

# The Practice and Ethics of Sexual Orientation Conversion Therapy

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Sexual orientation conversion therapy was the treatment of choice when homosexuality was thought to be an illness. Despite the declassification of homosexuality as a mental illness, efforts to sexually reorient lesbians and gay men continue. The construct of sexual orientation is examined, as well as what constitutes its change. The literature in psychotherapeutic and religious conversion therapies is reviewed, showing no evidence indicating that such treatments are effective in their intended purpose. A need for empirical data on the potentially harmful effects of such treatments is established. Ethical considerations relative to the ongoing stigmatizing effects of conversion therapies are presented. The need to develop more complex models for conceptualizing sexual orientation is discussed, as well as the need to provide treatments to gay men and lesbians that are consonant with psychology's stance on homosexuality.

The question of how to change sexual orientation has been discussed as long as homoeroticism itself has been described in the literature. For over a century, medical, psychotherapeutic, and religious practitioners have sought to reverse unwanted homosexual orientation through various methods: These include psychoanalytic therapy, prayer and spiritual interventions, electric shock, nausea-inducing drugs, hormone therapy, surgery, and various adjunctive behavioral treatments, including masturbatory reconditioning, rest, visits to prostitutes, and excessive bicycle riding (Murphy, 1992). Early attempts to reverse sexual orientation were founded on the unquestioned assumption that homosexuality is an unwanted, unhealthy condition. Although homosexuality has long been absent from the taxonomy of mental disorders, efforts to reorient gay men and lesbians persist. Recently, for example, a coalition of mental health practitioners formed an organization dedicated to the "rehabilitation" of gay men and lesbians. Many practitioners still adhere to the officially debunked "illness" model of homosexuality, and many base their treatments on religious proscriptions against homosexual behavior. Still others defend sexual reorientation therapy as a matter of free choice for the unhappy client, claiming that their treatments do not imply a negative judgment on homosexuality per se. They seek to provide what they describe as a treatment alternative for men and women whose homosexuality is somehow incongruent with their values, life goals, or psychological structures.

Of the articles to be examined in this review, few have addressed the question of how sexual orientation is defined. Such a definition seems necessary before one can describe how sexual orientation is changed. However, most research in this area offers a dichotomous view of human sexuality in which undesired homoerotic impulses can be eradicated through a program that replaces them with heterosexual competence. Few

studies even rely on the relatively simplistic Kinsey scale (Kinsey, Pomeroy, & Martin, 1948) to make an attempt at assessing a subject's sexual orientation. Although a comprehensive discussion is well beyond the scope of this article, I begin with a passing reference to what is meant by the terms *homosexuality* and *heterosexuality*.

The data of Kinsey et al. (1948) suggested that as many as 10% of American men considered themselves to be primarily or exclusively homosexual for at least 3 years of their adult lives. His assessment was based on the subject's actual behavior as well as the content of the subject's fantasy life. Subsequent efforts to quantify sexual orientation have incorporated gender-based, social, and affectional variables (Coleman, 1987). Several complex questions involved in the defining of sexual orientation have been either reduced or overlooked in the literature on conversion therapy. For instance, those conversion therapy programs that claim the greatest success included more subjects whose behavioral histories and fantasy lives appeared to have significant heteroerotic components (Haldeman, 1991). Instructing a "homosexual" subject with a priori heteroerotic responsiveness in heterosexual behavior appears to be easier than replacing the cognitive sociosexual schema and redirecting the behavior of the "homosexual" subject with no reported heteroerotic inclinations. Nevertheless, both types of "homosexual" subjects are often included in the same treatment group.

Any definition of sexuality based solely on behavior is bound to be deficient and misleading. Sense of identity, internalized sociocultural expectations, and importance of social and political affiliations all help define an individual's sexual orientation, and these variables may change over time. The content of an individual's fantasy life may provide information that is not influenced by the individual's need for social acceptance, but even these are subject, in some women and men, to variations in gender of object choice, based on environmental or political factors. Social demand variables also figure in describing sexual orientation, given the frequency with which gay men and lesbians marry (Bell & Weinberg, 1978). Writer Darrell Yates Rist examined the lives of gay men in rural America with respect to how sexual orientation is constructed (1992). He described "Sven," a heterosexually married father of two:

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It occurred to me that there were men—perhaps most men—whom sexual labels failed. Rudy seemed to think of Sven as a gay man stuck with a wife. Others might describe him as “bisexual,” yet a third sexual breed. But those terms, like “straight,” signify a way of life in which sex is deemed the core of identity, the single Freudian need or act that controls the psyche and determines the scope of a human being . . . such a way of looking at sex was beginning to seem exotic to me, a precious myth. One might as sensibly concoct natural categories out of the sports men choose to play or the foods they eat, religious dogmas or politics—any multitude of the changeable preferences to which men and women devote themselves. (1992, p. 141)

The categories homosexual, heterosexual, and bisexual, conceived by many researchers as fixed and dichotomous, are in reality very fluid for many. Therefore, in addition to how sexual orientation is defined, one must also consider how it is experienced by the individual. For many gay men, the process of “coming out” may be likened to an internal evolution of sorts, a conscious recognition of what has always been. On the other hand, many lesbians describe “coming out” as a process tied to choices or social and political constructions. In this regard, many lesbians may have more in common with heterosexual women than with gay men, suggesting a gender-based distinction relative to the development of homosexual identity.

Questions about the complex nature of sexual orientation and its development in the individual must be addressed before change in sexual orientation is assessed. Many previously heterosexually identified individuals “come out” as lesbian or gay later in life, and some people who identify themselves as gay or lesbian engage in heterosexual behavior and relationships for a variety of personal and social reasons. How, then, are spontaneously occurring shifts in sexual orientation over the life span to be differentiated from behavior resulting from the interventions of a conversion therapist? Essentially, the fixed, behavior-based model of sexual orientation assumed by almost all conversion therapists may be invalid. For many individuals, sexual orientation is a variable construct subject to changes in erotic and affectional preference, as well as changes in social values and political philosophy that may ebb and flow throughout life. For some, “coming out” may be a process with no true endpoint. Practitioners assessing change in sexual orientation have ignored the complex variations in an individual’s erotic responses and shifts in the sociocultural landscape.

### Psychological Conversion Programs

The case for conversion therapy rests on its ability to understand who is being converted and its ability to describe the nature of the conversion taking place. Acknowledging the theoretical complexities and ambiguities left unaddressed by most conversion therapists, the first question is “Are these treatments effective?” In assessing the efficacy of conversion therapy, psychotherapeutic and religious programs will be reviewed. Those interested in reviews of medical therapies (drug or hormonal and surgical interventions) are referred to Silverstein (1991) and Murphy (1992).

Psychotherapeutic approaches to sexual reorientation have been based on the a priori assumption that homoeroticism is an undesirable condition. Two basic hypotheses serve as the foundation for most therapies designed to reverse sexual orientation.

The first is that homosexuality results from an arrest in normal development or from pathological attachment patterns in early life. The second is that homosexuality stems from faulty learning. Therapies most closely associated with the first perspective are of the psychoanalytic and neo-analytic orientations.

Psychoanalytic tradition posited that homosexual orientation represented an arrest in normal psychosexual development, most often in the context of a particular dysfunctional family constellation. Such a family typically featured a close-binding mother and an absent or distant father. Despite the relative renown of this theory, it is based solely on clinical speculation and has never been empirically validated. Subsequent studies have indicated that etiologic factors in the development of sexual orientation are unclear but that the traditional psychoanalytic formulations concerning family dynamics are not viable (Bell, Weinberg, & Hammersmith, 1981).

Psychoanalytic treatment of homosexuality is exemplified by the work of Bieber et al. (1962), who advocate intensive, long-term therapy aimed at resolving the unconscious anxiety stemming from childhood conflicts that supposedly cause homosexuality. Bieber et al. saw homosexuality as always pathological and incompatible with a happy life. Their methodology has been criticized for use of an entirely clinical sample and for basing outcomes on subjective therapist impression, not externally validated data or even self-report. Follow-up data have been poorly presented and not empirical in nature. Bieber et al. (1962) reported a 27% success rate in heterosexual shift after long-term therapy; of these, however, only 18% were exclusively homosexual in the first place. Fifty percent of the successfully treated subjects were more appropriately labeled bisexual. This blending of “apples and oranges” returns us to the original question: Who is being converted, and what is the nature of the conversion?

Another analytically based study reported virtually no increase in heterosexual behavior in a group of homosexual men (Curran & Parr, 1957). Other studies report greater success rates: For instance, Mayerson and Lief (1965) indicate that, of 19 subjects, half reported engaging in exclusive heterosexual behavior 4.5 years posttreatment. However, as in Bieber et al.’s study, those subjects had heteroerotic traits to begin with; exclusively homosexual subjects reported little change, and outcomes were based on patient self-report. As in other studies, an expansion of the sexual repertoire toward heterosexual behavior is viewed as equivalent to a shift of sexual orientation.

California psychologist Joseph Nicolosi has developed a program of reparative therapy for “non-gay” homosexuals, individuals who reported being uncomfortable with their same-sex orientation. Nicolosi stated, “I do not believe that the gay life-style can ever be healthy, nor that the homosexual identity can ever be completely ego-syntonic” (1991, p. 13). This belief erroneously presupposes a unitary gay lifestyle, a concept more reductionist than that of sexual orientation. It also prejudicially and without empirical justification assumes that homosexually oriented people can never be normal or happy, a point refuted numerous times in the literature. Nonetheless, this statement is the foundation for his theoretical approach, which cites numerous studies that suggest that gay men have greater frequencies of disrupted bonds with their fathers, as well as a host of psychological concerns, such as assertion problems. These observations are

used to justify a pathological assessment of homosexuality. The error in such reasoning is that the conclusion has preceded the data. There may be cause to examine the potentially harmful impact of a detached father and his effect on the individual's self-concept or capacity for intimacy, but why should a detached father be selected as the key player in causing homosexuality, unless an a priori decision about the pathological nature of homosexuality has been made and unless he is being investigated as the cause? This perspective is not consistent with available data, nor does it explain the millions of heterosexual men who come from backgrounds similar to those of gay men, or for that matter, those gay men with strong father-son relationships. Nicolosi does not support his hypothesis or his treatment methods with any empirical data.

Group treatments have also been used in sexual reorientation. One study of 32 subjects reports a 37% shift to heterosexuality (Hadden, 1966), but the results must be viewed with some skepticism, because of the entirely self-report nature of the outcome measures. Individuals involved in such group treatments are especially susceptible to the influence of social demand in their own reporting of treatment success. Similarly, a study of 10 gay men resulted in the therapist's impressionistic claims that homosexual patients were able to "increase contact" with heterosexuals (Mintz, 1966). Birk (1980) described a combination insight-oriented-social-learning-group format for treating homosexuality. He claimed that overall, 38% of his patients achieved "solid heterosexual shifts." Nonetheless, he acknowledges that these shifts represent "an adaptation to life, not a metamorphosis," and that homosexual fantasies and activity are ongoing, even for the "happily married" individual (Birk, 1980, p. 387). If a solid heterosexual shift is defined as one in which a happily married person may engage in more than occasional homosexual encounters, perhaps this method is best described as a laboratory for heterosexual behavior, rather than a change of sexual orientation. A minority of subjects, likely with preexisting heteroerotic tendencies, may be taught proficiency in heterosexual activities. Eager to equate heterosexual competence with orientation change, these researchers have ignored the complex questions associated with the assessment of sexual orientation. Behavior alone is a misleading barometer of sexual orientation, which includes biological, gender-based, social, and affectional variables. No researchers who conducted conversion studies have displayed any such thoughtfulness in their assessment or categorization of subjects.

Behavioral programs designed to reverse homosexual orientation are based on the premise that homoerotic impulses arise from faulty learning. These studies seek to countercondition the "learned" homoerotic response with aversive stimuli, replacing it with the reinforced, desired heteroerotic response. The aversive stimulus, typically consisting of electric shock or convulsion- or nausea-inducing drugs, is administered during presentation of same-sex erotic visual material. The cessation of the aversive stimulus is accompanied by the presentation of heteroerotic visual material, supposedly to replace homoeroticism in the sexual response hierarchy. These methods have been reviewed by Sansweet (1975). Some programs attempted to augment aversive conditioning techniques with a social learning component (assertiveness training, how to ask women out on dates, etc.; Feldman & McCulloch, 1965). Later, the same in-

vestigators modified their approach, calling it "anticipatory avoidance conditioning," which enabled subjects to avoid electrical shock when viewing slides of same-sex nudes (Feldman, 1966). Such a stressful situation could likely inhibit feelings of sexual responsiveness in any direction; nevertheless, a 58% cure rate was claimed, with outcome criteria defined as the suppression of homoerotic response. Cautela (1967) reported on single subjects who were taught to imagine such aversive stimuli rather than undergo them directly. His later work focuses on structured aversive fantasy, in which subjects are asked to visualize repulsive homoerotic encounters in stressful circumstances (Cautela & Kearney, 1986). The investigators deny a homophobic bias to this therapeutic approach.

Other studies suggest that aversive interventions may extinguish homosexual responsiveness but do little to promote alternative orientation. One investigator suggests that the poor outcomes of conversion treatments are due to the fact that they "disregard the complex learned repertoire and topography of homosexual behavior" (Faustman, 1976). Other studies echo the finding that aversive therapies in homosexuality do not alter subjects' sexual orientation (McConaghy, 1981). Another study similarly suggests that behavioral conditioning decreases homosexual orientation but does not elevate heterosexual interest (Rangaswami, 1982). Methodologically, the near-exclusive use of self-report outcome measures is problematic, particularly in an area where social demand factors may strongly influence subjects' reports. The few studies that do attempt to externally validate sexual reorientation through behavioral measures show no change after treatment (Conrad & Wincze, 1976).

Masters and Johnson (1979) reported on the treatment of 54 "dissatisfied" homosexual men. This was unprecedented for the authors, as their previous works on heterosexual dysfunction did not include treatment for dissatisfied heterosexual people. The authors hypothesized homosexuality to be the result of failed or ridiculed attempts at heterosexuality, neglecting the obvious: that heterosexual "failures" among homosexual people are to be expected because the behavior in question is outside the individual's normal sexual response pattern. Despite their comments to the contrary, the study is founded on heterosexist bias. Gonsiorek (1981) raises a variety of concerns with the Masters and Johnson study. Of the numerous methodological problems with this study, perhaps most significant is the composition of the sample itself. Of 54 subjects, only 9 (17%) identified themselves as Kinsey 5 or 6 (exclusively homosexual). The other 45 subjects (83%) ranged from 2 to 4 on the Kinsey scale (predominantly heterosexual to bisexual). Furthermore, because 30% of the sample was lost to follow-up, it is conceivable that the outcome sample does not include any homosexual men. Perhaps this is why such a high success rate is reported after 2 weeks of treatment. It is likely that, rather than converting or reverting homosexual people to heterosexuality, this program enhances heterosexual responsiveness in people with already established heteroerotic sexual maps.

Evidence for the efficacy of sexual conversion programs is less than compelling. All research in this area has evolved from unproven hypothetical formulations about the pathological nature of homosexuality. The illness model has never been empirically validated; to the contrary, a broad literature validates the nonpathological view of homosexuality, leading to its declassi-

fication as a mental disorder (Gonsiorek, 1991). Thus, treatments in both analytic and behavioral modes are designed to cure something that has never been demonstrated to be an illness. From a methodological standpoint, the studies reviewed here reveal inadequacies in the selection criteria and the classification of subjects and poorly designed and administered outcome measures. In short, no consistency emerges from the extant database, which suggests that sexual orientation is amenable to redirection or significant influence from psychological intervention.

### Religion-Based Conversion Programs

In a recent symposium on Christian approaches to the treatment of lesbians and gay men, one panelist said of his numerous unsuccessful attempts at sexual reorientation: "I felt it was what I had to do in order to gain a right to live on the planet." Such is the experience of many gay men and lesbians, who experience severe conflict between their homoerotic feelings and their need for acceptance by a homophobic religious community. This conflict causes such individuals to seek the guidance of pastoral care providers or Christian support groups whose aim is to reorient gay men and lesbians. Such programs seek to divest the individual of his or her "sinful" feelings or at least to make the pursuit of a heterosexual or celibate lifestyle possible. Their theoretical base is founded on interpretations of scripture that condemn homosexual behavior, their often unspecified treatment methods rely on prayer, and their outcomes are generally limited to testimonials. Nonetheless, these programs bear some passing examination because of the tremendous psychological impact they have on the many unhappy gay men and lesbians who seek their services and because of some psychologists' willingness to refer to them. Lastly, many such programs have been associated with significant ethical problems.

Gay men who are most likely to be inclined toward doctrinaire religious practice are also likely to have lower self-concepts, to see homosexuality as more sinful, feel a greater sense of apprehension about negative responses from others, and are more depressed in general (Weinberg & Williams, 1974). Such individuals make vulnerable targets for the "ex-gay" ministries, as they are known. Fundamentalist Christian groups, such as Homosexuals Anonymous, Metanoia Ministries, Love In Action, Exodus International, and EXIT of Melodyland are the most visible purveyors of conversion therapy. The workings of these groups are well documented by Blair (1982), who states that, although many of these practitioners publicly promise change, they privately acknowledge that celibacy is the realistic goal to which gay men and lesbians must aspire. He further characterizes many religious conversionists as individuals deeply troubled about their own sexual orientation, or whose own sexual conversion is incomplete. Blair reports a host of problems with such counselors, including the sexual abuse of clients.

The most notable of such ministers is Colin Cook. Cook's counseling program, Quest, led to the development of Homosexuals Anonymous, the largest antigay fundamentalist counseling organization in the world. The work of Cook, his ultimate demise, and the subsequent cover-up by the Seventh Day Adventist Church, are described by sociologist Ronald Lawson

(1987). Over the course of 7 years, approximately 200 people received reorientation counseling from Cook, his wife, and an associate. From this ministry sprang Homosexuals Anonymous, a 14-step program modeled after Alcoholics Anonymous, which has become the largest fundamentalist organization in the world with a unitary antigay focus. Lawson, in attempting to research the efficacy of Cook's program, was denied access to counselees on the basis of confidentiality. Nonetheless, he managed to interview 14 clients, none of whom reported any change in sexual orientation. All but two reported that Cook had had sex with them during treatment. According to Blair, another homosexual pastor who used his ministry to gain sexual access to vulnerable gay people was Guy Charles, founder of Liberation in Jesus Christ. Charles was a homosexual man who had claimed a heterosexual conversion subsequent to his acceptance of Christ. Like Cook, Charles was ultimately disavowed by the Christian organization that sponsored him after charges of sexual misconduct were raised.

To date, the only spiritually based sexual orientation conversion program to appear in the literature has been a study by Pattison and Pattison (1980). These authors describe a supernatural healing approach in treating 30 individuals culled from a group of 300 who sought sexual reorientation counseling at EXIT of Melodyland, a charismatic ex-gay ministry affiliated with a Christian amusement park. The Pattisons do not explain their sampling criteria, nor do they explain why 19 of their 30 subjects refused follow-up interviews. Their data indicate that only 3 of the 11 (of 300) subjects report no current homosexual desires, fantasies, or impulses, and that 1 of the 3 subjects is listed as still being "incidentally homosexual." Of the other 8 subjects, several indicated ongoing neurotic conflict about their homosexual impulses. Although 6 of these men have married heterosexually, 2 admit to more than incidental homosexual ideation as an ongoing issue.

Recently, founders of another prominent ex-gay ministry, Exodus International, denounced their conversion therapy procedures as ineffective. Michael Busse and Gary Cooper, co-founders of Exodus and lovers for 13 years, were involved with the organization from 1976 to 1979. The program was described by these men as "ineffective . . . not one person was healed." They stated that the program often exacerbated already prominent feelings of guilt and personal failure among the counselees; many were driven to suicidal thoughts as a result of the failed reparative therapy ("*Newsbriefs*," 1990, p. 43).

The fundamentalist Christian conversion programs hold enormous symbolic power over many people. Possibly exacerbating the harm to naive, shame-ridden counselees, these programs operate under the formidable auspices of the Christian church, and outside the jurisdiction of any professional organizations that may impose ethical standards of practice and accountability on them. A closer look at such programs is warranted, given the frequency with which spiritual conversion programs seek to legitimize themselves with psychologists as affiliates.

An examination of psychotherapeutic and spiritual approaches to conversion therapy reveal a wide range of scientific concerns, from theoretical weaknesses to methodological problems and poor outcomes. This literature does not suggest a bright future in studying ways to reorient people sexually. Indi-

viduals undergoing conversion treatment are not likely to emerge as heterosexually inclined, but they often do become shamed, conflicted, and fearful about their homoerotic feelings. It is not uncommon for gay men and lesbians who have undergone aversion treatments to notice a temporary sharp decline in their sexual responsiveness, with some subjects reporting long-term sexual dysfunction. Similarly, subjects who have undergone failed attempts at conversion therapy often report increased guilt, anxiety, and low self-esteem. Some flee into heterosexual marriages that are doomed to problems inevitably involving spouses, and often children as well. Not one investigator has ever raised the possibility that conversion treatments may harm some participants, even in a field where a 30% success rate is seen as high. The research question, "What is being accomplished by conversion treatments?" may well be replaced by, "What harm has been done in the name of sexual reorientation?" At present, no data are extant.

### Ethical Considerations

We have considered the question of whether sexual orientations are amenable to change or modification by means of therapeutic interventions. Of equal, if not greater, import is the question of whether psychology should provide or endorse such "cures." Ethicists object to conversion therapy on two grounds: first, that it constitutes a cure for a condition that has been judged not to be an illness, and second, that it reinforces a prejudicial and unjustified devaluation of homosexuality.

The American Psychiatric Association's 1973 decision to remove homosexuality from its *Diagnostic and Statistical Manual of Mental Disorders* marked the official passing of the illness model of homosexuality. The American Psychological Association (APA) followed suit with a resolution affirming this anti-illness perspective, stating, in part, ". . . the APA urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations" (APA, 1975). Homosexuality was replaced with the confusing "ego-dystonic homosexuality" diagnosis, which was dropped altogether in 1987.

It is beyond the scope of this article to comprehensively review the literature on the depathologizing of homosexuality. Briefly, recent scholarship in the area suggests that human homosexuality, despite being nonreproductive in nature, is as biologically natural as heterosexuality.

Biological arguments cannot be used to distinguish morally between homosexuality and heterosexuality. Like left- and right-handedness, the two are expressions of a single human nature that can be expressed differently in different individuals. If homosexuality is therefore part of a range of behavior that has molded *Homo sapiens*, then it is clear that homosexuality is not a disease, and certainly the general object should not be to 'cure' it. (Kirsch & Weinrich, 1991, p. 30)

Homosexual behavior and identity exist in many cultures, and its relative normalcy seems to be more a function of subjective social attribution than of intrinsic properties.

Our society has taken a natural kind of sexuality and made it taboo, in a way that is completely unnecessary for its stability or its values. It is time for us to learn from other cultures that uniform sameness

is not a desirable goal for society. (Weinrich & Williams, 1991, p. 59)

Proponents of conversion therapy continue to insist, in the absence of any evidence, that homosexuality is pathological. This model was rejected because of a lack of such evidence, and its demise has been described by Gonsiorek (1991). This review underscores the faulty logic inherent in classic psychoanalytic theories of family dysfunction as etiologic of homosexuality. Researcher bias, as well as methodological inadequacies, characterize studies supporting the illness model. Psychological test data, from Hooker's (1957) study to present-day studies, have been reviewed and show no substantive differences between homosexual and heterosexual subjects.

Were there properties intrinsic to homosexuality that make it a pathological condition, we would be able to observe and measure them directly. In reality, however, there exists a wide literature indicating just the opposite: that gay men and lesbians do not differ significantly from heterosexual men and women on measures of psychological stability, social or vocational adjustment, or capacity for decision making. In fact, psychological adjustment among gay men and lesbians seems to be directly correlated to the degree that they have accepted their sexual orientation (Weinberg & Williams, 1974). In light of such evidence, the number of studies examining the pathogenesis of homosexuality has diminished in recent years.

Davison (1976, 1978, 1991) has detailed many of the ethical objections to conversion therapies. A behavior therapist once well known for his program to change sexual orientation, Davison believes that a disservice is done to the gay or lesbian individual by offering sexual orientation change as a therapeutic option. In Davison's view, conversion therapy reinforces anti-gay prejudice. He asks, "how can therapists honestly speak of nonprejudice when they participate in therapy regimens that by their very existence—and regardless of their efficacy—would seem to condone the current societal prejudice and perhaps also impede social change?" (1991, p. 141).

In his paraphrase of Halleck (1971), Davison states that therapeutic neutrality is a myth and that therapists, by the nature of their role, cannot help but influence patients with respect to values. Davison suggests that the question of whether sexual orientation can be changed is secondary to the consideration that it should not be changed, because of the devaluation and pathologizing of homosexuality implicit in offering a "cure" for it. Because therapists operate from positions of power, to affirm the viability of homosexuality and then engage in therapeutic efforts to change it sends a mixed message: If a cure is offered, then there must be an illness. This point is echoed by Begelman, who stated that "(conversion therapies) by their very existence, constitute a significant causal element in reinforcing the social doctrine that homosexuality is bad; therapists . . . further strengthen the prejudice that homosexuality is a 'problem behavior', since treatment may be offered for it" (1975, p. 180). Charles Silverstein (1977), points to social factors (e.g., rejecting families, hostile peer interactions, and disapproving society) as being responsible for people seeking sexual orientation change. These authors indicate that what were historically viewed as "ego-dystonic" responses to homosexuality are really internalized reactions to a hostile society.

Proponents of conversion therapy often deny any coercive intent, claiming that theirs is a valuable service for distressed lesbians and gay men who freely seek their services. However, the concept that individuals seek sexual orientation change of their own free will may be fallacious. Martin (1984) stated that "a clinician's implicit acceptance of the homosexual orientation as the cause of ego-dystonic reactions, and the concomitant agreement to attempt sexual orientation change, exacerbates the ego-dystonic reactions and reinforces and confirms the internalized homophobia that lies at their root" (p. 46).

State psychological associations have started to address the issue of conversion therapy, to provide reasonable guidelines to consumer and practitioner. In 1991, the Washington State Psychological Association adopted an advisory policy on sexual orientation conversion therapy. Here, this policy is stated in part:

Psychologists do not provide or sanction cures for that which has been judged not to be an illness. Individuals seeking to change their sexual orientation do so as the result of internalized stigma and homophobia, given the consistent scientific demonstration that there is nothing about homosexuality per se that undermines psychological adjustment. It is therefore our objective as psychologists to educate and change the intolerant social context, not the individual who is victimized by it. Conversion treatments, by their very existence, exacerbate the homophobia which psychology seeks to combat. (Washington State Psychological Association, 1991)

### Discussion

Our understanding of human sexuality is entering a new era, one in which formerly sacrosanct assumptions and classifications are no longer applicable. A new generation of individuals, no longer self-identified as gay or lesbian but as "queer," is developing a perspective of sexual orientation more complex and fluid than what has historically been viewed along rigid lines. This new construction of sexuality, combined with the antiquated, unscientific hypotheses on which conversion therapy has been based, render traditional reorientation therapy anachronistic.

The lack of empirical support for conversion therapy calls into question the judgment of clinicians who practice or endorse it. The APA "Fact Sheet on Reparative Therapy" opens with the following statement: "No scientific evidence exists to support the effectiveness of any of the conversion therapies that try to change sexual orientation." A review of the literature makes it obvious why this statement is made. Psychologists are obliged to use methods that have some empirically demonstrable efficacy, and there is a paucity of such evidence relative to conversion therapy. Moreover, there is a need to understand fully the potentially damaging effects of a failed conversion treatment.

A next logical question, then, involves standards of practice for the treatment of lesbians and gay men that are compatible with scientific data. In 1991, the APA's Committee on Lesbian and Gay Concerns published the results of a survey on bias in psychotherapeutic treatment of lesbians and gay men. This survey is an initial step in providing the clinician with guidelines that are consistent with science and that promote the welfare and dignity of the gay or lesbian individual. More research is needed to refine these recommendations for the myriad of issues that gay people bring to therapy. It is the responsibility of psychologists to provide accurate scientific information, partic-

ularly as so much misinformation is currently being used to further stigmatize and justify, even legislate, discrimination against gay people. The current wave of antigay political activity is founded on the mistaken assumptions that homosexuality is a chosen way of life and an abnormal one at that. It may be impossible to understand why so many people would believe that lesbians and gay men would deliberately choose a way of life that puts them at risk for discrimination and violence. It is, however, well within psychology's purview to disseminate accurate information from our considerable database about homosexuality.

Even more significant than the practical considerations of conversion therapy are the ethical concerns. Psychologists are obliged to use methods that promote the dignity and welfare of humankind. Conversion therapies fail in this regard because they are necessarily predicated on a devaluation of homosexual identity and behavior. Some contemporary conversionists would claim a value-neutral stance, insisting that conversion therapy is simply a matter of the client's right to choose treatment, but what is the purpose of attempting to change sexual orientation if it is not negatively valued? How many dissatisfied heterosexual men and women seek a similar conversion to homosexuality? What message does psychology send to society when it affirms the normalcy of homosexuality yet continues to give tacit approval to efforts to change it? Murphy, summarizing his review of the conversion therapy literature, addressed this:

There would be no reorientation techniques where there was no interpretation that homoeroticism is an inferior state, an interpretation that in many ways continues to be medically defined, criminally enforced, socially sanctioned, and religiously justified. And it is in this moral interpretation, more than in the reigning medical theory of the day, that all programs of sexual reorientation have their common origins and justifications. (1992, p. 520)

This morality is at work in all aspects of homophobic activity, from the alarming increase in violent hate crimes against gay men and lesbians to the political and legislative agendas of antigay organizations. Perpetrators of violence and antigay political groups justify their actions with the same devaluation of homosexuality that is used by conversion therapists.

Given the extensive societal devaluation of homosexuality and lack of positive role models for gay men and lesbians, it is not surprising that many gay people seek to become heterosexual. Homophobic attitudes have been institutionalized in nearly every aspect of our social structure, from the government and the military to our educational systems and organized religions. For gay men and lesbians who have identified with the dominant group, the desire to be like others and to be accepted socially is so strong that heterosexual relating becomes more than an act of sex or love. It becomes a symbol of freedom from prejudice and social devaluation. Psychology cannot free people from stigma by continuing to promote or tacitly endorse conversion therapy. Psychology can only combat stigma with a vigorous avowal of empirical truth. The appropriate focus of the profession is what reverses prejudice, not what reverses sexual orientation.

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