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Gay Rights, Patient Rights: The Implications of Sexual Orientation Conversion Therapy

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Therapies designed to change sexual orientation have come under increasing scrutiny from the profession and the public. The proposition that sexual orientation can be changed therapeutically is widely questioned, and there is concern that such therapies reinforce social devaluation of homosexuality and bisexuality. At the same time, conservative religious individuals wish to seek treatment appropriate to them, which may include attempting to change or control sexual orientation. The ethical questions and clinical and social implications of this complex issue are discussed. Guidance to practitioners interested in this issue is offered, including references to policies of the American Psychological Association.

When homosexuality was declassified as a treatable mental disorder nearly 30 years ago, it was assumed by many that the popularity of treatments intended to change sexual orientation would come to an end. At that time, treatments intended to change homosexual orientation, known as *sexual orientation conversion therapy*, were discounted by organized psychology and psychiatry as the last vestiges of an antiquated, prejudicial view of homosexuality. Although conversion therapies are marginalized in mainstream mental health organizations, they are experiencing a "renaissance" of sorts at present. There are several reasons for this. First and foremost, despite the dramatic changes in the ways that lesbians, gay men, and bisexual (LGB) men and women are viewed culturally, there remains a segment of society that rejects the notion that an LGB orientation is a normal variant of human sexuality. Some proponents of conversion therapies portray homosexuality as freely chosen and changeable, which appeals to those who would limit civil rights protections for LGB individuals. This position was reinforced by a high-profile advertising campaign designed to persuade ambivalent gay male and lesbian individuals that their unwanted homoerotic feelings can be changed (Haldeman, 1999).

There is another aspect, however, to the continuing discussion about the therapeutic modifications of sexual orientation having to do with individuals' religious and spiritual identities. The major mainstream mental health organizations have all issued policy statements affirming that homosexuality is not a mental disorder and disavowing treatments based upon this premise. Diversity in religious expression is also supported by organized mental health. So what of the individual whose religious beliefs are at odds with an LGB orientation? Should practitioners always view such individuals as having simply internalized homophobic doctrine and therefore limit access to the treatment that may facilitate an adaptation to a more ego-syntonic style of living on the basis of religious beliefs? How are the rights to treatment of such individuals supported without negating the gay-affirmative stance of organized mental health and endorsing homophobic treatments? These are the difficult questions around which the discourse on sexual orientation conversion therapy has lately centered and which the present discussion will attempt to address.

Historical Overview

There are a number of reviews (Drescher, 1998; Haldeman, 1991, 1994; Murphy, 1992; Stein, 1996) that examine numerous studies of treatments for homosexuality and their outcomes. Such treatment programs spanned a wide range of psychological interventions, from behavioral methods to psychoanalytic approaches. The most notorious behavioral approaches were aversive treatments, including the application of electric shock to the hands and/or genitals, or nausea-inducing drugs, which would be administered simultaneously with the presentation of homoerotic stimuli. Less cruel methods included masturbatory reconditioning, visualization, and social skills training. All had as their theoretical basis the premise that homosexual orientation was the result of learned behavior, which could be reconditioned through various means.

Psychoanalytic theories, still promoted by some advocates of conversion therapy, suggest that homosexuality constitutes a form of arrested psychosexual development. According to this notion, lesbians and gay men suffer from an incomplete bond and resultant identification with the same-sex parent, which is then symbolically repaired in psychotherapy (Nicolosi, 1991). Although this notion has gained some legitimacy with the ex-gay movement, there has never been sustained empirical support for this perspective. Finally, there are spiritual interventions used by "ex-gay" ministry groups designed to rid the individual of his or her sexual orientation through prayer and group support and pressure. Descriptions of these groups are generally absent from the professional literature, but this modality is thought to be one of the most common for individuals seeking to change their sexual orientation.

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Empirical Findings

What constitutes sexual orientation change? This basic question is addressed to varying degrees in studies of conversion therapy. In some reports, the eradication of same-sex fantasies and behavior are the criteria for sexual orientation change. In other studies, the criteria are far more lenient. Typically, conversion therapists expect that patients' homoerotic fantasies may continue but that they will be able to manage the fantasies so that they may legitimately claim a heterosexual identity, or at least function in a heterosexual relationship. Yet another option that some religious and pastoral counselors might advocate is celibacy. This option does not permit any interpersonal sexual expression at all, but it is thought of as preferable to the sin of homosexuality in some religious contexts.

Most studies purporting to demonstrate sexual orientation change focus heavily on personal testimonials. There is, of course, a place for personal reflection in the discussion of sexual orientation and whether or not it can be changed. Personal experience alone, however, does not enable us to judge favorably or unfavorably the efficacy of conversion therapies. We can infer that there appear to be many dissatisfied homosexually oriented individuals who seek psychological guidance or spiritual intervention to achieve a goal they identify as a change in sexual orientation. The source of this dissatisfaction is unclear. Most LGB theorists and other professionals would attribute it to the internalization of social stigma, whereas others would suggest that the discomfort derives from a basic incompatibility with personal religious beliefs, given the high proportion of strongly religious individuals in most conversion therapy samples.

Foremost among methodological problems with conversion therapy studies is sampling bias. It is nearly impossible to obtain a random sample of research participants who have been treated for their sexual orientation, and it is equally as difficult to assess outcomes in a way that does not contaminate the scientific process with social bias. This makes it difficult to make meaningful generalizations about these treatments. Nonetheless, without nonrandom surveys, there would probably be scant data on any aspect of sexual orientation, given the difficulty in accessing participants who are willing to be surveyed about their sexuality.

Critiques of the conversion therapy literature (Haldeman, 1994, 1999; Stein, 1996) show that sampling bias is but one of several methodological problems with studies of therapeutic interventions to change sexual orientation. Response bias is a major issue because of the social and cultural pressure experienced by both patient and therapist/evaluators. Research participants classified as "homosexual" are often more appropriately categorized as bisexual (Masters & Johnson, 1979). A more recent study (Nicolosi, Byrd, & Potts, 2000) reported that 34% of 882 participants, 96% of whom identified as placing great importance on religion or spirituality, indicated that they had made significant shifts toward heterosexuality after some form of conversion therapy or pastoral counseling. As is the case with similar studies, however, these results are not generalizable beyond the sample because of the sampling method (advertisements in religious newsletters, word-of-mouth through conversion therapists). Finally, few of the conversion therapy studies offer any follow-up data. This might be of particular interest, considering the fact that most conversion therapy studies claiming success in changing sexual orientation only report a 30% success rate.

Some authors have observed that the lengthy history of conversion therapy focuses only on that third of participants who report change in sexual orientation. Given the complexity of attempting to change something as deep and personal as sexual orientation, it would be reasonable to wonder if the large number of participants who failed in their treatments might have been harmed in some way. The reports of harm done by conversion treatments, however, are subject to the same methodological limitations as those affecting studies purporting to show a positive treatment outcome. In 20 years of clinical experience with individuals who have been through some form of sexual orientation conversion therapy, I have noted that different patients manifest different responses to their treatments. For some, particularly those who have been made vulnerable by repetitive, traumatic anti-gay experiences, or those who have been subjected to aversive treatments, conversion therapy has proved to be harmful. Typical negative sequelae of conversion therapies include chronic depression, low self-esteem, difficulty sustaining relationships, and sexual dysfunction (Haldeman, 2002). For other individuals, particularly those who are more resilient or have experienced less invasive styles of conversion therapy, the effects may not be adverse, or at least temporarily so. Recent qualitative research (Beckstead, 2001; Shidlo & Schroeder, 1999) has suggested that conversion therapy produces mixed results and that participants report a wide range of posttreatment aftereffects. Additionally, these researchers have reported that the actual methods and theoretical perspectives of conversion therapists vary widely. Finally, the above studies have indicated that social factors bear a strong influence on individuals seeking to change their sexual orientation through therapy.

Conversion Therapy in a Social Context

From the perspective of LGB theorists and activists, the question of conversion therapy's efficacy, or lack thereof, is irrelevant. It has been seen as a social phenomenon, one that is driven by anti-gay prejudice in society and anti-gay prohibitions in religious organizations. These attitudes, once internalized by an individual, may lead to self-negation and fears of a compromised life as an LGB person—including the possibility of discrimination and violence, rejection from family, and social marginalization. As long ago as 1975, conversion therapy was criticized by gay activists on the grounds that it "constituted a significant causal element in reinforcing the social doctrine that homosexuality is bad" (Begelman, 1975). It is on this basis that gay activists objected to conversion therapies. The question persisted regarding homosexuality, which had been dismissed as a mental illness some years earlier by the organized mental health professions: Why do we continue to provide a cure for that which has been judged not to be an illness? We do not see parallel treatment programs offered for dissatisfied heterosexuals, so how can this be other than a phenomenon calling for treatment of social influences, not individuals?

One of the first researchers to examine the ethical implications of conversion therapy was Davison (1991), who had been an advocate of "Playboy" therapy for homosexual men in the sixties. At the time, he had developed a method of treating homosexuality that relied on the pairing of homoerotic material with an aversive stimulus and on the cessation thereof with heteroerotic material. At a meeting of the American Association for Behavior Therapy in

the early seventies, Davison experienced his own "conversion" of sorts, leading him to conclude that dissatisfaction with (homo)sexual orientation was likely a function of internalized social stigma. Davison's work then shifted to focusing on the social factors involved in requests to change sexual orientation, viewing efficacy studies of conversion treatments as irrelevant.

Nevertheless, a systematic study of motivations of those who seek to change sexual orientation is only now being included in research protocols. Although it has been hypothesized that social pressure conspires, in varying degrees and from a variety of sources, to propel people into conversion therapy, any effort to assess this has been absent from the conversion therapy literature. This can be attributed to two factors: First, most programs of conversion therapy operate under the a priori assumption that homosexuality is undesirable. Therefore, unhappy individuals are automatically accepted into treatment without a careful inquiry as to their motivations. Second, it is difficult to obtain an accurate reading of individuals' true motivations in an area so affected by social desirability and response bias. Some participants may have a difficult time articulating their motives, even to themselves. Yarhouse (1998) defended the rights of some clients to choose conversion therapy because homosexuality is inconsistent with their "values framework." This, however, raises some questions: From where is our "values framework" derived if not from the world around us? In the case of those who have internalized cultural prohibitions about homosexuality, is it not more responsible to provide treatment that neutralizes the negative effects of such prohibitions than to try and change an individual's sexual orientation? The first task of the practitioner who works with patients on questions of sexual orientation is a careful assessment of motive.

The personal has lately become political in the context of conversion therapy. In 1998, a series of advertisements promoting conversion therapy featured persons who claim to have changed their sexual orientation. The theme of these ads, that "the truth can set you free," caused significant debate on the issue of changing sexual orientation. Many gay rights advocates feared that the ads might fuel anti-gay sentiment, indirectly increasing the likelihood of anti-gay violence. One recent examination of the ex-gay movement's impact on civil rights found that

> the ex-gay movement poses a significant new threat to efforts to secure civil rights for gay/lesbian/bisexual/transgender people. By using the ex-gay movement to convince people that lesbian, gay and bisexual people can become heterosexual, the Christian Right aims to foster the development of a restrictive legal environment in which only heterosexuals have legal rights. (Kahn, 1998, p. 4)

Janet Folger, the promoter of the ex-gay advertising campaign, stated that its purpose was to "strike at the assumption that homosexuality is an immutable trait" (Hicks, 1999, p. 509).

Some advocate for conversion therapy on the basis of individual choice, taking care not to pathologize any form of sexual orientation or religious expression. Others would conclude, as evidenced by the fact that some people claim that their sexual orientation can be changed by therapy, that LGB people do not need protection under antidiscrimination laws. This line of reasoning suggests that unlike other minority groups, LGB people can choose to change their minority status; therefore, they do not constitute a group or class deserving of protection. The question of whether same-sex orientation is a behavioral "choice" or whether it is an innate and immutable trait is complex and would be answered differently relative to one's experience of essentialist or social constructionist belief. As regards civil rights, however, the question may not be relevant, given that there are legal precedents for protecting people on the basis of their choices, including the exercise of religion.

Spiritual/Religious Identity and the LGB Client

The rights of individuals to their diverse experiences of religion and spirituality deserve the same respect accorded sexual orientation. For some, the experience of religious or spiritual identity is as deeply felt, and as highly valued, as the experience of sexual orientation. Miranti (1996) suggested that "the spiritual and/or religious dimensions inherent in each individual could possibly be the most salient cultural identity for a client" (p. 117). In some circumstances, it is more conceivable, and less emotionally disruptive, for an individual to contemplate changing sexual orientation than to disengage from a religious way of life that is seen as completely central to the individual's sense of self and purpose. The reasons for this are not entirely clear, although it is certainly true that gay male and lesbian individuals raised in religious environments are subject to the same influences on their psychosocial development as are others. Religion for many families provides a context for making sense of life, for offering comfort in difficult times, and for creating a context in which the family and society are valued. For gay men and lesbians, the lack of external social support can foster a tendency to turn '"inward" in the spiritual sense, as a means of finding solace (Haldeman, 1996). For these reasons, religion can serve as a central, organizing aspect of identity that the individual cannot relinquish, even if it means sacrificing sexual orientation in the process.

The prohibitions against homosexuality in numerous Judeo-Christian religious traditions are well documented (Haldeman, 1996). Because some religious institutions hold power over their congregants, the psychological effect of anti-gay religious doctrines can be devastating on lesbians and gay men. This is the primary cause for the antireligion backlash that exists in the LGB community. It has been noted that it is easier for some individuals to come out as lesbian or gay men in their communities of faith than it is to come out as spiritually or religiously oriented in the LGB community. Frequently, LGB individuals who have a strong spiritual inclination seek out religious communities that affirm and welcome people of all sexual orientations. This solution, however, is not always applicable for individuals who are strongly rooted in their original communities of faith.

However this distinction between religious identity and sexual orientation may be viewed, psychology does not have the right to interfere with individuals' rights to seek the treatments they choose. This is why the mental health organizations have adopted advisory policies about conversion therapy that affirm the right of LGB clients to unbiased treatment in psychotherapy and that reject treatments based upon the premise that homosexuality is a treatable mental disorder. They do not, however, ban the practice of conversion therapy outright out of concern for the individual whose personal spiritual or religious concerns may assume priority over his sexual orientation.

Guidance From Professional Organizations

The issues associated with sexual orientation and any therapeutic efforts to change it are varied and complex. In response to requests for guidance in this area from practitioners and the public, the American Psychological Association (APA) developed a policy on conversion therapy known as the "Resolution on Appropriate Therapeutic Responses to Sexual Orientation" (APA, 1998). This policy affirms psychological knowledge and ethical responsibilities relative to sexual orientation and "opposes portrayals of lesbian, gay, and bisexual youth and adults as mentally ill due to their sexual orientation" (p. 934). It calls on psychologists to refrain from discriminatory practices in their work, to recognize cultural differences, including those due to sexual orientation, and to respect individuals' right to self-determination.

The reason that the resolution does not ban conversion therapy outright is that the same arguments for diversity and autonomy can be used to support those who seek to change their sexual orientation on the basis of religious belief and practice. Psychology's role is to inform the profession and the public, not to legislate against individuals' rights to self-determination. Therefore, the resolution provides an ethical framework that all practitioners should bear in mind when working with clients who present with issues of sexual orientation.

The resolution makes several points. First, no school of therapy or organization that has as its basis the premise that homosexuality is a treatable mental illness can be supported. The reasons for this are long-standing and clear; there is no credible science supporting the mental illness view of homosexuality. Any individual or organization advocating the coercion of LGB, transgender, or questioning youth in conversion therapy is not only in likely ethical violation but liable to be committing child abuse as well.

APA's *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients* (Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force, 2000) elaborates on the suggestions for clinicians working with individuals struggling with their sexual orientation. In particular, Guideline 4 in this document offers a theoretical perspective from which practitioners can work effectively with those clients questioning their sexual orientation. The guideline reads, "Psychologists strive to understand how inaccurate or prejudicial views of homosexuality or bisexuality may affect the client's presentation in treatment and the therapeutic process" (p. 1443). This guideline points out that bias and misinformation about homosexuality and bisexuality are widespread in our society, as is social stigmatization (i.e., prejudice, discrimination, and violence).

It is not uncommon for clients struggling with their sexual orientation to blame themselves for experiences of rejection and/or maltreatment that are really rooted in society's devaluation of LGB orientations. When clients have been traumatized in one way or another because of their sexual orientation, or their perceived sexual orientation, it is critical that psychologists have an understanding of the potential effects of social stigma and inquire as to the client's experience in this regard. Otherwise, if the psychologist harbors prejudice or is misinformed about sexual orientation, she or he risks exacerbating the client's distress.

When a client presents with discomfort about sexual orientation, the psychologist should not reflexively attribute the distress to the client's sexual orientation itself or automatically agree to a client's request to change sexual orientation. The psychologist should assess the psychological and social context in which the discomfort occurs. Such an assessment might include an examination of internal and external pressures on the client to change his or her sexual orientation, the presence or absence of social support, models of positive LGB life, and the extent to which clients associate an LGB orientation with negative stereotypes and experiences. The psychologist's role, regardless of therapeutic orientation, is not to impose beliefs on clients but to examine thoughtfully the client's experiences and motives. Therefore, it is incumbent upon practitioners who might support conversion therapy not to assume that all dissatisfied LGB individuals are candidates for it. Such individuals need accurate information about the lives of LGB people, absent any willful distortions that accompany many conversion therapy experiences (Shidlo & Schroeder, 1999). Those who report having been harmed in conversion therapies frequently report that their prior therapist(s) attempted to frighten them into changing their sexual orientation by presenting images of gay men and lesbians as depraved, chronically miserable people (Haldeman, 2002). Such depictions had the effect of prolonging ineffective, and sometimes emotionally damaging, treatments.

By the same token, gay-affirmative therapists need to take seriously the experiences of their religious clients, refraining from encouraging an abandonment of their spiritual traditions in favor of a more gay-affirming doctrine or discouraging their exploration of conversion treatments. Many religiously oriented individuals have reported that their therapy ignored or attempted to devalue the spiritual aspects of their identity in the interest of facilitating their "coming out." With some individuals, such an approach imposes sexual orientation over spirituality, neglecting the primary task of integrating all aspects of identity.

Ideally, the individual ultimately integrates sexual orientation and spirituality into the overall concept of identity by resolving anti-gay stigma internalized from negative experiences in family, social, educational, and/or vocational contexts. But what of the individual who, after careful examination of the aforementioned factors, still feels committed to an exploration of changing sexual orientation or of managing sexual identity? Even with data to prove that all who request a change of sexual orientation are acting out of internalized social pressure, we would be hard-pressed to deny such individuals the treatment or spiritual interventions they seek. In the absence of empirically based conversion therapy models, such treatments are difficult to recommend. Nevertheless, we must respect the choices of all who seek to live life in accordance with their own identities; and if there are those who seek to resolve the conflict between sexual orientation and spirituality with conversion therapy, they must not be discouraged. It is their choice, in consultation with their therapists and/or pastoral care providers, to develop goals in treatment as they see fit, without undue interference from the practitioner. These goals may amount to attempting to change sexual orientation outright, aspiring to celibacy, or managing homoerotic impulses and feelings in the context of a heterosexual marriage (previously referred to as *sexual identity management*).

Historically, the choice between conversion therapy and gay-affirmative therapy excluded a large group of individuals who found neither model wholly satisfactory. In an effort to integrate the complicated and often-conflicting aspects of identity of sexual orientation and spirituality, Beckstead and Morrow (2001) pro-

posed a group-treatment model aimed at developing identity congruence. This model enables group participants to freely examine the significant elements of identity in an atmosphere without therapeutic agenda or personal judgment. The various behavioral strategies used to explore resolutions to these conflicts are all discussed and evaluated according to the individual's own sense of identity and ethics. The latter is particularly important when others are involved in an attempt at heteroerotic competence, or sexual identity management. This model does not presume a direction for the religiously conflicted gay man or lesbian. Rather, it enables the individual to explore and, if need be, change the fundamental concepts of identity without subscribing to either conversion or gay-affirmative therapy. This model can also be used for practitioners of individual treatment who wish to facilitate their clients' setting their own therapeutic agenda, often in the face of social pressure in one direction or another.

Summary

The intersection of psychology, gay rights, religion, and public policy has formed a crucible, in which conversion therapy sits at an often-stormy center. Psychology has an important role in the controversy surrounding conversion therapy, as it clarifies the position that homosexuality and bisexuality are not indicative of mental illness but are normal variants of human sexuality. Psychology also has a responsibility to disseminate accurate information about sexual orientation and to actively counter the misrepresentations of some conversion therapists who would create a market for their services by peddling prejudicial notions of sexual orientation to fearful and confused potential clients. Finally, psychology has a major responsibility in offering reasonable, nonrestrictive guidance to the profession in helping its members responsibly address the needs of their LGB patients.

We sometimes forget, however, that religious identity and practice is a form of human diversity that is also often misunderstood and that deserves psychology's attention. Although it is sometimes the case that attempting to combat scriptural references to homosexuality with psychological knowledge about the subject is like trying to have a conversation in two different languages, that does not mean that we should turn away from the conversation. It also does not mean that we should superimpose religious values and beliefs on science, or vice versa. Rather, our task is to work on integrating these sometimes disparate elements of the human experience. Optimal psychological functioning depends upon one's ability to integrate the various aspects of the self as fully as possible. In striving toward this goal for all patients, we move toward the most important work of all: not what changes sexual orientation, but what changes society so that we may all live and work together while respecting each other's differences.

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