual abstinence a life goal, it has not always worked in the long-term even for them and the negative impacts of electing celibacy have included depression and loneliness (APA Task Force, 2009, p. 47, 61). Even a conservative scholar as Abdul Hakim Murad acknowledges that given that long term abstinence fails for most individuals, as they are not super moral figures; most Muslims with a same-sex orientation

would commit transgressions (Ali, 2006, p. 88). Another scholar counsels against fighting nature through a celibate lifestyle (Amjad, 1997). Thus, if Muslim scholars accept that permanent celibacy is against human nature and increases the probability of committing sins, then would it not be reasonable to apply the same logic for gays and lesbians?

Prescriptions that ignore legitimate human needs lead to *taklif ma la yutaq* (creation of obligations that cannot be met). The jurist Shatibi (d. 1388) recognized that some human dispositions are so inherent that to deny them would be to harm human beings irreparably (Emon, 2010, p. 175). Likewise, Hallaq notes that none of the attributes that a man is born with is subject to adverse legal rulings (Hallaq, 1999, p. 182). This substantiates rejecting the prescription of permanent celibacy for Muslim gays and lesbians.

The three scriptural texts

Dr. Ahmed, bases his views on the prohibition of "homosexuality" by referencing two sets of verses, 26:160-75 and 7:80-81 and a Hadith. However, it is important to note that the words 'fornicate' in verse 26:265 and 'adultery' in verse 7:80, as quoted by Dr. Ahmed, are improper translations of *atatoona* (approach) and *fahisha* (enormity) respectively. Had the Muslim jurists understood these words as alluding to adultery, they would not have disagreed on the penalties they prescribed for *liwat.* Stripped from their context, the principal verses that are usually quoted by conservative Muslims are as follows.

Most surely you come to males in lust besides females; nay you are an extravagant people (Qur'an, 7:81)

What! Do you come to the males from among the creatures? And leave what your Lord has created for you of your wives? Nay, you are a people exceeding limits (Qur'an, 26:165-166)

The key phrases used in these verses are *atatoona L-dhukrana* (26:165) or *latatoona L-rijjala* (7:81 and 27:55) both of which refer to approaching the men, and *L-nisai* (7:81), which refers to the women. The definite article *L* (the) is used to particularize both men and women, which may specifically refer to the travelling men visiting Sodom and the wives of the people of *Lut* (Lot) respectively. The synonym of the word *rijjala* in verse 7:81 is *dhukrana*, as used in verse 26:165, and which according to the classical Arabic dictionary *Lisan Al Arab* means 'male', 'male genital', 'hard/harsh' or 'non-receptive'. Likewise, the synonym for the word *nisa* in verse 7:81 is *untha* which has the connotation of 'female, 'female genital', 'soft' or 'receptive'. Thus, it would be reasonable to elicit the understanding that the Qur'an is admonishing the people of *Lut* for approaching men, specifically the travelers, who are non-receptive to their advances, instead of women, specifically their wives, who may be more receptive to their advances. Such a one-sided sexual pursuit of a non-willing partner constitutes rape, as consent is absent on the receptive partner, a point assumed by the past jurists. As such, superimposing the verses on the people of *Lut* onto Muslim gays and lesbians is unreasonable and unjustified.

Apart from the two sets of verses, Dr. Ahmed presents a Hadith text, which indicates that Allah has cursed the one who engages in bestiality and *liwat*, to substantiate his view on the prohibition of "homosexuality." However, the collection on Hadith narrators *Tahtheeb Al Kamal* indicates severe/clear weaknesses in the transmission chain of this text. The narrators Ikrimah (d. 723-24) and Amro Bin Abi Amro have been deemed untrustworthy or weak by past Hadith experts like

Sa'id Ibn Al Misayeb (d. 715), Malik Ibn Anas (d. 795), Abu Dawood (d. 889), Yahya Ibn Ma'in (d. 233 AH/847), Bukhari (d. 870) and Muslim (d. 875) amongst others (Tahtheeb Al Kamal, 2004).

Hadith texts on "homosexuality", some of which are eschatological in nature, have the Prophet prescribe the death penalty for *liwat*, define *liwat* as adultery, or portentously express concern on Muslims engaging in *liwat*. However, even conservative Muslim scholars like Shinqiti (2008) have questioned the authenticity of these texts, specifically of those that have the Prophet prescribe the death penalty for *liwat*. While, a detailed analysis of these texts is beyond the scope of this article, it is important to note that these texts are not found in the more celebrated works of Bukhari and Muslim because of the strong doubts that both these and other Hadith authorities have raised on these texts.

Since, Dr. Ahmed only quoted two sets of verses and a Hadith, analysis of other verses and Hadith falls outside the scope of this article. While readers are encouraged to explore works like Kugle (2010) and Menyawi (2012), a brief case for Muslim same-sex unions is delineated below as an alternative to the prescription of permanent celibacy.

The case for Muslim same-sex unions

The analysis of the Qur'anic verses, Hadith texts, and rulings of the past jurists indicates that the case for the prohibition of same-sex unions is not reasonably justified. The prohibition of anal sex is not textually substantiated and rests on the argument to prevent harm to the wife, a point confirmed by the conditional permissibility of this act in Shii jurisprudence. The analysis of the

Qur'anic verses shows the stark difference between gays and lesbians and the people of *Lut*, whose actions include inhospitality, ambushing travelers, evil deeds in public assemblies, and forcibly accessing *Lut's* guests. Texts from the exegetical literature substantiate the point that *Lut's* people sexually subjugated males. The analysis of the Hadith texts indicates how terms like *liwat* are a product of later juristic thought, which further weaken the credibility of these texts.

The rulings of the past jurists indicate that the reprehensibility of *liwat* is based on extra-textual assumptions that were informed by the socio-cultural mores and medical knowledge of those times. Specifically, *liwat* was viewed in the context of beardless youth and men suffering from *ubnah*, a disease of the anus, whose diagnosis is foreign to Islamic texts. Furthermore, *liwat* was viewed as one-sided and one bereft of not only love and intimacy but also from desire and pleasure. Past jurists viewed the desire to penetrate the anus of a beardless boy or *ma'bun* (receptive partner suffering from disease) as consistent with the desire to penetrate the vagina and therefore felt that intercourse through marriage would be sufficient for those engaged in *liwat*. They ruled on anal intercourse outside the folds of a legal contract by males who could have satisfied their desires with women. However, the question of a legal contract for same-sex couples has not been addressed in Muslim jurisprudence.

In order to legitimize Muslim same-sex unions, the discourse has to be shifted from one based on whims to indulge in *liwat* to one that acknowledges the constitutional orientation of a minority of Muslims. Such an orientation can be accepted on the basis of the fact that Muslim scholars have accepted the inner constitution of the *khuntha mushkil* (intersex persons) irrespective of external features. Acknowledging the exclusive orientation of a minority group of Muslims, the definition

of marriage as a legal contract and the juristic precedent of allowing for the marriage of the *khuntha mushkil,* substantiates the case for Muslim same-sex unions. This case can be justified as an *ijtihadi* (independently reasoned) opinion through the framework of *maslaha* (public interest) and the principle of *raf al harj* (alleviating hardships), both of which are based on upholding human dignity and justice. Indeed, the promotion of human dignity is an overriding objective of the Sharia along with justice, equality, realization of lawful benefits for people, prevention of harm and removal of hardship (Kamali, 2005a, p. 166).

According to Menyawi (2012), past-jurists were able to go against the grain of their societies based on the principle of *adl* (justice) as opposed to explicit Qur'anic backing and jurists like Tufi (d. 1316), Abduh (d. 1905) and Rida (1935) advocated deriving rules even if they were not directly confirmed by the texts. According to Tufi if the rules derived from the *nass* (clear text) do not uphold the good then the texts have to be reinterpreted (Emon, 2010, p. 162). Indeed, Ali notes how past jurists bypassed even clear Qur'anic verses based on interpretive devices (Ali, 2006, p. xxi). Likewise, Kamali asserts that even if no specific authority is found for the purpose of justification (Kamali, 2005b. p. 48), efforts for justice will always be in harmony with the Sharia (Kamali, 2005a, p. 174). Furthermore, he asserts that some jurisprudential rulings of earlier times may now be deemed unjust due to a different set of circumstances (Kamali, 2005a, p. 169, 175). According to Kamali, the legal maxim that *ijtihad* (independent reasoning) is irrelevant in the presence of a *nass* should be revised because of the possibility of fresh interpretation in a different context (Kamali, 2005a, p. 158).

Since the Qur'an refers to marriage as *mithaq ghaliz* (firm covenant) in verse 4:21 (Menyawi, 2012), matrimonial laws fall in the category of *muamalaat* (social transactions) (Kamali, 2005a, p. 151), which are subject to changes based on changing social conditions. According to jurists of the Hanbali school, one of the four in Sunni jurisprudence, in the absence of a clear text that prohibits contracts, the normative position on contracts including marriage is *ibaha* (permissibility) and therefore, on the basis of Qur'anic verse 4:19 that teaches that contracts be based on mutual consent, and given that consent alone creates binding rights and responsibilities (Kamali, 2005a, p. 162), the case for Muslim same-sex unions can be supported.

Muslim same-sex unions can be based on the values espoused by the Qur'an on marriage. In verses 30:21 and 2:187, the Qur'an views marriage as forming the basis of *mawadda* (affection), *rahma* (compassion) and as an institution through which spouses find tranquility and companionship as they become a *libaas* (protective garment) to each other, guarding their dignity and honour (Kamali, n.d.). Such unions can also be supported on the basis of verse 9:71 that depicts mutual protectorship of men and women and verse 2:187 that depicts cooperation and harmony between them (Ali, 2006, p. 183). Thus, given that the Qur'an allows marriage for the purpose of contentment, *mawadda* (affection) and compassion, and given that sterile couples and elderly women are allowed to get married, there seem no reasonable grounds to prohibit the realization of these benefits for same-sex couples.

In recent developments, Muslim academics Omid Safi and Mohammad Fadel have expressed support for same-sex marriage in a secular North American context. Safi expressed his support as follows.

I have seen these families show the same love, affection, and attention on their children that my own heterosexual family does. Love is love. Family is family, though they come in different shapes. My children have gay and lesbian friends. They belong to a social club at school that is an alliance of straight, gay, lesbian, and bi-sexual students (Safi, 2013).

Likewise, in the context of the 2012 elections in the U.S., Fadel expressed.

We can support the idea of same-sex marriage because what we want is to make sure that all citizens have access to the same kinds of public benefits that other people do … Islamic law can at least qualify the endorsement of the idea, at least in the context of democratic, non-religious states (Jahangir, 2013, March 28).

In Indonesia, Dr. Siti Musdah Mulia and other Muslim scholars were reported to have concluded that same-sex orientation was from God and that same-sex relationships were permissible in Islam (Khalik, 2008). Muslims for Progressive Values (MPV) in the U.S. and Universalist Muslims in Canada have come out in full support of same-sex unions. Pamela Taylor of MPV stated that condemning gay Muslims to celibacy would go against the "fundamental Islamic ideals of fairness, equality of all human beings, compassion and mercy" (Jahangir, 2012). Progressive Muslims of varying theological backgrounds have created spaces that are inclusive of LGBTQ Muslims, such as the El Tawhid Juma Circle Unity Mosques, MPV Unity mosques and Inclusive Mosque Initiatives (Jahangir, 2013, Marh 13).

Concluding Remarks

Dr. Ahmed passes a value judgment that young Muslim adults should not try to make "homosexual" conduct compatible with Islam. He comes to this conclusion due to his understanding of the Muslim scriptures and his reading of the scientific literature. Similar opinions continue to be upheld by conservative Muslim professionals and leaders. Consequences of the intransigent opinions of Muslim community leaders include the severe cognitive dissonance experienced by Muslim gays and lesbians, as witnessed in online forums where Muslims struggling with their sexual orientation and faith seek counsel. Therefore, Dr. Ahmed's approach that holds currency amongst conservative Muslim leaders deserves to be thoroughly critiqued.

While mainstream psychiatrists reject reparative therapy, even practitioners of reparative therapy concede the failure of their techniques in changing sexual orientation. Eventually, reparative therapists, like Dr. Ahmed, prescribe celibacy as the solution. However, permanent celibacy is a value foreign to Islam and is rejected as a solution for Muslim gays and lesbians. Furthermore, in contrast to Dr. Ahmed's approach, "homosexuality" cannot be associated with promiscuity, AIDS, mental health issues and illicit sexual intercourse. Moreover, it would be unreasonable to superimpose the framework of *liwat,* defined as anal penetration of beardless youth, male slaves, or those suffering from *ubnah* (incurable disease of the anus), onto Muslim gays and lesbians. The two sets of verses and the Hadith quoted by Dr. Ahmed were shown to posit no relevance for Muslim gays and lesbians. Finally, a brief case for Muslim same-sex unions was delineated along with recent developments in Muslim communities in support of Muslim gays and lesbians.

Given the innateness of sexual orientation, disavowal of celibacy, rejection of analogies with adultery and promiscuity, the distinction between *Lut's* people and Muslim gays and lesbians and given the richness of Muslim jurisprudence, we invite Muslim scholars to dispassionately study the issue, which has hitherto been addressed with erroneous assumptions and misinformation. We invite them to investigate the issue on the basis of a higher ethic based on the teachings of the Prophet. In this context, the Prophet's teachings can be paraphrased as 'Do not harm and accept no harm', 'wish for your brother what you wish for yourself', 'when some Muslims hurt other Muslims ache', 'facilitate, do not cause difficulties or cause people to detest the law' and 'do not fall into extremities but seek the middle path'.

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