Attempts to Modify Sexual Orientation: A Review of Outcome Literature and Ethical Issues

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Abstract

In light of the American Counseling Association's (ACA) recent resolution expressing concerns about conversion therapy, this article reviews the effectiveness and appropriateness of therapeutic efforts to change sexual orientation. The concept of sexual orientation is briefly reviewed, and found to be of limited clinical use.

The article reviews successful efforts to modify patterns of sexual arousal from psychoanalytic, behavioral, cognitive, group, and religious perspectives. An ethical analysis of the ACA resolution is presented. The author concludes **that efforts to assist homosexually oriented individuals who wish to modify their patterns of sexual arousal have been effective, can be conducted in an ethical manner, and should be available to those clients requesting such assistance**.

If any conclusion can be drawn from the literature, it is that change in sexual orientation *is possible.*

Since 1972, the mental health professions have been assessing and reassessing the status of homosexuality in mental health. During the last three decades, homosexuality has been conceptualized as a *disorder*; a *possible disorder* in the case of the DSM-III ego-dystonic homosexuality; and most recently, as *neutral* as it relates to the mental status of an individual (Rubinstein, 1995).

Recently we have seen the emergence of *opposition* to any form of counseling to attempt to change the sexual orientation of a client from homosexual to heterosexual. Davison (1976), Martin (1984) and Haldeman (1994) have suggested that psychotherapeutic efforts to change sexual orientation are unethical.

In 1997, after nearly two years of debate and study, the American Psychological Association (APA) passed a resolution expressing concern that clients may request conversion therapy due to "societal ignorance and prejudice about same-gender sexual orientation" and "family or social coercion and/or lack of information" (APA, 1997; Sleek, 1997). In March 1998, the American Counseling Association passed a similar resolution at its annual convention in Indianapolis (ACA, 1998).

Recent Threats to Practice

The ACA resolution was proposed by the association's Human Rights Committee, and the motion to accept was made by the representative of the Association for Gay, Lesbian and Bisexual Issues in Counseling (AGLBIC). The resolution was titled, "On Appropriate Counseling Responses to Sexual Orientation" **and proposed to place the ACA in opposition to any form of conversion therapy**. The proposed resolution originally read, "be it further resolved that the American Counseling Association *opposes the use of so-called 'conversion or reparative' therapies in counseling individuals having a same-gender sexual orientation*; opposes portrayals of lesbian, gay, and bisexual youth as mentally ill due to their sexual orientation; and supports the dissemination of accurate information about sexual orientation, mental health, and appropriate interventions in order to counteract bias that is based in ignorance or unfounded beliefs about same-gender sexual orientation." (ACA, 1998, p. 1-2).

During debate over the resolution, the association's governing council deleted the phrase above, concerning opposition to conversion therapies (ACA, 1998). Thus, the opposition was maintained if the conversion therapy portrays "gay, lesbian or bisexual youth as mentally ill," or a counselor spreads inaccurate information or has "unfounded beliefs" about sexual orientation (ACA, 1998, p 1-2).

As it stands, the resolution's impact is difficult to gauge. The resolution seems to discourage efforts to promote a shift from homosexual to heterosexual orientation, but comes short of clear opposition. **If passed as originally proposed, the resolution would have had enormous impact on practice**. Mental-health counselors would have been constrained to tell clients who want to modify their

sexual arousal patterns that **such an objective is faulty**. Mental-health counselors who believe homosexuality can be modified would be in danger of being charged with a violation of the ethics code. Even counselors outside of the membership of ACA would be at risk, since most states adopt the ACA code of ethics in their counselor licensing statutes.

Since most states automatically adopt subsequent revisions of that code, mental-health counselors performing activities deemed unethical based on a reading of the code would be in danger of review by state licensing authorities.

This ACA resolution, along with a companion resolution supporting same-gender marriage, created immediate controversy (Lee, 1998). The association's Western Regional Assembly voted to request that the governing council rescind the motions, and the Southern Regional Assembly requested the issue be reexamined (Gerst, 1998). Given the impact on counselors practicing conversion techniques and the controversy surrounding the issue, an examination of the major issues raised by the resolution is needed.

Counselors must respect the dignity and wishes of all clients -- Even those who seek conversion therapy

Is Conversion Therapy Ethical and Effective?

The ACA resolution opposed conversion therapy on the grounds that such therapy is both **ineffective and unethical**. This article will examine the effectiveness and ethicality of helping clients redirect their sexual orientation. First, I will examine the concept of sexual orientation, followed by a review of the literature concerning the modification of sexual orientation. Finally, I present an ethical analysis of the ACA resolution concerning conversion therapy.

In reviewing the literature concerning sexual orientation change, several terms have been used. Reparative therapy has been popularized by Joseph Nicolosi (1991, 1995), a psychologist who believes that a gay or lesbian adjustment is never a satisfactory resolution of sexual identity. Thus, counseling is "reparative" in that it helps restore the client to a more appropriate sexual adjustment.

Conversion therapy is a term used to designate therapy designed to effect a shift in sexual preference. Some behavioral counselors speak of modifying patterns of sexual arousal (Barlow & Durand, 1995). For the purpose of this article, mental-health counseling approaches that attempt to effect a change in patterns of sexual attraction and arousal will be referred to as conversion therapy. Conversion implies a profound change, which is certainly true when someone modifies sexual orientation.

A Word about Sexual Orientation

Haldeman (1994) suggested that before questions of change in sexual orientation are considered, clinicians and researchers should examine "the complex nature of sexual orientation and its development in the individual" (p. 222). I agree with this caution and submit that before opponents of conversion therapies attempt to eliminate sexual reorientation as an acceptable therapeutic goal, they must confront the same issue.

As Haldeman (1994) asserts, sexual orientation is not a well-defined concept. There are many suggestions in the literature concerning the proper method of defining sexual orientation. The point of departure for defining sexual orientation is often the work of Kinsey (Kinsey, Pomeroy & Martin, 1948). Kinsey suggested that sexual orientation ranges along a continuum from exclusively homosexual (Kinsey rating "6") to exclusively heterosexual (Kinsey rating "0") (House & Miller, 1997). Gonsoriek, Sell and Weinrich (1995) recommended assessing "same- and opposite-sex orientations separately, not as one continuous variable." (p.47). They suggested treating each orientation as a *continuous* variable.

For clinical purposes, such scales would be interesting but not terribly helpful to assess the impact of efforts to modify sexual orientation. Why? There are no norms or points along each continuum where clinicians may designate a given sexual orientation. Since researchers are mixed as to where on the continuum to declare a client "truly gay" or "straight," how can clinicians know if they are aiding clients to change from one sexual orientation to another?

Gonsoriek et al (1995) noted that the most common means of assessing sexual orientation is via self-report. However, they also noted that "there are significant limitations to this method." (Gonsoriek, et al, 1995, p. 44). The most obvious problem is the subjective nature of self-assessment. Being homosexual means different things to different people. Some define their sexual orientation by their behavior or attractions or fantasies or some combination of each dimension. After summarizing the difficulties in defining sexual orientation, Gonsoriek et al (1995) stated, "Given such significant measurement problems, one could conclude there is serious doubt whether sexual orientation is a valid concept at all." (p. 46).

Concerning the potential for assessing change of orientation, Gonsoriek et al (1995) noted, "Perhaps the most dramatic limitation of current conceptualizations is change over time. There is essentially no research on the longitu-

dinal stability of sexual orientation over the adult life span." (p. 46). *If there is no research concerning change, how can professional associations be certain that sexual orientation **cannot** change*? Thus, defining sexual orientation as a concept is a work in progress. Counselors ought to articulate this lack of certainty in an unbiased manner.

In absence of any sure way to define sexual orientation, assistance for questioning individuals should not be limited. Even if one accepts the presumption that sexual orientation cannot be changed, *how does one know* when a client's sexual orientation is settled? Without a more certain way to objectively determine sexual orientation, perhaps we should place considerable weight on the self-assessment of clients. Clients who want to change cannot reliably be told that they cannot change, since *we cannot say with certainty that they have settled on a fixed trait.*

Sexual- Orientation Change *Is* Possible

If any conclusions can be drawn from the literature, it is that change in sexual orientation is possible. For instance, in their review of the literature on once-married lesbians, Bridges and Croteau (1994) found that 25-50% of lesbians in various reports had once been in heterosexual marriages. While heterosexual marriage alone may not be a complete gauge of sexual orientation, the reasons for the marriage should offer some insight into the sexual identity of the women at the time. Kirkpatrick (1988) reported that once-married lesbian women often married because they were in love with their husbands. In examining the reasons for the shift in sexual expression, Charbonneau and Lander (1991) found two broad explanations. One group felt they had always been lesbian and were becoming true to themselves. However, another group viewed their change as a "choice among sexual options." If counselors are not to assist clients in their wishes for a shift in sexual orientation, how would ACA's governing council wish for counselors to respond to such women wanting to become more settled in their choice of a lesbian identity?

More practically, I do not know with certainty if I have ever been successful in "changing" a person's sexual orientation since I do not know how to precisely define sexual orientation, or if it is even a valid clinical concept. However, I have assisted clients who were, in the beginning of mental health counseling, primarily attracted to those of the same gender, who declare they are *now primarily attracted to the opposite gender*. I fear that resolutions such as passed by APA and ACA will prevent such outcomes, which are viewed quite positively by the clients who have experienced them.

We can never reliably tell a client, "You cannot change."

What Studies Show Treatment Success?

From a gay-affirming perspective, Martin (1984) and Haldeman (1994) reviewed studies which claimed to demonstrate change in sexual orientation. Their view was that there were *no empirical studies* which supported the idea that conversion therapy can change sexual orientation. However, they omitted a number of significant reports, and failed to examine the outcomes of many studies which have demonstrated change.

Narrowly, the question to be addressed is: Does conversion therapy work to change unwanted sexual arousal? I submit that the case against conversion therapy requires opponents to demonstrate that *no clients have benefited from such procedures* or that any benefits are too costly in some objective way to be pursued, even if they work. The available evidence supports the observation of many counselors - that many individuals with a same-gender sexual orientation ***have been** able to change* with a variety of counseling approaches.

Psychoanalytic Approaches

Beginning with Freud, psychoanalytic writers have proposed multiple explanations for the development of sexual orientation (Bieber, et al, 1963). According to Bieber, Freud proposed a "continuum between constitutional and experiential elements" (p.3) as a broad explanation for a gay or lesbian adjustment. Thus, in certain cases sexual adjustment could result from mostly nature, and in other cases, nurture should be considered the prime factor. About same-gender sexual orientation, Freud wrote to a mother of a gay son, "we consider it to be a variation of the sexual function produced by a certain arrest of development" (Freud quoted in Bieber, et al, 1962, p. 275). According to Bieber, Freud believed the developmental arrest is stimulated by heightened castration anxiety. For gay men, females are avoided either to avoid the loss of the male organ via intercourse, or to avoid unconscious incestual feelings with mother which provoke fears of castration from father. Consistent with this view, Bieber interpreted his research and clinical findings concerning a gay adjustment as pointing to a "hidden but incapacitating fear of the opposite sex." (Bieber, et al, 1962, p. 303).

While Freud generally took a negative view of modifying sexual orientation, quite a number of psychoanalytically-oriented therapists who followed him, including his daughter Anna (Freud, 1951), exerted therapeutic efforts to explore change (e.g., Bieber et al, 1962; Fairbairn, 1952; Mayerson & Lief, 1965; Ovesey & Woods, 1980; Poe, 1952; van den Aardweg, 1986; Socarides, 1978; Sullivan, 1953; Wallace, 1969).

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For instance, Bieber et al (1962) reported on the psychoanalysis of 106 gay men. Of the exclusively homosexual clients, 19% finished analysis totally heterosexual. Half of those considered bisexual were considered heterosexual post-treatment. Considering the entire sample of 106, **27% of the clients reported a shift to exclusive heterosexuality**. When one considers that about one-third of the sample *did not* express a desire to change their sexual orientation, the rate of change is even more impressive.

Bieber et al (1962) also found that 78% of the participants who became heterosexual wanted to realize this objective. However, six subjects who became heterosexual had not expressed a pre-treatment wish to change. Although motivation to change was clearly important to this effort, individuals may change patterns of sexual arousal without making such change a primary therapeutic goal.

Hatterer (1970) described a supportive, somewhat active, psychodynamic approach to treating gay males. He proposed a traditional environmental explanation for a gay sexual orientation including fear of women and detachment from male identity. He presented case information concerning 143 clients for whom an initial Kinsey rating of sexual orientation was conducted, and follow-up adjustment was assessed. Of the entire group, 49 (34%) were considered as having achieved a heterosexual adjustment, with 18 clients "partially recovered" and the remaining 53% unchanged. Breaking down the results, it appears that *client motivation* and *degree of identification with a gay identity* are keys. For instance, only 4.6% clients who were rated "exclusively homosexual" reported a heterosexual change. The vast majority of these men demonstrated no motivation to change. However, among the exclusively gay men who were highly motivated to change, 24% reported a heterosexual adaptation after counseling. Among 21 clients with a Kinsey 4 or 5 rating, the change rate was 57%. Each of these clients were at least moderately motivated to realize a heterosexual outcome.

Socarides (1979) reported that in his practice, 20 of 45 (44%) gay men seen in psychoanalytic psychotherapy between 1966 and 1977 achieved "full heterosexual functioning."

MacIntosh (1994) reported a survey of 285 psychoanalysts who analyzed 1215 psychoanalytic gay and lesbian clients (824 male; 391 female). The survey respondents reported that 23% of their gay and lesbian clients changed to heterosexuality. Also, the analysts reported their assessment that 84% of the clients reported significant benefits from analysis.

Recently a systematic approach to sexual orientation change has been advanced by Nicolosi (Nicolosi 1991, 1995). In his review of conversion therapies, Haldeman (1994) critiqued Nicolosi's theory of homosexual development, but failed to include an evaluation of the successful treatment results claimed by Nicolosi and his colleagues. Nicolosi's writings detail a multi-dimensional view of the antecedents of homosexual arousal and a psychoanalytic approach to the treatment of individuals who struggle with unwanted same-gender sexual orientation. Nicolosi offered numerous case studies of clients who have moved from primarily homosexual identity to heterosexual adaptation. Concerning the function of same-gender sexual orientation in men, Nicolosi (1991) stated, "in many homosexual men, same-sex eroticism is used as symbolic reparation of a deficit in masculine strength" (p. 157). Because many gay men have traditionally feminine interests and behaviors as young boys, they often experience rejection from their fathers and male peers. This rejection leads to what Nicolosi (1991) called a "defensive detachment" (p. 57) from father. This defensive detachment leads the pre-gay male to reject masculinity as portrayed by the father, but to simultaneously long for a close relationship with a strong man.

Nicolosi and other recent psychoanalytic clinicians have demonstrated some success in assisting individuals attain heterosexual arousal. For instance, Nicolosi, Byrd and Potts (1998) reported the results of a national survey of 882 clients engaged in sexual reorientation therapy. At the beginning of therapy, 318 of the sample rated themselves as having an exclusive same-gender sexual orientation. Post-treatment, 18% of the 318 rated themselves exclusively heterosexual, 17% rated themselves as "almost entirely heterosexual" and 12% viewed themselves as more heterosexual than gay or lesbian. Thus, 47% of this sub-group went from the self-rating of a Kinsey 6 to less than a Kinsey 2 rating. Of the entire 882, only 13% remained either exclusively or almost exclusively gay or lesbian after treatment.

Countering claims that reorientation therapies are harmful, the survey also asked clients concerning psychological and interpersonal adjustments both before and after therapy. The survey respondents also reported significant improvements in such areas as self-acceptance, personal power, self-esteem, emotional stability, depression, and spirituality (Nicolosi, Byrd, & Potts, 1998).

In summary, psychoanalytic approaches report rates of change ranging from 19% to 44% of clients. Rates for some modification of sexual orientation are even higher in some of the reports. None of the reports document negative side-effects of such efforts, and indeed seem to show positive results for a significant number of participants, even those who do not change sexual orientation. Clients who have had some prior heterosexual experience, and are motivated to change, seem most likely to report modification of sexual orientation.

Behavior Therapy Approaches

There are numerous reports of behavioral interventions which have resulted in modification of sexual arousal. While Haldeman (1994) primarily reviewed aversive therapies, a variety of other behavioral techniques have been employed, including covert sensitization, systematic desensitization,

assertiveness training and multimodal approaches.

Generally, behavioral counselors point to principles of learning to explain sexual behavior and attraction. A gay or lesbian adjustment is most likely to be established when such behavior is followed by physical and/or social reinforcement, and/or when heterosexual behavior is followed by negative events, such as punishment or humiliation. A chain of events which are reinforcing to one sexual orientation, and aversive to another, would lead to a greater likelihood to engage in behavior consistent with the positively reinforced sexual orientation (Greenspoon & Lamal, 1987).

Aversive therapies, beginning with Max (1935), were early behavioral attempts to change sexual orientation. Treatment results were mixed. For instance, Feldman, MacCulloch and Orford (1971) reported follow-up results of research conducted between 1963-1965 concerning 63 gay clients wishing to shift sexual orientation. Indicators of change were the cessation of homosexual behavior, only occasional homosexual fantasy or attraction, and strong heterosexual fantasy and/or behavior. As defined by these indicators, they reported that 29% of the clients who had no prior heterosexual experience had changed, while 78% of a group who had some prior heterosexual experience had changed, yielding a 65% rate for the entire group. Bancroft (1974), Thorpe, Schmidt, Brown and Castell (1964) and Larson (1970) also reported reorientation success with subjects using variations of aversive conditioning.

Callahan (1976), Kedrick and McCullough (1972), Mandel, (1970) and Segal and Sims (1972) describe successful reorientation outcomes with the use of covert sensitization. For instance, Callahan (1976) described the use of covert sensitization and assertiveness training applied to the case of 25-year-old single male who was sexually abused at age six by an uncle. The client had several same-gender sexual experiences through junior high school. He dated three girls in high school but felt little attraction for them. Callahan told his client that same-gender sexual arousal is learned and "can thus be changed, or accepted as a natural and normal human experience." (p. 235). The client regarded this explanation as support for his decision to supplant same-gender arousal with heterosexual arousal. Then the client was introduced to relaxation training and developed a list of arousing scenes. The covert sensitization technique involves pairing negative imagery with gay sexual fantasies (Callahan, 1976). After the intense phase of this treatment, the client "reported spontaneous sexual arousal to the sight of women for the first time." (Callahan, 1976, p. 242). At four-and-a-half year follow-up, the client was married, and reported good sexual adjustment with no same-gender sexual arousal.

Non-aversive classical conditioning techniques using sexually arousing materials have been reported. For instance, McCrady (1973) reported the successful therapy of a 27-year-old gay man who had occasional same-sex experiences from age 16. However, "for both moral and practical reasons, when he entered therapy, he was highly motivated to increase his heterosexual behavior (and to decrease his homosexual behaviors)" (McCrady, 1973, p. 257). McCrady showed the client a nude female and then faded the image into a nude male. During the course of therapy, the client reported the onset of heterosexual fantasies. After the fifth session, the client began referring to himself by saying, "when I used to be homosexual." (McCrady, 1973, p. 260). Barlow and Agras (1973) reported similar techniques although in their procedure, the nude male pictures were faded into the nude female pictures. These researchers reported physiological measures of changed arousal which improved in a heterosexual direction at follow-up for all three subjects in their study.

Systematic desensitization has been used to facilitate a shift in sexual orientation (Bergin, 1969; Huff, 1970; Kraft, 1967; James, 1978; Phillips, Fischer, Groves & Singh, 1976; Ramsey & van Velzen, 1968). For instance, Phillips et al (1976) described a 31-year-old gay man who requested sexual reorientation. The authors note that "the gay world was losing its appeal" to the client (Phillips, et al, 1976, p. 226). The client experienced anxiety concerning heterosexual physical contact and was assisted through two desensitization hierarchies. He was then able to initiate heterosexual contact and at 18 months follow-up reported no same-gender sexual activity.

Many behavioral counselors advocate the use of a variety of behavioral techniques to achieve sexual reorientation (Barlow, 1973; Barlow & Durand, 1995; Bergin, 1969; Blitch & Haynes, 1972; Freeman & Mayer, 1975; Gray, 1970; Greenspoon & Lamal, 1987; Hanson & Adesso, 1972; Marquis, 1970; Rehm & Rozensky, 1974; Stevenson & Wolpe, 1960; Tarlow, 1989; Wilson & Davison, 1974). For instance, Stevenson and Wolpe (1960) described the use of reeducation and assertiveness training in the successful reorientation of two gay men. In one case, the authors describe a 22-year-old gay man whose first same-gender sexual experiences began at age 14. The client had begun to consider himself exclusively homosexual and viewed counseling as his last possibility before accepting this conclusion. The counselor suggested to the man that he may have been "premature in assigning himself to the group of permanent homosexuals" and that the man's homosexual activity "was chiefly driven by a wish for friendly companionship with other men" (Stevenson & Wolpe, 1960, p. 738). After 10 sessions of encouragement of assertive behavior, the client terminated with plans to marry. The man reported heterosexual adjustment at a three-year follow-up.

In summary, behavioral approaches to the modification of sexual orientation progressed from a reliance on aversive approaches, to the use of sophisticated multi-modal approaches. Generally, the cases reported in the behavioral counseling literature support the efficacy of efforts to modify sexual orientation. The multi-modal approaches attempt to extinguish same-gender attraction and then provide a

variety of behavioral and supportive counseling techniques to facilitate heterosexual responsiveness. As Kraft (1970) noted, desensitization techniques are preferable to aversion techniques because they promote the incorporation of heterosexual activity. Greenspoon and Lamal (1987) suggested that the effects of office-based conditioning programs can be *undone* by lack of reinforcement in heterosexual functioning. They stress the development of social skills necessary in heterosexual situations through role-playing, homework and supportive counseling.

Cognitive Approaches

In 1959, Ellis described the treatment of a gay man who was "one of the first clients treated with a special therapeutic approach which the therapist developed after many years of practicing orthodox psychoanalysis and psychoanalytically-oriented psychotherapy" (p.339). Ellis then described his "Rational Psychotherapy" which later became Rational-Emotive-Behavior Therapy (REBT). The client had not ever had heterosexual experience and had a great fear of rejection. Ellis made no attempt to rid the client of homosexual feelings, but rather wrote that the goal of therapy was to help the client "overcome his irrational blocks against heterosexuality" (p.339). Ellis reported that by the 12th week of rational psychotherapy, the client "had changed from a hundred per cent fixed homosexual, to virtually a hundred per cent heterosexual" (Ellis, 1959, p. 342).

Although he gave no precise rates of change, he stated about his new approach in 1965, "I have treated, in my private practice in New York City, scores of homosexual patients during the last 10 years, and I have found that the rational-therapeutic approach is much more effective...than was my previous psychoanalytic approach to therapy" (Ellis, 1965, p. 109;).

While Ellis no longer believes that same-gender sexual orientation is a sign of inherent emotional disturbance, he wrote in 1992 that people are free to "try a particular sexual pathway, such as homosexuality, for a time and then decide to practically abandon it for another mode, such as heterosexuality" (Ellis, 1992, p.34). The most recent indicator of Ellis' belief that client options should not be abridged was his membership on the Committee of Concerned Psychologists (CCP) (CCP, 1995). When the APA first considered a resolution to discourage the use of conversion therapies in 1995, an ad hoc group of psychologists opposed the motion. Ellis was one of more than 40 psychologists who signed a letter which urged the rejection of the motion and branded it as "illegal, unethical, unscientific and totalitarian" (CCP, 1995, p. 4).

Group Psychotherapy Approaches

Rogers, Roback, McKee and Calhoun (1976) reviewed the group psychotherapy literature for a variety of therapeutic outcomes. They determined that "homosexuals can be successfully treated in group psychotherapy whether the treatment orientation is one of a change in sexual pattern of adjustment, or whether a reduction in concomitant problems is the primary goal" (Rogers, et al, 1976, p. 24).

Birk (1980) reports probably the highest success rates of any therapist. Using a combination of behavioral-group and individual psychotherapy, Birk reports that 100% of exclusively gay men beginning therapy with the intent to change sexual arousal were able to attain a heterosexual adaptation. The other criterion for this subgroup of clients is that they remained in therapy for over two-and-a-half years, or had achieved their goals prior to this cutoff period. Of those 14 clients who had shifted, Birk reports that 10 of the 14 (71%) *were satisfactorily married at follow-up*. Contrary to Haldeman's supposition that the men in Birk's treatment group may have had "preexisting heteroerotic tendencies" (Haldeman, 1994, p. 223), one of Birk's criteria for inclusion in this analysis was that these clients were **exclusively gay** and had not experienced heterosexual intercourse (Birk, 1980). Birk pointed to **pretreatment motivation** as a major key in understanding the results. Of those clients not expressing any pretreatment interest in sexual orientation change, four out 15 (27%) reported a shift to heterosexual adaptation.

Religiously Oriented Approaches

Religious affiliation often motivates gay and lesbian clients to seek a shift in their pattern of sexual arousal (Wolpe, 1973). Some clients have changed through religiously based interventions. Pattison and Pattison (1980) presented case studies of 11 white males who reported that they had changed sexual orientation through participation in a church fellowship. The group self-identified as gay at an average age of 11. Nine had pre-change Kinsey ratings of 6, with ratings of 4 and 5 rounding out the group. Following religious participation, five individuals rated themselves a Kinsey 0, three rated themselves a Kinsey 1 and three a 2 rating.

Many reports of change are testimonials produced by ex-gay ministry groups. For instance, the Presbyterian Church (USA) supports OneByOne, "a ministry which educates and equips congregations in the Presbyterian Church (USA) to minister to those people in conflict with their sexuality" (OneByOne, nd, p.1). In their booklet, *Touched by His Grace*, seven former gay men and four former lesbians describe their experience of gaining heterosexual adaptation and spiritual freedom (OneByOne, nd). Exodus International and Transformation Ministries are prominent support ministries for ex-gays.

As Haldeman (1994) documents, it is true that some ex-gays have become ex-*ex*-gays. However, the stories and research reports of those individuals who consider themselves former homosexuals should not be minimized. Clearly there are persons who have shifted their sexual orientation as an

aspect of following their religious beliefs (Davies & Rentzel, 1994; Saia, 1988).

Summary of Counseling Approaches

While no consensus has emerged concerning the most appropriate means of pursuing sexual reorientation, the reports above demonstrate that modification of sexual orientation **is possible for some clients**. While offering differing techniques, the counseling approaches seem to agree that necessary counseling tasks include the following: (1) increasing assertiveness, (2) addressing a learned fear of relationship with the opposite sex, (3) and the development of heterosexual social skills. Each approach also emphasizes the role of motivation and social support for maintaining change.

The inconsistent rates of change may relate more to the relative lack of systematic research in this area, than to a hypothesized inability for humans to change sexual orientation. Further research and clinical study may assist mental health professionals to better focus such efforts for individuals who want to pursue change.

Ethical Principles and Conversion Therapies: Another Look

The psychological literature seems unclear about the ethics of conversion therapy. While Haldeman (1995) portray such therapies as unethical, Garnets et al, (1991) in the *American Psychologist*, specify "biased, inadequate and inappropriate practice" and "exemplary practice" when clients present with sexual-orientation issues. As an example of an exemplary response, Garnets et al (1991) include this theme: "A therapist does not attempt to change the sexual orientation of the client without strong evidence that this is the appropriate course of action, and that change is desired by the client" (p.968). They presented as an exemplar of this theme the following comments by a survey respondent, "...I had a male client who expressed a strong desire to 'go straight.' After a careful psychological assessment, his wish to become heterosexual seemed to be clearly indicated, and I assisted him in that process" (Garnets, et al, 1991, p.968). This course is at odds with the proposed the APA and ACA resolutions which originally sought to deem conversion therapy unethical and therefore clinically inappropriate.

The ACA resolution begins by affirming ten principles concerning treatments to alter sexual orientation. The first is that homosexuality is not a mental disorder. While some writers who practice reparative therapy believe homosexuality is a developmental deficit (Nicolosi, 1991), it does not seem necessary to believe homosexuality is a disorder in order to offer counseling to modify sexual feelings. In fact, counseling as a profession has traditionally held that one **does not need to have a disorder** in order to profit from counseling. Thus, if a client requested such counseling, offering it would not require the counselor to view the client as mentally ill.

What Diagnosis Could Fit the Dissatisfied Homosexual?

Even if one asserts that offering a mode of treatment implies a disorder, there is a condition in the DSM-IV which would be the proper object of conversion therapies — Sexual Disorder, Not Otherwise Specified (NOS) (American Psychiatric Association (ApA) , 1996). Though the diagnosis of ego-dystonic homosexuality was removed from the DSM-III, Sexual Disorder, NOS remains in the DSM-IV with several descriptors, one of which is "persistent and marked distress about sexual orientation." (American Psychiatric Association, 1996, p. 538). Certainly, many individuals who seek conversion therapy could be described in this manner.

The second principle is that counselors should not discriminate against clients due to their sexual orientation. Contrary to this principle, banning efforts to modify sexual orientation would require the ACA to *discriminate against those clients who want to change.*

Should Sexual Arousal Take Precedence Over Moral Convictions?

The third principle is that counselors will "actively attempt to understand the diverse cultural backgrounds of the clients with whom they work."(ACA, 1998). Nothing in conversion therapy negates this principle. When such conflicts occur, what makes one set of loyalties more important than another set? If professional associations discredit efforts to modify sexual orientation, *they may be implying that sexual arousal is more vital than any conflicting personality variables or moral convictions.* I believe mental health counselors who practice conversion therapy **do** attempt to understand the cultural background of a client who presents in deep conflict over sexual impulses and deeply held moral convictions.

Principle four requires the counselor to inform clients concerning the "purposes, goals, techniques, procedures, limitations and potential risks and benefits of services to be performed." Nothing in this principle prohibits conversion therapy. As the above review of the literature demonstrates, it would be a *violation of this point* to say that *there is no empirical evidence of efficacy* of various conversion therapies.

The fifth principle states that "clients have the right to refuse any recommended service and be advised of the consequences of such refusal." This is true of nearly all mental-health treatments.

The sixth principle supports the availability of conversion therapies. The resolution quotes the ACA code of ethics, section A.3.b which states that counselors "offer clients freedom to choose whether to enter into a counseling relationship (ACA, 1998). It is my experience that clients *ask for assistance* with unwanted homosexual feelings. Clients should have the freedom to choose the approaches which

help them meet their goals. The availability of conversion therapy is supported by this principle.

The seventh principle states "when counseling minors or persons unable to give voluntary informed consent, counselors act in these clients' best interests." (ACA, 1998). Mental-health counselors engaging in counseling to modify sexual orientation have a duty to act in the client's best interests, whether a minor or an adult. Since it has not been shown that such counseling is intrinsically harmful, assisting a minor client who wishes to engage in such counseling does not violate this principle. When a parent's and child's counseling objectives differ, achieving a working alliance with the family requires skill in conflict resolution and family interventions no matter what kind of problem is presented.

When the Values of the Religious Client are Denigrated

In the eighth principle, counselors are reminded to be "aware of their own values, attitudes, beliefs, and behaviors and how these apply in a diverse society, and avoid imposing their values on clients." (ACA, 1998). But when conversion therapy is *opposed*, what does this say to clients? To clients who want to explore the possibility of change, it means that their wish is diminished, *not to be taken seriously*. For individuals who are morally opposed to homosexuality as a lifestyle, it means that the professions have *denigrated their moral convictions*. For individuals who have successfully changed, who now are heterosexual, it means that the professions have *criticized their accomplishments*.. The most appropriate response when the client's goals and the mental health counselor's skills do not match is to refer to another mental health counselor.

Should the Counselor Change the Client's Religious Convictions?

The ninth principle, related to the above point, is the statement from the ACA code of ethics (section A.6.a) that counselors "are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of clients." The counseling profession has been oblivious to a double standard concerning sexual orientation and religious conviction. While the ACA has opposed the modification of an individual's homosexual feelings, *there has been no movement to avoid the disruption of an individual's religious convictions*. For instance, Barret and Barzan (1996) in their article concerning spirituality and the gay experience suggest that "assisting gay men and lesbians to step away from external religious authority may challenge the counselor's own acceptance of religious teachings." (p.8). According to Barret and Barzan (1996), "most counselors will benefit from a model that helps them understand the difference between spiritual and religious authority." (p. 8).

The last principle requires counselors to "report research accurately and in a manner that minimizes the possibility that results will be misleading." As noted above, **evidence exists for the efficacy of conversion therapies**. However, these findings have not been consistently reported in the counseling and psychological literature over the last two decades. A search of the *Journal of Mental Health Counseling, Journal of Counseling and Development, Counseling and Values and the Journal of Multicultural Counseling and Development* reveals **no articles on conversion therapy**. All articles concerning homosexuality espouse the gay-affirming approach to therapy. I think the information given in this article, previously unreported in counseling journals, should be widely distributed .

Discussion

The purpose of this review has been to demonstrate that therapeutic efforts to help clients modify patterns of sexual arousal have been successful, and should be available to clients wishing such assistance. I believe the available literature leaves no doubt that some degree of change is possible for some clients who wish to pursue it.

The literature on therapeutic assistance for unwanted same-gender sexual arousal suddenly came to a near halt in the early 1970s, but clients wishing assistance did not cease to come to counseling. *I personally have experience with clients who have wanted assistance to change their pattern of sexual arousal and due to their reports, believe such change is possible.*

As stated above, sexual orientation as a concept has limited clinical utility. Since the definition of sexual orientation is somewhat arbitrary, I submit it is inappropriate to tell a client that it cannot be changed or modified. Bell and Weinberg (1978) in their large study of homosexuality in the San Francisco area, defined a homosexual as anyone with a Kinsey rating of four or higher. In the literature cited above, rates of change for individuals with Kinsey ratings of 4 and 5 were in the 57-78% range (Feldman, MacCulloch, & Orford, 1971; Hatterer, 1980; Mayerson & Lief, 1965). Thus, defined in the manner of the Bell and Weinberg study, an impressive majority of clients were able to modify sexual orientation. Whether one can say that sexual orientation is being changed depends on how narrowly one defines sexual orientation, or if it can be defined at all.

So what should mental health counselors do when confronted with clients who request sexual reorientation? I propose the following guidelines:

1. Neither gay-affirmative nor conversion therapy should be assumed to be the preferred approach. Generally, gay-affirmative therapy, or referral to such a practitioner, should be offered to those clients who want to become more satisfied with a same-gender sexual orientation. Conversion therapy or referral should be offered to clients who decide they want to modify or overcome same-gender patterns of sexual arousal. Assessment should be conducted to help clarify the strength and persistence of the client's wishes.

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2. For those clients who are in distress concerning their sexual orientation and are undecided concerning reorientation, mental-health counselors should not assume what approach is best. They should inform clients that many mental-health professionals believe same-gender sexual orientation cannot be changed, but that others believe change is possible. Clients should be informed that some mental-health professionals and researchers dispute the concept of an immutable sexual orientation. Mental-health counselors should explain that not all clients who participate in gay-affirming therapy are able to find satisfaction in a gay adjustment, nor are all clients who seek sexual reorientation successful. When clients cannot decide which therapeutic course to pursue, mental-health counselors can suggest that clients choose a therapy consistent with their values, personal convictions and/or religious beliefs (Nicolosi et al, 1998).

3. Since religion is one of the client attributes which mental health counselors are ethically bound to respect, counselors should take great care in advising those clients dissatisfied with same-gender sexual orientation due to their religious beliefs. To accommodate such clients, counselors should develop expertise in methods of sexual reorientation, or develop appropriate referral resources.

Finally, mental health counselors have an obligation to respect the dignity and wishes of all clients. ACA and other mental health associations should not attempt to limit the choices of gays and lesbians who want to change.

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