Division 44 Psychologist Urges Colleagues To Be Social-Political Advocates

He says researchers avoid doing some gay-health studies for fear of results.

The Fall 2005 issue of the American Psychological Association's Division 44 newsletter features an article by Michael R. Stevenson on the importance of gay psychologists acting as advocates for lesbian/gay/bisexual/transgender issues.

According to Stevenson, "Psychologists possess both the data and the skills to advocate as content experts, role models, and witnesses. We can help to diminish the influence of heterosexist norms. We can influence the educational development of all health and mental health professionals." Stevenson believes that much of this advocacy can be accomplished through the APA's Public Policy Office and its Office of Lesbian, Gay, and Bisexual Concerns. This work is carried on at the federal level to influence public policy decisions.

In addition, Stevenson believes that gay political advocacy can be accomplished through the Coalition to Protect Research, "which came into being after Congress threatened to de-fund significant research on sexual behavior." Says Stevenson: "Making the assumption that researchers are better equipped to judge the merit of scientific research than are most politicians, the Coalition lobbies against efforts to restrict funding for peer-reviewed research."

Stevenson urges gay psychologists to offer their services as "expert witnesses" on various levels and to help develop educational materials that "affirm diversity, broadly defined." He also urges support for organizations such as the Institute for Gay and Lesbian Strategic Studies (IGLSS) "in its efforts to debunk the myths and misinformation promoted by those who would prefer we return to the closet."

'Political Uses Of Data' Are A Concern To Gay Advocates

He also urges that more research be done on health concerns of those within the LGBT community. Stevenson notes, however, that many gay researchers are reluctant to conduct such research for fear that it might be used by those who would wish to re-pathologize homosexuality. "Having worked so hard to de-pathologize homosexuality, researchers interested in LGBT concerns may be reluctant to investigate health-related behaviors in fear of the potential political uses of such data."

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to wipe the floor with us." We didn't have long to wait, as we were immediately noticed by The American Psychiatric Association and their Committee on Gay, Lesbian, and Bisexual issues. The Journal of The American Psychiatric Association reported that the GLB committee proposed finding a way to "isolate" NARTH.

It was really to Charles Socarides that this attempt to silence NARTH was directed, as he was the most outstanding, outspoken, and listened-to member of the American Psychoanalytic and American Psychiatric organizations who was willing to take such a position. It was Charles who would be the one to provide the most unyielding lift-off energy with his fundamentalist Greek commitment to science, and his truthful, direct talk, in which the rest of us found support for our own convictions. He liked to cite a psychoanalytic researcher who said something like this: "...make one concession on science, and you might as well pack it in." But Charles will always be remembered best by his patients whom he loved and helped to find the happiness he felt every human deserved.

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Ethical Treatment
(Continued from page 2)

hope), they may work in order to please him or her, thus undermining a more intrinsic motivation for their own work. This can lead to premature beliefs or expressions of cure in which the client reports more progress than is accurate. It also places a bind on the client who eventually decides to engage in a homosexual relationship, which could induce shame and secrecy. This is a breach of AAMFT ethical code 1.3: *Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid condition...with clients that could impair professional judgment or increase the risk of exploitation.* Too strongly leading a client can establish expectations the client is not prepared to manage, and the dependent client may hide this bind.

Over-emphasize cause-and-effect relations about the etiology of the individual's attractions, i.e., "you have homosexual feelings because...." Over-simplification of causes or too much emphasis on "why" a person has these feelings trivializes the array of experiences and real causes—known and unknown—a person has in the development of his or her own brand of sexuality. Further, it may appear to the client that since cause-and-effects can be easily known, solutions should just as easily follow. A lot of frustration can ensue if this does not turn out to be true for the client.

Have real homophobia or homo-negative beliefs and expressions. A therapist may believe that a person can never experience happiness, comfort, or relational value in GLB relationships, when clearly many people report that they do. A therapist may misrepresent the array of experiences and feelings reported by GLB people. A therapist may feel disgusted by hearing accounts of homosexual activity. Feminine expressiveness in men or masculinity in women may be appalling to the therapist. Such attitudes may lead the therapist to downplay the real pain of a client who has experienced direct or indirect prejudice in a society that consistently misunderstands this issue. Every therapist has some limit as to what is difficult to hear or tolerate, and has an ethical mandate to be aware of his or her beliefs, biases, and limitations. A therapist who has difficulty tolerating clients with homosexual concerns should refer them, in accordance with AAMFT ethical code 1.1: *MFT's assist persons in obtaining other therapeutic services if the therapist is unable or unwilling, for appropriate reasons, to provide professional help.*

Believe that everyone has the same heterosexual potential, "If only you can apply principles A, B, and C." Not distinguishing among characteristics and capacities of individuals who present for help inevitably leads to error in clinical judgment and therefore places unrealistic expectations on clients. The overly optimistic "conversion" therapist may never value and avoid discussions of GLB options, when the client needs to discuss such. APA ethical principle A states *psychologists seek to safeguard the welfare and rights of those with whom they interact professionally*. The right to choose and have the therapist be available to openly and non-judgmentally discuss choices is perhaps the most fundamental element of therapy.

Haldeman (2002) observed "...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" (p. 261).

Clients who have long-standing homosexual feelings and report little-to-no heterosexual desires routinely have more difficulty developing heterosexual feelings than clients who report sensing homosexual urges later or who have some heterosexual attraction (Nicolosi, Byrd, & Potts, 2001). They may be more susceptible to therapeutic harm or disappointment in not achieving heterosexual functioning, and may feel quite compelled toward GLB explorations. Any therapist who performs therapy with clients with homosexual concerns who want to work toward change, should be cautious in his or her expectations and safeguard against harm.

Category Two: Therapists who are willing to work with clients with unwanted homo-erotic attractions, and are unsure about their own competency to treat such or who are consistently skeptical about the pos-

sibility of change, even though they have entered into an agreement to help the client. These therapists may:

Feel pressure to take too literally a request to change sexual orientation. A client who, through despair or demandingness, "must" change his or her orientation may frighten, unnerve, or anger a therapist. Taking sexual orientation too literally means that the client or therapist is overly-anxious to get to a preferred outcome. Such clients may not value the process of dealing with their attractions within their value frame, or be willing to be patient as they make adjustments and new adaptations that *may* lead to heterosexual attraction and functioning. Just as children do not actively go about willfully trying to achieve heterosexuality, one should not place too much pressure to accomplish the sexual component of sexual orientation work. The APA's guide *Answers to Your Questions about Sexual Orientation and Homosexuality* states "...many scientists share the view that sexual orientation is shaped for most people through complex interactions of biological, psychological, and social factors." Such a problem would usually require a long time to understand, manage, or overcome, so it is helpful to value the process. The therapist should seek adequate training to understand psychological and developmental problems that are often associated with SSA.

Incorrectly view therapy that addresses sexual orientation as being altogether different from therapies that address other kinds of problems. Some therapists who do this work eventually see many similarities across therapies and do not view sexual orientation work as entirely different or unique.

The successful treatments of unwanted homo-erotic attractions do not over-focus on a direct alteration of sexual attractions. Successful treatments have much similarity with treatments for depression and anxiety-related problems. Among what is emphasized is treating common psychological mistakes in engaging with a nagging problem, e.g., the more you "try" not to be depressed or anxious, the more you are; the more you try to not have homosexual urges, the more you do.

This critique should be coupled with the ethical mandate to treat within the boundaries of our competencies. Therapists who wish to work with clients toward changes in sexual attractions should follow the AAMFT Ethical Principle 3.7: *While developing new skills in specialty areas, MFT's take steps to ensure the competence of their work to protect clients from possible harm. MFT's practice in specialty areas new to them only after appropriate education, training, or supervised experience.*

The therapist may wait too long to unite with the goals of the client, due to the therapist's own ambivalence about the possibility of change. A therapist may be too skeptical about the possibility of attraction-management or increasing heterosexual feelings. This is a case of not believing that a self-determined person really can make a difference in her own sexual functioning. A client may unnecessarily lose motivation or a sense of hope with such a therapist, especially if the client and therapist share religious values and goals. A therapist who cannot join with the client with some enthusiasm and confidence, after negotiating an agreement about therapeutic goals, should take the responsibility to develop a stronger competency in this area, or refer the client to someone who has competency.

The therapist may wait too long to encourage a client to move out of contemplative ambivalence, losing opportunities to help a client experiment with new behaviors, attitudes, and adaptations. There is a difference between a client who is genuinely trying to understand and process issues, and one who is perpetually stuck in contemplation. In agreement with the ethical code to develop competency, a therapist should assess and understand problem areas, such as listed in Appendix B (Cohen, 2000), common to people struggling with SSA, to motivate and facilitate growth.

Category Three: GLB-affirming therapists. These therapists have tended to err in a different direction with regards to ethics (see for example, Perez, DeBord, & Bieschke, 2000). They may:

Present a strong pro-GLB agenda that influences the decisions of clients. Some of these clients may want to be more contemplative about the nature of same-sex attraction and homosexuality or move away from an identity based on sexuality. Therapists who

have strong agendas and who use persuasive means can be coercive and unethical in that therapy becomes an attempt to override a client's values and self-determination, and promotes the interests of the therapist over those of the client. This may be especially harmful when interacting with SSA youth, who are only beginning to consider the meaning of such attractions. This kind of therapist is acting more in the role of GLB guide and advocate than therapist, which may confuse consumers of therapy. This kind of therapy may show a blatant disregard for family and larger-system relationships which the client holds dear and unnecessarily creates conflict.

APA Ethical Principle E states: *Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making.* Affirmation therapists may err on the side of treating people as fragile as a general rule, needing to save them from unconscious internalized homophobia and an oppressive society. Such a therapist may believe that these clients cannot really self-determine a non-GLB future or establish realistic therapeutic goals for themselves, other than accepting homosexual integration.

This attitude was expressed clearly by Tozer and McClanahan (1999). "An individual's desire to change [sexual orientation] is a reflection of an oppressive and prejudicial society wherein lesbian, gay, and bisexual persons are considered deviant and inferior. Therefore, this request is not truly voluntary" (p. 731). Morrow (2000) indicated that SSA clients are always, at the beginning of therapy "already suffering from internalized homophobia and self-hatred" (p.139). APA guidelines are adamant that individuals with homosexual feelings or behaviors have no intrinsic mental illness. To believe that such individuals can be so deceived by society so as to not even be able to rationally weigh the issues involved makes no sense, and actually takes a step backward toward a pathologizing approach. To be extreme in this thinking is in violation of APA Ethical Principle E: *Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination.* A client may very well determine that a non-GLB lifestyle is more dignified and fitting of her or his values and goals.

Therapists may downplay the promiscuity that is a part of a dominant GLB culture and community. These therapists may diminish attention to health risks and problems—physical and psychological—associated with homosexuality. They may encourage youth to experiment with sexuality, even if under safe conditions. See Appendix A for a current update of some health risks.

Therapists may fail to promote an understanding of or research concerning etiology of same-gender attractions, believing that such explorations are an appendage to homo-negative attitudes. This is in violation of a principle of APA ethics stated in the preamble: *Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication.* To discount or ignore research that has demonstrated that individuals can and do manage and even make changes in their sexuality within a variety of values frameworks is misinforming.

Therapists who discount important value systems that question or oppose homosexuality, believing they are necessarily prejudicial to people. Within the AAMFT Ethical Principle 1, categories of possible discrimination include, in addition to sexual orientation, religion and culture, which may include family culture. To dismiss these significant influences out-of-hand as prejudicial and homophobic is systemically naïve, underhanded, and harmful to clients who depend on them.

Therapists who may value adolescent and adult sexual exploration and activity. What would be considered promiscuous and psychologically, interpersonally, and spiritually unhealthy by a majority of religions and people, is celebrated, encouraged, and even required by elements of the GLB culture. Bepko and Johnson (2000) detailed common rules among relationship-committed and non-monogamous gay male couples. "...rules exist such as no emotional affairs, only tricking (one-time sexual liaisons), no disclosures about outside sex (or full disclosure about it), or

mutual participation in outside sex only as a threesome or in larger groupings." (Such behavior is rarely a part of lesbian culture.) This behavior would seem to undermine the role of sexuality in the development of secure attachments. It also privileges the status of male recreational sexuality among values. Monogamy is generally regarded as an absolutely critical relational ethic among close, committed sexual partners.

Therapists who dismiss entirely the possibility of heterosexual development and the diminishing of unwanted homo-erotic attractions. In the APA's guide *Answers to Your Questions about Sexual Orientation and Homosexuality* the answer given to the question "Can therapy change sexual orientation?" is "No," and further, that engaging in such therapy is harmful and likely unethical. The authors acknowledge that sexual orientation is "extremely important to an individual's identity," yet foreclose on a person's being able to do anything about it other than acceptance. The question is worded rather deceptively in such a way as to make the answer correct: probably no one believes that "therapy changes sexual orientation." This is like saying "therapy eliminates depression." If the question was "Have people reported that therapy assisted them to diminish same-sex attraction or increase heterosexual feeling," then, according to research, the answer would be, "Yes."

The *DSM IV* diagnostic code 302.9 *Sexual Disorder Not Otherwise Specified* subcategory: *Other sexual orientation problems* were created in part for people who are distressed about their sexual orientation. This created clinical room for people to explore and take initiative about unwanted elements of sexual orientation. The APA, in negating a range of effective therapeutic modalities, is clearly expressing a political bias.

Numerous recent and historic studies have indicated that it is possible for some individuals to completely diminish same-sex attraction and enjoy heterosexuality (see Beckstead, 2001; Byrd & Olsen, 2001; Nicolosi, Byrd, & Potts, 2000; Spitzer, 2003 [this article contains an excellent, state-of-the-profession series of 26 peer commentaries concerning research in sexual orientation and change]; Throckmorton, 2002, Yarhouse, 1998). Perhaps a larger majority of clients who have been successful in altering sexual attractions have done so with a kind of negotiation—homosexual compulsions, intrusive thoughts, or overwhelming feelings are treated and generally resolved, yet heterosexual attractions are not as strong as homosexual ones. Sometimes, and in the course of years (*an average of two years post therapy, reported by Spitzer*), heterosexual attractions emerge more strongly, especially toward a spouse or partner in a committed, loving relationship (not usually generalized to many people of the other sex). Even so, researchers indicate that more than one-third of clients who seek a change in orientation are not successful. These people may be glad that they "at least tried"; others may be very disappointed, angry and resentful, or suffer damage to their self-esteem and sense of identity. With these clients, it is important to monitor expectations in therapy and help them achieve realistic goals.

Final Comments

These lists and considerations are not exhaustive, nor are they axioms to conclude without debate. Ethical guidelines exist to help clinicians protect themselves and their clients against harm. I encourage clinicians to consider their own values, practices, limitations, and strengths regarding this type of therapy, and seek continual training to provide competent help. I also encourage ongoing dialogue among clinicians of different faiths and belief systems, as these have important influences in our clinical work. We do not help clients when we are militant or take strong political stances *and* expect our clients to do the same. A common goal among all therapists is to reduce or eliminate harm, and help clients lead healthy lives that are congruent with their values.

Appendix A
Research Regarding Health Risks For Practicing Homosexuals

Although the American Psychiatric Association in 1973 removed homosexuality as a form of mental illness, people who report homosexuality in adulthood and adolescence, compared to people who do not, are two to four times more likely to receive mental health services (Clark & Serovich, 1997). Homosexuality has been correlated with higher incidences of suicidal thinking and attempts (Herrell, Goldberg, True,

Ramakrishnan, Lyons, Eisen, & Tsuang, 1999), self-harm (Skegg, 2003), eating disorders among male homosexuals (Cartat & Camargo, 1991), and anxiety-related problems (den Aardweg, 1985).

A standard conclusion across research articles is that gay men usually have more sexual partners within specified periods of time than heterosexual men, and that sexual monogamy across a lifetime is so rare as to be not reported (Bepko & Johnson, 2000). In a 1996 *Genre* magazine survey of 1,037 volunteer male respondents, 24% said they had 100 or more partners in their lifetime; another 16% said they had more than 40. They also report much more permeable sexual boundaries in committed gay relationships than would be expected in heterosexual relationships.

Among more conservative people with SSA, Spitzer's (2003) highly religious sample of 143 men and 57 women (N = 200; 14 people were LDS) who had undergone therapeutic or group attempts to modify sexual orientation, 13% of males and 4% of women had never engaged in consensual homosexuality; 47% of males and 94% of women one to 50 partners, and 34% of males, 2% of women said they had had over 50 partners. One-half of these males and two-thirds of the females had also had consensual heterosexual sex.

Despite large efforts to educate those who practice homosexuality, health problems and risk behaviors are on the rise. Gross (2003) reported—as predicted in 1997 by the CDC—a 14% upsurge in HIV among US homosexual men in the years 1999-2001, not including data from the gay-dense states of California or New York.

This author also reported "unprecedented outbreaks of syphilis and increasing rates of rectal gonorrhea" among homosexuals. In one report, one-third of all black homosexual men in six major U.S. cities America had HIV, the majority going a significant amount of time without knowing it.

Kauth, Hartwig, and Kalichman (2000), in the *Handbook of Counseling and Psychotherapy with Lesbian, Gay, and Bisexual Clients* published by the APA stated "...gay and bisexual men have no greater physical health problems than heterosexual men, with few exceptions."

This statement seemed to downplay what they in the chapter later acknowledged, that gay and bisexual men (compared to men who have never had sex with men) on average are sexually more active at early ages and report more lifetime partners, have more anal intercourse (a much higher health risk behavior than male/female intercourse), experience more hepatitis B, HIV and STD's and complications of physically traumatic intercourse. These authors examined research between 1991-1997 and found that approximately one-third of men surveyed in those studies had recently had unprotected anal sex, and that men under 30 commonly had unprotected sex—behavior that accounts for 47% of AIDS cases in America. Koblin, et al (2003) reported that among 4,295 HIV-negative homosexual men who had engaged in anal sex with one or more partners in previous year, "48% and 54.9% respectively reported unprotected receptive and insertive anal sex in the previous six months."

LDS youth may be particularly unlikely to use protection methods during sex, which would put them at higher risk for contracting sexually transmitted diseases. LDS youth/young adults might consider sexual planning premeditated and wrong, leading to "accidental" or impulsive, unprotected sex. It would not seem a far stretch to believe that most same-sex attracted LDS youth and young adults would also not plan for having sex, and often sexual behavior would be unprotected in new relationships.

Clearly, the decision to enter a homosexual relationship is not benign as to health risks. Part of informed consent is to non-coercively help clients have at least a reasonable understanding of health and safety risks associated with choices in behavior.

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College Newspapers Using NARTH As Research Source

An editorialist in the April 20, 2006 issue of San Jose State University's *Daily Spartan* quoted Dr. A. Dean Byrd's research paper on gender complementarity in arguing against gay adoption. Dr. Byrd's online paper is being widely quoted in media sources. The author, Jill Rae Seib, admitted that she had never thought there might be a problem with gay adoption until she read Dr. Byrd's article.

NARTH's web site had 122,000 visitors in March 2006 and hundreds of NARTH's research papers are being downloaded and distributed. NARTH's web site is becoming a significant presence on the Internet as a reliable resource of information on sexual orientation issues.

APA Members Invited To Sign Petition To The President Of The American Psychological Association

NOTE: If you are a member of the American Psychological Association (APA), you are invited to sign the petition in support of a client's right to choose. Simply forward an email to Kim Niquette at kniquette@cfl.rr.com to give us permission to include your name.

PETITION

We, the undersigned members of the American Psychological Association (APA) petition the President and Governance of APA to acknowledge, affirm and promote client autonomy, self-determination and diversity in matters relating to human sexual adaptation.

Further, we petition APA to support the individual's inalienable right to either claim a homosexual identity or to pursue change in sexual adaptation in accordance with the ethical principles of APA and consistent with an individual's expressed value system.

Finally, we petition APA to recognize, accept and provide opportunities for both gay affirming therapists and re-orientation therapists to express views and announce programs in The Monitor and otherwise under APA's purview.