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Therapeutic antidotes: Helping gay and bisexual men recover from conversion therapies

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Therapeutic Antidotes: Helping Gay and Bisexual Men Recover from Conversion Therapies

Douglas C. Haldeman, PhD

SUMMARY. Studies of sexual orientation conversion therapies have focused on the efficacy, or lack thereof, of treatments designed to change sexual orientation. Recently, given the typically low success rate achieved in most conversion therapy studies, some researchers have examined the potential for such treatments to harm patients. It is the author's impression, after twenty years' clinical work with individuals who have undergone some form of conversion therapy, that these treatments can indeed be harmful. This article identifies the various problems commonly presented by patients following an unsuccessful therapeutic attempt to change sexual orientation. Such problems include poor self-esteem and depression, social withdrawal, and sexual dysfunction. Case material illustrates these concerns, and therapeutic approaches to address them are suggested. Directions for future study are identified. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2001 by The Haworth Press, Inc. All rights reserved.]

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To date, the controversy over conversion therapies has focused almost exclusively on the question of whether or not they are effective. Only recently has the potential harm to patients of such treatments been considered (Shidlo and Schroeder, 1999). It is the author's impression, after twenty years' clinical work with individuals who have undergone some form of conversion therapy, that these treatments can indeed be harmful. The present discussion will consider common negative psychological *sequelae* of conversion therapies and suggest therapeutic remedies.

In 1998, the American Psychiatric Association adopted a resolution rejecting therapies based upon the premise that homosexuality is a mental disorder (American Psychiatric Association, 2000). This resolution notes that treatment for homosexuality is most often provided to people who have been adversely affected in some way by their culture or society, and that such treatments put some people at risk for a variety of emotional problems. The American Psychological Association (1998) adopted a policy on conversion therapy in 1997, which reaffirms the view that homosexuality is not a treatable mental illness. The resolution further opposes portrayals of lesbians, gay and bisexual men as mentally ill due to their sexual orientation, and reminds the practitioner of the numerous ethical principles related to the treatment of sexual orientation.

In addition, the American Psychological Association recently adopted practice guidelines for practitioners working with lesbian, gay and bisexual clients (American Psychological Association, 2000). One guideline in particular, "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," offers empirically based suggestions for how a therapist might deal with a client whose discomfort with his/her sexual orientation is so severe that he or she wishes to change it. The policies of these professional associations support the rights of lesbian, gay and bisexual psychotherapy clients to respectful treatment that is not based on the disproved theory that homosexuality is a treatable disorder. Although these policies allude to the possibility that some patients will be harmed by attempts to convert their sexual orientation, they do not specify the nature of the potential concerns. The following discussion will therefore examine the issues commonly faced by individuals who have had adverse experiences in conversion therapy.

THE POTENTIAL HARMS OF CONVERSION THERAPY

The professional literature has examined the theoretical and empirical bases of conversion therapy (Drescher, 1998; Haldeman, 1994; Stein, 1996; Tozer and McClanahan, 1999). Theoretical discussions in the conversion therapy literature have included speculations as to what might cause a homosexual orien-

tation, inevitably with the underlying assumption being that homosexuality is pathological. Usually, some variant of the "distant or absent father and over-intimate mother" configuration is blamed for causing men to become gay.¹ Such studies generally examine outcomes after a conversion treatment procedure of one sort or another; these have historically included behavioral (including aversive therapy), cognitive and psychodynamic interventions. These studies are characterized by serious methodological flaws that render them difficult to interpret, and make it impossible to generalize from them. The most common flaws include subject selection and classification, defining what constitutes change of sexual orientation, the effects of response bias in self-report, and what follow-up is conducted to assess the stability of treatment effects. These methodological problems have been noted and assessed by several reviewers (Haldeman, 1994; Stein, 1996; Tozer and McClanahan, 1999).

Even the most enthusiastic of conversion therapists claim roughly a 30% "success" rate (Haldeman, 1999). This low frequency is typically explained by the fact that sexual orientation is very difficult to change. Where others might consider a 30% success rate as less than optimal, in the domain of conversion therapy it is the accepted standard. The apparent lack of concern on the part of conversion therapists regarding their treatment "failures" is significant. Only recently, for example, has the obvious question been raised, "What about the other 70%?" (Shidlo and Schroeder, 1999). Given the tremendous psychological implications of trying to change something as profound and complex as sexual orientation, it might be reasonable to wonder if any harm results in the vast majority of individuals who do not successfully change in these treatments. That possibility has not been addressed, and is even ignored by conversion therapists who, because of a strong anti-gay bias, see any chance at changing unwanted homosexual or bisexual orientation as being worth whatever risks might be involved.

What follows are the author's impressions of those risks, based on twenty years of clinical practice with individuals who have been through a variety of efforts to change their sexual orientation. Typical adverse responses have been thematically grouped according to the clinical issues most often presented by the treatment failures of conversion therapies. It should be noted that although these observations are not systematically derived, they do convey common clinical presentations of individuals who feel they have been harmed by conversion therapies. Clearly, all of the potential outcomes of conversion therapy need to be further documented and assessed.

The term "reparative therapy" has often been used interchangeably with conversion therapy. The term "reparative therapy," however, supports an inaccurate theoretical construct, namely, that homosexuality and bisexuality are a form of "brokenness." Therefore, the term "conversion therapy" is used here. It should be further noted that there is no universal response to the experience

of having undergone a conversion therapy. Individuals' reactions may depend upon a variety of factors: their own constitutional resilience, the level of "invasiveness" of the treatment they have undergone, and the relative degree of social support, or lack thereof, that they enjoy. Not all individuals appear to be harmed by conversion therapy. It is not uncommon, in fact, for some to report that a failed attempt at conversion therapy had an odd, indirectly beneficial effect. This effect can be described as an individual's final "letting go" of the denial surrounding his sexual orientation. One patient stated, in reference to his experience in an ex-gay Christian counseling group, "I finally 'got' it. There was nothing else I could do and nowhere else to turn, so I figured I'd better get on with my life as a gay man."

Unfortunately, this is not everyone's experience. For many, a failed attempt—or a series of failed attempts—at conversion therapy signals an ending, not a beginning. The hope of conforming to social expectations of family, culture and church comes to an end with a failed attempt to change sexual orientation. With the end of this hope comes a host of potential losses: expulsion from family, loss of position in society, rejection from familiar institutions, loss of opportunities to raise children, loss of faith and community, and vulnerability to anti-gay prejudice. Combined with the difficulty that many "ex-ex-gay" individuals have integrating themselves into the gay community, the period following "unsuccessful" conversion therapy can be fraught with emotional issues. Generally, these include depression and guilt related to multiple losses, intimacy avoidance, sexual dysfunction, and religious and spiritual concerns. These issues can be overlapping in nature, and an individual may experience one, several, or all of them. They will be described in greater detail with brief case material, followed by suggestions for how therapists can address them clinically.

DEPRESSION RELATED TO LOSS

When asked why he attempted to change his sexual orientation—several times in individual therapy and in spiritually based prayer groups as well—Dan answered: "I just felt it wasn't *me* to be gay." When pressed further, he explained that he saw nothing wrong for others to be gay, but that it was incongruent with a picture he had of himself that included having a wife and children. Elaborating on this picture, he described a life in which he enjoyed support from his family and church community as a heterosexual, married man with children. Now, having been unable to make this fantasy a reality, he reported feeling very depressed, guilty and hopeless. He feared that the dream of support from his family would never come true if he were to live openly as a gay man; furthermore, he believed that he would no longer be able to partici-

pate in the church community that had been the mainstay of his social world since early childhood.

Conversion therapy alone did not induce Dan's depression. Rather, the failure of the treatment signaled to the client what he likely felt all along: that the social benefits derived from his family and community would require him to engage in a lifelong masquerade to hide his homosexual orientation. The fact that Dan now realizes the impossibility of this situation, however, makes it no less painful to relinquish. His future, which was once founded on a desired image of himself that would become possible with a successful course of conversion therapy, is now in doubt. He is letting go of the fantasy that he would somehow overcome a significant element in his identity in order to take his place in society, but as yet has nothing with which to replace it. He has no sense of connection to the gay community; on the contrary, he is afraid of what he perceives as its strangeness, and has difficulty conceptualizing himself as part of it. In general, he is plagued by guilt, and his self-esteem is contaminated with feelings of failure.

These significant losses require grief work. The feelings associated with these losses cannot be dispelled with optimistic encouragement to come out, be proud, find a partner and adapt to life in the gay community. Dan's first task is to acknowledge the pain associated with the losses he has suffered, and to begin neutralizing the toxic effects of the shame and guilt he has internalized. In so doing, he begins the process of disengaging what he will come to experience as his true self from the numerous expectations that have been placed on him. Part of the neutralization of shame takes place by examining a self that has been firmly embedded in a sociocultural environment that did not value the self for who it was, but that required it to change (or hide) in order to be acceptable. Ultimately this is not a problem of the self, but of the social environment. The environment, imbued with such powerful attributes as love, acceptance and potential for success, and the threat of eternal damnation, seemed implacable. Ultimately, however, one lesson of a failed conversion treatment is that life must be lived for the self, not for the environment.

In further assessing a depression related to loss, it is important to inquire specifically about what the client has learned about sexual orientation in conversion therapy. It is not uncommon for clients to need re-education, because conversion therapists have either convinced them that homosexuality is a state of arrested psychological development or a moral insufficiency. Initial research in this area (Shidlo and Schroeder, 1999) suggests that many clients in conversion therapy report that their therapists presented them with distorted information about homosexuality. This misinformation can only serve to intensify whatever guilt the client is already feeling. If there are inaccurate beliefs about sexual orientation that linger, they need to be examined and challenged. Shidlo and Schroeder (1999) also note that a significant number of

conversion therapy clients report having lied to their therapists in order to please them. It is important to reinforce the notion that post-conversion therapy treatment does not require the client to switch to a pro-gay perspective. Although he will probably be experiencing ambivalence about his sexual identity, the ambivalence need not be hidden to please the gay-affirmative therapist. It should be treated as a welcome element in the treatment.

Gonsiorek and Rudolph (1991) propose a model of gay identity development that is useful in working with men who have just come out. This model is particularly useful for individuals who have recently abandoned conversion therapy, but as yet have a limited frame of reference for what it might mean, both psychologically and socially, to be gay. The model draws parallels with Kohut's self-psychology theories of childhood psychosocial development. According to Gonsiorek and Rudolph, the first stage of gay identity development involves an exploration of one's own narcissism. The gay man seeks encouragement simply to "be" himself, and as he is ready, avails himself of environments that provide support, encouragement and connection. Often, those who have struggled with conversion therapy have avoided the company of other gay men, save for impersonal sexual encounters. When the time is right, clients who are in the first stages of distress over identity disruption can benefit from being in the company of others who can reflect the new (gay) aspect of identity in a positive way.

An important concern with clients like Dan involves the individual's emotional state. It is important not to minimize the impact that the multiple losses of family and self-concept can have; some clients experience depression to the point of feeling suicidal. Suicidal clients should be offered the resources needed to keep them safe—including psychiatric consultation or hospitalization, if necessary. For more stable clients, it is important, in a gentle way, to offer resources through which the individual can inform him or herself about sexual orientation. In addition to a number of excellent self-help and workbooks available for newly out individuals (Alexander, 1997; Clark, 1997; Hardin, 1999; Signorile, 1996) there are resources on the Internet and support groups that meet in most medium-sized cities. In some cases, the treatment with clients such as Dan may amount to ego reconstruction.

INTIMACY AVOIDANCE

Intimacy issues are often of central importance in psychotherapy with gay men (Alexander, 1997; Haldeman, 2001). This can be especially true for clients who have undergone conversion therapy. Paul came to therapy following a lengthy, traditional "talk-therapy" format of conversion treatment that relied heavily on cognitive-behavioral interventions. Part of this therapy involved

exercises in assertive behavior toward women and heterosexual dating. Paul reported that he realized, after many unsuccessful attempts at heterosexual relating, that he was “undeniably gay” and terminated treatment. In the time that followed, he believed that he had resolved all of the shame and self-recrimination he had experienced about being gay. However, he reported a pattern of difficulty in developing long-term relationships, which he attributed to a pattern of seeking out either unavailable or unsuitable people. Paul did not, however, connect this pattern to his experiences in conversion therapy.

Therapy with Paul revealed that his primary beliefs about himself as a gay man were not as settled as he had thought. Although he generally endorsed the belief that as a gay man he was entitled to satisfying, functional interpersonal relationships, he acknowledged that he still harbored a certain degree of critical judgment against himself for being gay. In theory, Paul reported, it was acceptable to be gay, but coming out tapped into a significant level of his internalized homophobia. This resulted in a pattern of seeking out unavailable men, or focusing on men to whom he was not particularly attracted, and then quickly losing interest in the relationship.²

The pattern of sequential, unstable attachments in same-sex relationships appears to be rooted in Paul’s lack of acceptance of himself as a gay man. This lack of acceptance, and the implications thereof, need to be examined and understood before Paul will be able to participate fully in a primary relationship with another man. Furthermore, the adverse effects of Paul’s conversion therapy experiences need to be understood. His efforts at heterosexual dating stemmed from a neurotic need to please his therapist, as well as his having adopted the belief that his value as a man was rooted in his success at dating women. The conversion therapy, which used the transference as the fulcrum on which heterosexual orientation ultimately develops, is responsible for Paul’s intimacy dysfunction. Instead of achieving a heterosexual shift, Paul became doubly shamed at his gayness, as well as his failure at becoming a “real” man because of his inability to date women.

Conversion therapies typically rely on the therapeutic relationship to catalyze a shift in sexual orientation. The client is expected to identify with the male therapist, to bond with him emotionally, and to delight in his approval when the client is able to develop heterosexual relationships. When the process fails, the potential for harm is significant. The failure at heterosexual dating, once admitted, did not leave Paul an enthusiastic and self-affirming gay man. Rather, the awkwardness he felt in response to his failed attempts at heterosexual dating has been resurrected in his life as a gay man. Paul’s homoerotic feelings trigger conflict between his natural arousal and the conversion therapy-induced overlay of shame. To correct this, appropriate risk-taking and careful exploration of the feelings associated with intimacy with another man set Paul on a path of interpersonal relating that was right for him.

Paul's case illustrates the second stage of Gonsiorek and Rudolph's model of gay identity development. In this stage, the individual has progressed through the narcissistic stage and is ready to internalize the values and beliefs of the (gay) community around him. Such values and beliefs that might be applicable to Paul have to do with the understanding that gay identity can be expressed in relationships, both affiliative and romantic, and that both kinds of relationships are positive and necessary enhancements for a fulfilling life.

SEXUAL DYSFUNCTION

Jim came to therapy having undergone one of the more brutal and psychologically invasive forms of conversion therapy: electric shock treatments. While still in college, Jim had agreed to aversive treatment for homosexuality on the advice of a leader in his church. This leader explained to Jim that unless he eradicated his homosexuality, not only he, but his entire family would be barred from heaven. A devoted son and brother, these words had such a strong impact on Jim that he agreed to undergo this treatment. As part of his therapy, he was instructed to visit pornographic bookshops and select homoerotic material that he found particularly arousing. During treatment sessions, Jim would view the pictures while an electric shock was simultaneously delivered to his hands and genitals. The cessation of the shock would be accompanied by heteroerotic material. The goal of this method was to extinguish homoerotic responses, and replace them with heteroerotic ones.

This treatment was not successful in changing Jim's sexual orientation. It did, however, leave him extremely confused and conflicted about his natural homoerotic feelings. When the conversion therapy failed, Jim finally acknowledged his homosexuality to his family who promptly disowned him. He moved to a large city, where he worked as a model. He tried unsuccessfully, with a number of individuals, to establish a loving relationship, but was troubled by chronic erectile dysfunction. These were the days before Viagra, and Jim was rarely able to sustain an erection. For him, sexual arousal was associated with an aversive experience. Additionally, he had deeply rooted shame related to his sexual response, partly as a result of his culture, and partly having been reinforced by his conversion therapy. His newfound cognitive recognition that it was permissible for to love another man paled in contrast to the firmly established sense of shame about his gayness, reinforced by conversion therapy. As a result, his new relationships were invariably affected by impotence. As the problem progressed, Jim started avoiding sex altogether.

Jim's situation is not uncommon among survivors of conversion therapies, although those who have been through aversive treatments seem to be especially vulnerable to sexual dysfunction. This may be due to the fact that

aversive treatments affect the individual on a physical as well as a mental level, and the body responds in kind by manifesting ambivalence about sexual expression. The stress associated with sexual difficulties is often exacerbated by the sometimes hypersexual climate of the gay male community. Frequently, conversion therapy refugees who struggle with sexual concerns avoid potentially romantic or sexual situations and become socially isolated.

Sex therapy resources for practitioners working with gay men are somewhat limited, since most of the sex therapy literature is written by and for heterosexuals. However, work with clients whose sexual functioning concerns are in part attributable to a conversion therapy history is aided by the use of exercises that are equally applicable to gay, bisexual or heterosexual men (cf. Zilbergeld, 1994). These exercises vary depending upon the condition to be addressed. Typically, the sexual concerns of gay men who have been in conversion treatments include arousal problems or ejaculatory competence. The former can be successfully treated with sensate focus and relaxation exercises. The latter are often treated with the use of autoerotic exercises that gradually involve the introduction and participation of the partner. This assumes, of course, that a partner is available for practice, which is often not the case. Sexual concerns are partly caused by sex-negative attitudes, reoccurrence of the problem, and shame. Successful treatment of psychogenic sexual dysfunction requires that the attitudes and feelings surrounding sexual interaction be considered.

DE-MASCULINIZATION

Many conversion therapy models conceptualize homosexuality as an arrest in normative psychosexual development due, in part, to an inadequate identification with the same-sex parent. In order to correct this hypothetical defect, conversion therapists often rely on therapeutic transference to replicate the paternal attachment. Additionally, some conversion therapists encourage their clients to engage in a variety of "male bonding" activities, including attending and participating in sporting events, or visiting social venues for heterosexual men. In these conversion therapies, the desired shift to heterosexuality is strongly connected to stereotypically male social activities. For those who discontinue their conversion therapy, there can be an accompanying sense of lost masculinity. The client equates his failure at heterosexuality with failed manhood.

For a gay man, a sense of male identity is important, given that his affiliative and romantic relationships will be with other men (Haldeman, 2001). Some men feel de-masculinized after abandoning conversion therapy. This, in turn, has an adverse effect on self-concept and relationships with

other men. Post-conversion therapy treatment often includes an assessment of the degree to which the individual's sense of "maleness" is intact. This means reinforcing the legitimacy of their decision to abandon conversion therapy. Furthermore, it may mean supporting them in developing a male identity consistent with their own sense of self. For some, this may still mean playing basketball, going fishing, or watching the Super Bowl. Conversely, it may mean engaging in stereotypically female pursuits, and yet not feeling less masculine. One's gender identity is the unique right and responsibility of the individual to define. It may rely upon conformity to stereotypical gender roles only to the extent that this matters to the individual.

SPIRITUALITY AND RELIGION

Without question, the single most difficult area to be navigated with many clients following conversion therapy is that of spirituality and religion. This is in part due to the fact that deeply held religious and spiritual beliefs can be as important an aspect of the self as sexual orientation. The reasons for this importance may be varied and complicated, but many individuals' religious beliefs and experience serve as a primary rudder in an otherwise anxiety-provoking, amorphous existence. Religion can be associated with comfort, structure, and the nurturing of family. As mentioned before, these are significant losses to contemplate. When religion and sexuality are in conflict, a tremendous obstacle to integration of the self is created. For most individuals, the very reason they sought out conversion therapy in the first place is related to their religious beliefs. The failure of conversion treatment does not necessarily dissipate the strength of the religious feelings, or provide an easy mechanism for reconciling them with sexual orientation.

Bill came to therapy seeking to reconcile his religious beliefs with his sexual orientation. After a series of ex-gay ministry experiences, he began to entertain the notion that perhaps he was intended to be gay, and that he should adopt a more accepting attitude toward himself. As soon as he abandoned his efforts to become heterosexual, Bill reported feeling an enormous sense of relief, and a deep spiritual conviction that he had taken the correct path. At the same time, he found that it was difficult to integrate his spiritual self with others in the gay community. He remarked that the challenges associated with yet another "coming out" process, of being a gay man with strong religious beliefs, was surprisingly difficult. One main reason for this is that the influence of organized religion as an oppressive force in the lives of gay, lesbian and bisexual people is without institutional parallel. Many mainstream religious denominations still preach that homosexuality is a sin, or at least that celibacy is a prerequisite for welcoming lesbians and gay men in their congregations. Many

denominations still forbid the ordination of openly gay or lesbian clergy. These prohibitions are frequently used by persons who seek to justify their prejudice against lesbian, gay and bisexual individuals. For this reason, many lesbian, gay and bisexual people see organized religion in a negative light.

Nonetheless, Bill pursued avenues within the gay community where he could be both openly gay and a person of faith. At present, there are a number of gay-specific congregations and houses of worship, as well as numerous mainstream denomination "reconciling congregations" that welcome lesbian, gay and bisexual people and affirm their spiritual needs. After having found a home in one such congregation, Bill was much better able to integrate these historically conflicted, but important, aspects of his self.

This illustrates the third and final stage of Gonsiorek and Rudolph's model of gay identity development. Following the establishment of an integrated self, including positive introjects from the community, the gay person enters the "idealized" sector. In this stage, the gay person is "one among many," whose sense of self is maximized by a connection to others. In this regard, significant others and the community itself serve a surrogate familial function, offering the individual a context for both comfort and contribution.

Not all internal conflicts between religion and sexuality end with a successful integration, however. Clients whose strongly held religious beliefs cannot be adapted to fit the emerging understanding of the (gay) self are those most likely to abandon gay-affirmative treatment and return to conversion therapy. For some, the power of familial rejection and religious condemnation, coupled with the possibility of a poor connection with the gay community, is simply too much to overcome. While the majority of lesbian and gay individuals who come from unaccepting religious backgrounds appear able to separate from their histories, and if need be, their families of origin, in a healthy way, this is not the case for all.

CONCLUSION

Public campaigns promoting conversion therapy harm gay, lesbian and bisexual people by distorting the truth about sexual orientation, and fueling prejudice (Haldeman, 1999; Kahn, 1998). The relationship between the religious political activists whose "purpose (is) to strike at the assumption that homosexuality is an immutable trait" (Hicks, 1999) and the groups promoting conversion treatments has been documented. The publicity surrounding "cures" of homosexuals is intended to influence public opinion that homosexuality can be changed, and that gay men and lesbians should not receive anti-discrimination protection in housing and employment, and that "sexual orientation" should be excluded as a category in legislation against hate crimes.³ The offer-

ing of conversion therapists by antihomosexual religious conservatives is therefore a significant element in reinforcing social stigma against homosexuality.

In contrast to the social harms of conversion therapy, activists and professionals alike have paid less attention to the potential adverse consequences of conversion therapy to the individual. The present discussion is a cursory examination of issues common to individuals who have undergone some form of conversion therapy, and highlights those concerns that deserve further, systematic study. Each case is unique, and the cases mentioned here are intended to offer the clinician a perspective on the kinds of issues that are frequently presented by clients, as well as some considerations as to how they might be addressed therapeutically. The issues of depression and poor self-image, relationship and intimacy avoidance, sexuality and spirituality are certainly not exhaustive. Research in this area will undoubtedly expand and refine this list.

It is important, however, to document that conversion therapy practices can have adverse consequences—some very serious—on numerous individuals. These range in severity from poor self-esteem, to chronic unhappiness in relationships and up to suicide. This is not to suggest that all conversion therapies are harmful, or that the mental health professions should try to stop them. It must be remembered, however, that a client's request to change sexual orientation is fraught with socially driven implications. Such a request should not be met with reflexive agreement on the part of the therapist, but should be carefully questioned and examined.

As long as antihomosexual elements persist in our culture and our social institutions, there will be frightened, unhappy individuals seeking conversion therapy. The time has come for the research in this area to shift from the question, "Does it work?"—a question that has been answered many times. The more important research questions that are finally being addressed are, "Why did you attempt a conversion therapy in the first place?" "Did it help you?" should be accompanied by, "Did it hurt you?" (Shidlo and Schroeder, 1999). For years, critics of conversion therapy have maintained that these treatments do not change sexual orientation. For the sake of the clients who have been harmed, it is time to learn more about what the effects of conversion therapy truly are.

NOTES

1. The neglect of lesbians in the conversion literature suggests that they are of less concern to these theorists.

2. Paul's case raises another issue that has not been addressed in the conversion therapy literature. As part of their treatment, clients in conversion therapy are frequently

encouraged to date members of the opposite sex. What are the appropriate procedures for disclosure in this regard? What responsibilities does the conversion therapy client bear toward the opposite-sex partners who are serving as therapy homework? These issues are absent from the conversion therapy literature, yet the ex-girlfriends, ex-wives and children of such failed "experiments" constitute a significant element of the conversion therapy equation. Their needs, particularly when the relationships they thought were likely to last fail because of a partner's undisclosed homosexuality, deserve attention in this discussion.

3. Antigay forces call attempts to gain such protections the "special rights" argument.

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