I. Response to APA Claim: There Has Been No Conclusive or Convincing Evidence That Sexual Orientation May Be Changed Through Reorientation Therapy

While no published study has sought a random population from which to assess treatment success rates for clients seeking to change their unwanted homosexuality and develop their heterosexual potential, such treatment has been widely documented in the literature since the late 19th century. Clinicians and researchers who have used or investigated a variety of reorientation approaches have reported positive outcomes.

Definition and Measurement of "Change"

Treatments specifically aimed at changing sexual orientation have been available for more than a century, and positive outcomes have been documented. These interventions are often referred to as *therapies* and fall under the categories of conversion, sexual reorientation, reparative, or ex-gay religiously-mediated therapies.

The methodologies and techniques used in these interventions have varied. Clinicians and researchers typically defined "successful" treatment as an intentional shift in sexual desire from homosexuality toward heterosexuality, either through self-reporting or through measurements such as penile plethysmography or the 7-point Kinsey scale (Kinsey, Pomeroy, & Martin, 1948), the multi-item Klein Sexual Orientation Grid (KSOG) (Klein, 1978), or other measures (Sell, 1997). Since there is no consensus of what constitutes a successful outcome, various authors maintain their own autonomy in how to define an outcome as successful.

Despite variations in defining success, change in orientation is measurable. One of the several widely used tools is Kinsey's Heterosexual-Homosexual Rating Scale, commonly referred to as the "Kinsey scale" (Kinsey et al., 1948). A person can be assigned a position on a 7-point scale for each period in life. Kinsey used this scale because it "comes nearer to showing the many gradations that actually exist" (Kinsey et al., 1948, p. 656). The points represent the gradations as:

0 *Exclusively heterosexual*
1 *Predominantly heterosexual, only incidentally homosexual*
2 *Predominantly heterosexual, but more than incidentally homosexual*

3 *Equally heterosexual and homosexual*
4 *Predominantly homosexual, but more than incidentally heterosexual*
5 *Predominantly homosexual, only incidentally heterosexual*
6 *Exclusively homosexual*

Klein's KSOG took the Kinsey scale a step further, concluding that sexual orientation can change over time. But even more important than defining sexuality as fluid was Klein's introduction of different factors that can influence identity.

As a result, the KSOG retains Kinsey's 7 intervals, but also investigates sexual experience and fantasies in three time periods: *present* (the most recent 12 months), *past* (prior to 12 months ago), and *ideal* (which is as close as one can get to the intention and prediction of future behaviors) (Klein, 1978). For each of these time periods, people are asked to which gender they are sexually attracted, with which gender they actually have sex, which gender they fantasize about, and to which gender they feel more drawn or closest to emotionally. They are also asked with which gender they like to socialize, in which community they prefer to spend their time, in which community they feel most comfortable, and how they label or identify themselves.

There are also several ways of measuring change or treatment success. Glover (1960) divides the degrees of treatment success into three categories: (a) *cure*—conscious homosexual impulses are gone and the full extension of heterosexual impulses exist; (b) *much improved*—conscious homosexual impulses are gone, but the full extension of heterosexual impulses is not developed; and (c) *improved*—ego integration is increased, and the person has the capacity to control homosexual impulses.

Karten (2006) defined four hallmarks of treatment success:

1. Increased sexual feelings and behaviors toward the opposite gender.
2. Decreased sexual feelings and behaviors toward the same gender.
3. A stronger heterosexual identity.
4. Improvement in psychological well-being.

Some take a more simplistic view of success. One example is religiously-based treatment, which defines celibacy as an acceptable outcome (Harvey, 1987, 1996; Jones & Yarhouse, 2007). In this case, however, people do not necessarily change sexual *orientation,* rather sexual *identity* and/or *behavior.*

Another view focuses on sexual performance. Conrad and Wincze (1976) treated three homosexual men with masturbatory conditioning (orgasmic reconditioning). All three men were able to perform sexually with women, no longer needed male sexual partners, and reported complete adjustment to their sexuality. As a result, the treatment was considered successful.

Some attempts to change sexual orientation are now seen as invasive, such as aversion therapies. Although aversion therapists were successful in treating a variety of unwanted homosexual thoughts, feelings, and behaviors (Thorpe, Schmidt, Brown, & Castell, 1964; McConaghy, 1969; Hallam & Rachman, 1972),[1] aversion therapies are no longer used for sexual reorientation because of ethical considerations.

Any type of psychological treatment can result in unwanted outcomes, including the potential for perceived harm, complete failure, and relapse (Shidlo, Schroeder, & Drescher, 2001; Shidlo & Schroeder, 2002; Lambert & Ogles, 2004). And as with any psychological treatment, the client's

1 To illustrate the historical continuity of the clinicians' and researchers' reports, references here and in the remainder of Section I are listed in chronological order unless otherwise indicated. This is a deviation from the *Publication Manual of the American Psychological Association* (APA, 2001), which suggests alphabetization.

motivation and determination to comply with treatment predicts the greatest positive response in most cases (Fine, 1987; Clarkin & Levy, 2004).

Researchers document that sexual orientation is not a single, one-dimensional phenomenon (Weinrich & Klein, 2002). For example, Kernberg (2002) concluded that some women have an "elective orientation"—homosexuality later in life that is usually "preceded by an extended heterosexual lifestyle and that may revert to a heterosexual lifestyle" (p. 16).

There is no universal definition of *sexual orientation*; some see it as fixed, while others see it as fluid. According to Schneider, Brown, and Glassgold (2002), sexual orientation is defined in terms of the gender (or genders) of the people to whom individuals are sexually and affectionately attracted and toward whom they experience feelings of love and/or sexual arousal. It is defined as a continuous rather than a dichotomous variable. Most people are primarily oriented toward one gender (their own or the opposite), but some people have some degree of attraction to or history of sexually gratifying behavior with persons of the other gender as well. Other individuals experience more or less balanced attractions to both women and men.

Even though sexual attraction can be conceptualized on a continuum (such as that measured by the Kinsey scale), people in Western cultures tend to describe themselves as one of three orientations: *homosexual* (gay or lesbian), *bisexual,* or *heterosexual.* A person's declared sexual orientation may or may not be congruent with that person's actual sexual activities, which include behaviors, cognitions, and fantasies related to sexuality (Schneider et al., 2002, p. 266).

When cross-preference scales were compared among homosexual and heterosexual men, it was clear that homosexual men were likely to accept cross-preference sexual feelings, while heterosexual men were not. That is, heterosexual men do not report thinking about sex with men—but homosexual men occasionally think about sex with women. This shift in erotic preference is more common in homosexual men than in heterosexual men. In one study, one third of homosexual men reported experiencing sexual thoughts and feelings about women, but none of the heterosexual men reported sexual feelings about men (Storms, 1980).

A review of the literature by Whitehead and Whitehead (2007) shows that homosexuals—and, to a much lesser extent, heterosexuals—demonstrate evidence of sexual fluidity, including "spontaneous" as well as "assisted" reorientation. "A summary of these studies . . . is that about half of those with exclusive SSA [same-sex attraction] were once bisexual or even heterosexual. And about the same number changed from being exclusively SSA to bisexual or even heterosexual" (Whitehead & Whitehead, 2007, Chapter 12, p. 3).

Among studies finding evidence of the fluidity of sexual orientation, Bell, Weinberg, and Hammersmith (1981) reported that approximately 2 percent of the heterosexual population they surveyed had reported having been exclusively homosexual at an earlier time. Bell and Weinberg (1978) found that those who report themselves as homosexuals showed variety in their sexual experiences when measured on a continuum: 65 percent of homosexual men and 84 percent of homosexual women reported having had heterosexual intercourse.

Of the homosexual women interviewed, 70 percent reported that their first sexual experience was with a man (Paczensky, 1984, as cited in Warczok, 1988), and 43 percent of homosexual men reported that they had engaged in heterosexual intercourse more than once (Dannecker & Reiche, 1974, as cited in Warczok, 1988). Warczok reported that seeing an attractive woman "intensively" excited 13 percent of a sample of homosexual men (Warczok, 1988, p. 181). Tanner reported that as many as half of the lesbians whom she knew had reportedly been heterosexual until middle age (Tanner, 1978, cited in Whitehead & Whitehead, 2007). And in the last decade, Diamond (2003, 2005a, 2005b, 2006, 2008) reported longitudinal data that clearly shows the fluidity of the sexual orientation of women.

There is little documentation about shifts in erotic preferences in exclusively heterosexual men. While Greer and Volkan (1991) note that it is not unusual for heterosexual men to report "homosexual fantasies" (p. 109) in the course of psychoanalysis or intensive psychotherapy, those fantasies are not accompanied by erotic arousal. In their work with nonincarcerated men, Goyer and Eddleman (1984) reported that a man who previously identified himself as exclusively heterosexual changed his sexual preference as a result of being sexually assaulted by two men. After the rape, the man experienced sexual identity confusion and began voluntarily engaging in homosexual activity (p. 578).

Recent Reports of Assisted Sexual Reorientation

Reports from the current decade are discussed to introduce the 125-year history of therapeutic efforts to change homosexual orientation (Nicolosi, Byrd, & Potts, 2000a, 2000b; Beckstead, 2001; Spitzer, 2003; Karten, 2006; Cummings, 2007; Byrd, Nicolosi, & Potts, 2008).

With significant support from NARTH, Nicolosi et al. (2000b) used a 70-item client-answered scale "to explore the experiences of individuals who have struggled with homosexuality during a time in their lives, were dissatisfied with that orientation, and have since sought and experienced some degree of change" (p. 1074). A total of 882 subjects, including 689 men and 193 women, completed surveys that retrospectively document the degree of change toward heterosexuality and away from homosexuality experienced as a result of psychotherapy, pastoral counseling, and/or self-help efforts, including participation in religiously-mediated ministries. A total of 216 (24 percent) reported having participated in reorientation therapy with only a professional therapist, 229 (26 percent) with both a professional therapist and a pastoral counselor, 223 (25 percent) with only a pastoral counselor, and 156 (18 percent) through self-help efforts that included religiously-mediated group ministries.

After receiving therapy, pastoral counseling, and/or individual or ministry-based self-help, 34.3 percent of participants retrospectively reported a shift from a homosexual orientation to an exclusively or almost exclusively heterosexual orientation. While more than 67 percent of participants indicated they were exclusively or almost exclusively homosexual at one time in their lives, only 12.8 percent perceived themselves in that way at the time of the survey.

Of the 318 who identified themselves as exclusively homosexual before treatment, 56 (17.6 percent) reported that they viewed themselves as exclusively heterosexual following treatment, 53 (16.7 percent) as almost entirely heterosexual, and 35 (11.1 percent) as more heterosexual than homosexual. Thus, 45.4 percent of the participants who reported exclusive homosexuality before treatment retrospectively reported a major shift in their sexual orientation. Participants reporting success described substantial reductions in the frequency of homosexual thoughts and fantasies, as well as significant improvements in various areas of their psychological, interpersonal, and spiritual well-being.

On the other hand, 35.1 percent of participants were unsuccessful in making significant changes in orientation. Nonetheless, the majority of participants reported that they were functioning better emotionally after such therapy, even though in most cases the shift toward heterosexuality was not complete.

A subsequent qualitative analysis (Byrd et al., 2008) of open-ended questions posed to these subjects revealed more. Participants reported that areas in which they needed and experienced healing included "deficits in emotional needs, deficits in family and social relationships, and the effects of abuse." Mechanisms of change included having "an understanding, caring or nurturing therapist or spiritual leader"; a support group whose members offered each other accountability, encouragement, acceptance, and empathy; spirituality; and an understanding of the "root causes" of one's homosexual attractions, "identifying unmet needs," and learning to meet such needs in "healthy, nonsexual ways" (p. 23).

After studying a smaller sample, Beckstead (2001) found less evidence to support the possibility of sexual reorientation. He used a structured interview with 18 men and 2 women who reported that sexual reorientation therapy was beneficial to them. Beckstead found that overall, his subjects acquired an increased sense of "peace and contentment" because they resolved conflicts between their same-sex feelings and behaviors and their religious beliefs. But he reasoned that this "did not indicate a change in sexual orientation but in self-acceptance, self-identity, focus and behavior patterns. No substantial or generalized heterosexual arousal was reported, and participants were not able to modify their tendency to be attracted to their same sex" (p. 103)

Psychiatrist Robert Spitzer (2003) reported personal communication with Beckstead, who explained that "many of his participants did report increased heterosexual attraction following reparative therapy" (p. 414) However, Beckstead concluded that this change was not a change in sexual reorientation because

> it was not "generalized heterosexual arousal." . . . Either the arousal was limited to only one person (e.g., only the subject's spouse), whereas typically heterosexuals are attracted to more than one member of the opposite sex; or because the opposite sex arousal in his participants didn't have the "intensity" that is typically present in heterosexuals. (Spitzer, 2003, p. 414)

Spitzer (2003) opines that Beckstead understated the significance of his findings. Spitzer explains that persons who made "substantial changes in sexual attraction, and were now for the first time enjoying heterosexual sex" (p. 414)—even with a "continued tendency to same sex attraction" (p. 414)—achieved significant reorientation.

> It makes no clinical sense to ignore such . . . change, and this would never be done in the case of evaluating the efficacy of any psychosocial or pharmacological therapy. . . . [Likewise,] one would not judge a psychosocial treatment for a sexual dysfunction as a failure if it did not result in sexual function indistinguishable from that of individuals who had never experienced such a disorder. (Spitzer, 2003, p. 414)

In his own research on the validity of self-reported sexual reorientation, Spitzer (2003) interviewed by telephone 200 people—143 men and 57 women—who had participated in sexual reorientation treatment and who considered their therapeutic and/or religiously-mediated experiences successful. As with the Shidlo and Schroeder (2002) study—which was initiated to locate people who felt "harmed" by efforts to change—Spitzer's sample was selective and nonrepresentative; he specifically sought people who reported that they had experienced sexual reorientation. Spitzer used a sexual-orientation interview consisting of 114 closed-ended questions. All of the subjects reported having been sexually attracted to members of their own sex; 62 percent of the men and 42 percent of the women reported that they had experienced opposite-sex attraction as teenagers either "never" or "only rarely"; and 53 percent of the men and 33 percent of the women said they had not experienced "consensual heterosexual sex" before participating in a reorientation change process (p. 408).

Overall, Spitzer found that the mean scores on the Sexual Attraction Scale (SAS) and the Sexual Orientation Self-Identity Scale for both men and women shifted from the "very high homosexual range" before attempting reorientation to the "very high heterosexual range" after having attempted reorientation. Specifically, before their attempts, no men or women reported exclusive opposite-sex attractions, and 46 percent of the men and 42 percent of the women reported exclusive same-sex attraction. After their various interventions (21 percent of the subjects were still participating in some

form of change process), no subjects reported exclusive same-sex attractions, and 17 percent of the men and 54 percent of the women reported exclusive opposite-sex attraction. Based on these findings, Spitzer concluded that change in actual sexual orientation—not just in sexual identity or behavior—does occur:

> In this self-selected sample, almost all of the participants reported substantial changes in the core aspects [sic] sexual orientation, not merely overt behavior. Even individuals who made a less substantial change in sexual orientation reported that the therapy was extremely beneficial in a variety of ways. Change in sexual orientation should be seen as complex and on a continuum. Some people seem able to change only sexual orientation self-identity. Others appear also able to change overt sexual behavior. This study provides evidence that some gay men and lesbians are able to also change the core features of sexual orientation. (p. 415)

We consider it noteworthy that Spitzer questions the validity of these findings when he asks: "Are the participants' self-reports of change, by-and-large, credible or are they biased because of self-deception, exaggeration, or even lying?" (p. 412). Spitzer acknowledges the lack of more objective and longitudinal data and the limitations that such lack imposes, but he offers a number of reasons why his subjects' reports—and his conclusions about them—should not be dismissed:

First, study participants seem more credible because of the wide range and limited nature of their reported outcomes; few reported that they achieved complete reorientation.

Second, participants readily provided detailed answers when asked to describe specific outcomes of interventions (such as fantasies about the opposite gender).

Third, participants reported that on average their changes occurred gradually; most experienced a gradual lessening of homosexual feelings followed only later by an increase in heterosexual feelings.

Fourth, Spitzer's finding that women on average reported greater success in reorienting than did men is consistent with the findings of other researchers.

Fifth, while "most participants who were married did report significant improvement in marital adjustment, . . . they did not report a current level of adjustment higher than that of the normative reference group for" the research instrument used to measure marital adjustment (p. 412).

Finally, Spitzer reports that the strategies for change used by men and women in his study are commonly considered effective when used in psychotherapy in general. He concludes that all six of these factors support the plausibility of his participants' reports and the validity of his study's findings (pp. 412–413).

Spitzer's study was peer-reviewed, and Spitzer himself clearly identified its methodological limitations. Gay activists who responded to its publication attempted to dismiss Spitzer's findings by citing his study's limitations, holding it to a higher standard than other similarly conducted research, including studies often cited in support of activist claims. The responses of activist-authors (many of whom are mental health professionals) in the *Journal of Gay and Lesbian Psychotherapy* (Drescher, 2003) conveyed a tone of "suppression and personal attack" instead of "one that valued the scientific spirit of investigation and openness" (Byrd, 2008; Byrne, 2008; cf. Byrd, 2006).[2]

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2 Byrd (2008) offered additional criticism of the unprofessional critiques of Spitzer's study: "It appears that the activist-authors of the *Journal of Gay and Lesbian Psychotherapy* were outraged that the study was published at all, a sad commentary for a professional journal. Spitzer's motives were questioned, his credibility attacked and his research subjected to a kind of scrutiny unparalleled in any scientific arena. . . . As a scientist, I find the journal's approach in this issue to be both disingenuous and intolerant. Disagreement among scientists is healthy. Name-calling and intimidation tactics are not."

In support of Spitzer's conclusions, Hershberger—a distinguished scholar and statistician who is a self-identified essentialist (one who believes that homosexuality is biologically determined and who is very supportive of gay causes)—subjected Spitzer's results to additional scrutiny: a Guttman analysis. The Guttman analysis is a statistical procedure that determines the veracity of participant reports by determining if the reported changes in sexual orientation occurred in an orderly fashion.

After his analysis of the method and results of Spitzer's study, Hershberger concluded:

> The orderly, law-like pattern of changes in homosexual behavior, homosexual self-identification and fantasy observed in Spitzer's study is strong evidence that reparative therapy can assist individuals in changing their homosexual orientation to a heterosexual orientation. Now it is up to those skeptical of reparative therapy to provide comparably strong evidence to support their position. In my opinion, they have yet to do so. (Hershberger, 2006, p. 440)

Table 1. Compilation and Overall Average Outcome of Recent Surveys of Reorientation Therapy Consumers

Survey	*N*	*Number and percent reporting exclusive opposite-sex attraction shift fully successful*
Nicolosi et al. (2000b)[1]	318	114 (36%)
Shidlo & Schroeder (2002)	202	8 (4%)
Spitzer (2003)[2]	183	96 (52%)
Total	703	218 (31%)

1. There was a total N = 883 for the entire study; however, only 318 reported being exclusively homosexual pre-treatment and 114 of these reported themselves exclusively heterosexual post-treatment.
2. There was a total N = 200 for the entire study; however, only 183 were included in calculations of exclusive post-treatment opposite-sex attraction.

Table 1 is a compilation and average of three recent consumer survey reports (Nicolosi et al., 2000b; Shidlo & Schroeder, 2002; Spitzer, 2003) and reveals an average success rate of 31 percent. There was large divergence in the success rates between the Nicolosi et al. (2000b) and Spitzer (2003) studies and the Shidlo and Schroeder (2002) study, likely due to different sampling methods. Nicolosi et al. (2000b) and Spitzer (2003) sampled men and women who would more likely provide positive results—for example, people who thought they had reoriented successfully—while Shidlo and Schroeder (2002) initially sampled persons who thought that they had been harmed by their reorientation efforts. Shidlo and Schroeder's study is discussed in detail below and in Section II.

Inspired by Spitzer's landmark study, Karten's (2006) dissertation examined the sexual reorientation experiences of a convenience sample of 117 men using a survey-based correlational design. At least six months before participating in the study, potential subjects participated in some type of reorientation intervention or activity aimed at changing homosexual attraction and/or behavior—whether administered by a mental health professional, a religiously-mediated or nonreligious support group, and/or a self-directed support group. Subjects were recruited through three main sources: 41.0 percent through private-sector psychotherapists, 38.5 percent through nonreligious/nondenominational organizations

(such as NARTH and People Can Change), and 20.5 percent through ex-gay ministries and religious organizations (p. 65).

Karten's dissertation specifically investigated the following variables: relationship to father, sexual self-identity, quality of psychological relatedness to other men, religious values, and self-reported change. Based on a review of relevant literature, Karten defined successful reorientation as "an increase in heterosexual functioning, a decrease in homosexual functioning, improved psychological well-being, and a greater heterosexual self-identity" (p. 59).

Karten used a modified, inverse Kinsey scale (Kinsey et al., 1948), with 1 (instead of 6 on the Kinsey scale) indicating "exclusive heterosexuality" and 7 (instead of 0) indicating "exclusive homosexuality" (p. 79). Karten found that as intervention began, subjects reported a mean score of 4.81 (5 = predominantly homosexual, only incidentally heterosexual; 4 = predominantly homosexual, but more than incidentally heterosexual). After intervention, they reported a statistically significant lower mean score of 2.57 (3 = equally heterosexual and homosexual; 2 = predominantly heterosexual, but more than incidentally homosexual). Karten interpreted these changes in reported sexuality as evidence that meaningful sexual reorientation had occurred.

Karten found that the following variables predicted greater treatment success: high lack of psychological relatedness to other men, reduction of conflict associated with restrictive affectionate behavior between men, the conscious choice to take on a heterosexual identity, and the prior presence of absent/weak bonding with father. "Perhaps the most robust finding . . . was that a reduction in conflict associated with expressions of [nonsexual] affection toward other men was associated with treatment success" (p. 105).

Karten conjectured that while "poor bonding between father and son may not be amenable to sexual reorientation interventions, problematic masculine identity may be" amenable. This conjecture is consistent with the finding that "activities that focus on strengthening one's masculinity, (i.e., attending a men's weekend, mentoring) were rated as most helpful" for facilitating the degree of reorientation that subjects experienced (p. 125). Also, contrary to the initial hypothesis, *lower* intrinsic religiosity was found to be a better predictor of treatment success. This finding may be simply an artifact of the high average religiosity among all subjects, and Karten conjectured other possible reasons (pp. 111–112).

Comparing how they were at the time they began reorientation activities and how they were at the time of the study, subjects on average reported statistically significant decreases in discomfort with expressions of caring between men (p. 143) and in homosexual feelings and behavior (pp. 143–144), and a corresponding statistically significant increase in heterosexual feelings and behavior (p. 144).

On average, the men in the study also reported positive changes with respect to psychological well-being as a result of their change efforts. In particular, 100 percent of the men reported increases in self-esteem and 99.1 percent in social functioning, while 92.3 percent reported decreases in depression, 72.6 percent in self-harmful behavior, 58.9 percent in suicidal ideation and attempts, and 35.9 percent in alcohol and substance abuse (pp. 87–88).

> Understanding better the causes of one's homosexuality and one's emotional needs and issues was considered the most helpful technique [for facilitating reorientation], . . . followed by developing nonsexual relationships with same-sex peers, mentors, family members and friends; and exploring linkages between one's childhood, family experiences and same-sex sexual attraction and behavior. (p. 89)

As a category of interventions, "self-education (e.g., intense individual study) and religious interventions (e.g., pastoral counselor, ex-gay or other religious ministry support group) were rated as most

helpful" (Karten, 2006, p. 108). Among "individual interventions. . . . men's weekends/retreats, psychotherapy with a psychologist, and a mentoring relationship were found to be the most helpful" (p. 122). Men who became more comfortable with expressing their thoughts and feelings to other men and with nonsexualized touch and affection reported more reorientation success as a result of their respective interventions (pp. 148–149). Overall, the results of Karten's study are consistent with other recent research (discussed above) showing that homosexuality is fluid, not fixed—and, thereby, changeable—and that it is possible for persons with unwanted homosexual orientation to reorient with therapeutic, religiously-mediated and/or other self- and group-guided help.

Cummings (2007), former APA president, served as Chief of Mental Health with the Kaiser-Permanente Health Maintenance Organization. During a 20-year period ending in 1980, he estimates that he saw more than 2,000 patients, and that his staff saw another 16,000, who presented with concerns regarding homosexuality. Most did not express a goal of reorienting, but rather entered treatment to resolve a number of issues and dissatisfactions concerning their lifestyle, including the transient nature of their relationships, disgust or guilty feelings about promiscuity, fear of disease, and the wish to have a traditional family. Cummings and his staff did not try to reorient those with same-sex attraction to heterosexuality unless they expressed a strong desire to reorient. No more than 10 percent of the 18,000 clients initially said they wanted to change sexual orientation. After working on other lifestyle issues and dissatisfactions, however, additional clients developed a desire to attempt orientation change.

Overall, Cummings estimates that approximately 67 percent of clients had satisfactory outcomes. The majority of these (at least 10,000 of the 18,000) attained a happier and saner homosexual lifestyle with more stable relationships; another approximately 2,400 clients successfully reoriented their sexuality to heterosexuality. The remaining third of the 18,000 had unsuccessful outcomes that included continued promiscuity, unhappiness, and addictive behaviors.

Finally, Jones and Yarhouse (2007) conducted a prospective and longitudinal study that, by contemporary standards, is the most methodologically rigorous research to date designed explicitly to investigate the possibilities both of changing sexual orientation and of being harmed through attempting reorientation. While the researchers studied nonprofessional, religiously-mediated approaches to change, their study is mentioned here for three reasons. First, the methodological quality of the study was very good. Second, other studies highlight the importance of religiously-mediated aids for reorientation, with or without psychotherapy (Nicolosi et al., 2000b; Shidlo & Schroeder, 2002; Spitzer, 2003; Karten, 2006; Byrd et al., 2008). And third, the APA explicitly criticized religiously- as well as therapeutically-mediated efforts in its warnings about the actual or potential unhelpfulness and harmfulness of attempts to promote—or seek—sexual reorientation (Just the Facts Coalition, 2008).

Jones and Yarhouse (2007) began studying 98 men and women who were at least 18 years old, were seeking help to resolve unwanted homosexual attractions and behaviors through various ministries of Exodus International, and had been involved in the change process for fewer than three years (preferably less than one year). The men and women were initially administered various questionnaires and assessment measures and were interviewed live. They were then reassessed approximately one year—"the vast majority . . . nine-to fifteen-month[s]"—later, and were then reassessed a third time an average of 18 months after the second assessment (pp. 128–129).

Of the 98 subjects who began the study, 77 completed all three phases of assessment. Standard and, in the case of sexual orientation, multiple measures were used to assess sexual orientation, including Kinsey 1- and 2-time and expanded ratings variables, Shively and De Cecco (1977) ratings variables, KSOG, and others. Psychological distress was assessed through Symptom Check List-90-Revised (Derogatis, 1994). Spiritual functioning was assessed through the Spiritual Well-Being Scale (Paloutzian & Ellison, 1991) and the Faith Maturity Scale (Benson, Donahue, & Erickson, 1993).

A combination of quantitative and qualitative findings led Jones and Yarhouse to characterize the reorientation experiences of the 77 subjects who participated in all three phases of the study as follows:

- *Success: Conversion*—15 percent reported "considerable resolution of homosexual orientation issues and substantial conversion to heterosexual attraction."
- *Success: Chastity*—23 percent reported that "homosexual attraction is either missing or present only incidentally and in a way that does not seem to bring about distress."
- *Continuing*—29 percent reported only a "diminution of homosexual attraction" but were "not satisfied and remain[ed] committed to the change process."
- *Nonresponse*—15 percent reported having "experienced no significant sexual orientation change" but had "*not* given up on the change process, [and] may be confused or conflicted about which direction to turn next."
- *Failure: Confused*—4 percent reported having "experienced no significant sexual orientation change and [had] given up on the change process but without yet embracing a gay identity."
- *Failure: Gay Identity*—8 percent having "clearly given up on the change process and [having] embraced gay identity" (Jones & Yarhouse, 2007, p. 369).

For Jones and Yarhouse, "success" in sexual reorientation included at least a change in sexual identity and a significant reduction in homosexual attraction and behavior. For some, success also included a substantial increase in heterosexual attraction and functioning, while for others, success involved learning to lead well-adjusted celibate lives. "Failure" meant no diminishment of homosexuality and giving up on further attempts at sexual reorientation. Some of these re-embraced a gay identity.

Surprisingly, the participants whom Jones and Yarhouse (2007) predicted to change the least as a group actually changed the most. These subjects were classified as "truly gay"—they had reported on the Kinsey and Klein scales "high levels of homosexual sexual attraction/fantasy and exclusive or highly disproportionate levels of homosexual behavior and strong self-identification as gay or lesbian" (pp. 232–235). Overall, the "truly gay" subjects reported the greatest amount of reorientation change, both away from homosexual attraction, fantasy, and behavior and toward heterosexual (pp. 259–261, 267–269, 326).

Jones and Yarhouse's study is notable not only for its method and results, but also for the scholarly humility evidenced by their self-criticisms, alternative explanations, and painstaking efforts to neither exaggerate nor minimize the meaning of their findings. The conclusion to the book-length report of their study bears repeating:

> In the end we believe we have provided evidence that change of homosexual orientation may be possible through involvement in Exodus ministries. The change may take the form of a reduction in homosexual attraction and behavioral chastity; it may also take the form of a reduction in homosexual attraction and an increase in heterosexual attraction with what might be described as satisfactory heterosexual adjustment. Those who report chastity regard themselves as having reestablished their sexual identities to be defined in some way other than by their homosexual attractions. Those who report heterosexual adjustment regard themselves as having changed their sexual orientation.
>
> We also found little evidence that involvement in the Exodus change process was harmful to participants in this study. Taken together, these findings would appear

> to contradict the commonly expressed view of the mental health establishment that change of sexual orientation is impossible and that the attempt to change is highly likely to produce harm for those who make such an attempt. (2007, p. 387)

Historical Review of Documented Success in Sexual Reorientation

In the clinical and scholarly literature over the past 125 years, mental health professionals and researchers document many different ways to assist men and women to successfully change from a homosexual to a heterosexual orientation. Reorientation assistance includes a variety of approaches, such as psychoanalysis, behavior and cognitive therapies, group therapies, sex therapies, hypnosis, pharmacological treatment, and religiously-mediated activities. Other incidents of reorientation are attributed to spontaneous change, unknown methods, a combination of therapies, and other factors. There are also anecdotal accounts of change that have not been clinically or scientifically validated. What follows is a historical review of reports of assisted sexual reorientation, beginning at the end of the 19th century.

Pre-Freudian Hypnosis

Before Sigmund Freud's introduction of psychoanalysis, several researchers reported success in the treatment of homosexuality. In 1882, Charcot published a paper titled *Inversion of the Genital Sense.* Already famous for his treatment of hysterics through hypnotic induction, Charcot applied the same type of therapy to homosexual men. He reported success because "the homosexual became heterosexual" (as cited in Horstman, 1972, p. 5).

Albert von Schrenck-Notzing (1892) reported success in treating 32 cases of *sexual perversions* using suggestion and hypnosis therapies (Prince, 1898, p. 237). Twenty of those patients had homosexual desires, behaviors, or both. Schrenck-Notzing used the term "contrary sexual feeling" (p. 117) or "contrary sexual instinct" (p. 217) to describe them, which meant they "had impulse toward the same sex with diminution or entire absence of feeling for the opposite sex" (p. 117). Of the 32 cases, 12 (37.5 percent) were classified as "cured" (Prince, 1898, p. 256). The term *cured* meant that patients were completely able to "combat fixed ideas [about homosexuality], deepen a sense of duty, self-control, and right-mindedness" (p. 255).

Psychoanalysis

The history of successful treatment using psychoanalysis is rich and fairly consistent over the last seven decades. Sigmund Freud referred to homoeroticism as an "inversion." Although many of his colleagues condemned homosexuality outright, Freud did not. He theorized that the condition of the homosexual man occurred as the result of a rejecting father and a close, binding mother, which intensified the Oedipal rivalry so much that it inhibited the choice of a female partner (Hunt, 1993). He maintained that given these circumstances, in some cases homosexuality (inversion) could be successfully treated through psychoanalysis.

Freud (1920a, 1920b) reported that a homosexual could change sexual orientation if strongly motivated to do so; however, he thought that such change was not always possible or necessary (Freud, 1951). Mitchell (2002) reported that while Freud thought that some degree of change was possible, Freud was pessimistic about the possibility of a full reversal from exclusive homosexuality to exclusive heterosexuality.

Carl Jung reportedly helped a homosexual man to become heterosexual through dream analysis and the breakdown of the negative child-mother bond, which had interfered with the man's sexual-orientation development (Fordham, 1935).

Following the tradition of Sigmund Freud, Gordon (1930) reported a case in which his homosexual patient made a heterosexual adjustment. After a one-year followup, Stekel (1930) reported four cases of success using psychoanalysis. Stekel's benchmark for success was that these patients married and were happy. In 1952, Anna Freud (1968) reported four cases involving two patients who were exclusively homosexual at the onset of treatment, and "became heterosexual" (p. 251) as an outcome of treatment.

London and Caprio (1950) reported successful psychoanalysis with two men who were considered exclusively homosexual at the onset of treatment, and who made a heterosexual adjustment as a result of treatment. Allen (1952) recorded two cases of overt homosexuals (one man, one woman) who were "completely cured" (p. 139). Allen stated that he or she was *cured* "if by treatment he [or she was] weaned from [practicing homosexual behaviors] and indulg[ed] in sexual behavior with one of the opposite sex" (p. 139).

Caprio (1954) asserted that lesbianism could be changed through the psychoanalytic process that helped patients change personality patterns and eliminated mental blocks that stood in their way of heterosexual adjustment. Although not providing specific numbers, Caprio reported that "many patients of mine, who were former lesbians, have communicated long after treatment was terminated . . . that they are convinced they will never return to a homosexual way of life" (p. 299).

Bergler (1956) reported that in his 30 years of practice, he had successfully used psychoanalysis to help approximately 100 homosexuals change their orientation, and that a real shift toward *genuine heterosexuality* had indeed occurred. Using psychoanalysis, Bergler and his associates reported a 33 percent cure rate—that is, following treatment these patients were able to function as heterosexuals, whereas before treatment they were exclusively homosexual. Eidelberg (1956) reported that two out of five cases were still successfully functioning as heterosexuals three years after treatment.

Albert Ellis (1956) concluded that those who engaged in psychoanalytically oriented psychotherapy could be "distinctly helped to achieve a satisfactory heterosexual orientation" (p. 194) if they sought such change. In a sample of 40 individual cases, Ellis concluded that 18 men and 12 women had outcomes of either "distinct or considerable improvement" (p. 192). This meant that they began to lose their fears of the other sex, to enjoy effective heterosexual relations, and to lose their obsessive thoughts about or compulsive homosexual activity. Not all patients were identified as exclusively homosexual prior to treatment. Six of the men and 6 of the women had moderate or considerable heterosexual activity prior to treatment, whereas the rest had little or none.

An unpublished 1956 report of the Central Fact-Gathering Committee of the American Psychoanalytic Association was one of the first surveys that compiled results of treatment of unwanted homosexuality. Of those who completed treatment (total number not reported), 8 were cured and 13 were improved. Another 16 who did not complete treatment were also considered improved. In the 8 reported cures, followup showed that the patients had assumed full heterosexual roles and functioning (Socarides, 1978).

Using Kinsey's scale of sexual orientation (Kinsey et al., 1948), Curran and Parr (1957), in a followup study of 59 patients in private analytic practice, found that 9 patients "reported less intense homosexual feelings, or increased capacity for heterosexual arousal" (p. 799). Only one of these patients was diagnosed as exclusively homosexual at the onset of treatment. Treatment "consist[ed] of a mixture of physical, psychological, social, and environmental measures in varying proportions according to the case" (p. 799).

In Berg and Allen's (1958) study, Allen wrote, "It definitely is not true that homosexuality is incurable" (p. 104), and he discussed 14 people that he considered cured. "Cures" ranged from compete attraction change—as in the case where a man, homosexual from the onset, married a women to whom he became "sexually adjusted" at the termination of therapy and had "lost all attraction to other men" (p. 77).

Allen also reported other, less exclusive changes, as in the case when the patient was able to be "normal sexually with a girl, but admitted that he had had occasional homosexual dreams." Allen explained that "since [the patient's] heterosexuality [became] so much stronger than his homosexuality . . . it was felt that this could be regarded as a cure" (Berg & Allen, 1958, p. 80). Allen concluded, "Obviously from such a small number of cases no statistical conclusions can be drawn. Nevertheless, these sample cases are typical of others in my long experience with the . . . treatment of homosexuality" (p. 104).

Hadfield (1958), who conducted treatment with patients over a 30-year period, discussed nine men who were freed of their unwanted homosexuality. In the example of one patient, Hadfield reported that "[he lost] his propensity to his own sex and his sexual interests [were] directed towards those of the opposite sex" (p. 1323). Hadfield emphatically noted that these men were not merely able to manage self-control; they had changed their attractions. Four cases were later followed up by Hadfield; all four reiterated that they "were completely cured . . . with no further episodes" (p. 1324).

Robertiello (1959) gave a detailed report of a homosexual woman who developed a deeper understanding of her unconscious after analysis with free association and dream interpretation. This led to Oedipal resolution, and she became heterosexually adjusted. Two years later, she had not returned to her previous homosexuality.

Monroe and Enelow (1960) treated seven men using classic psychoanalysis with free association. Theoretical orientation for treatment was based on classical psychoanalytic theory, which explained homosexuality as a deviation that originated from constitutional-developmental issues. At onset of treatment, the men were described as "homosexual" with minimal prior heterosexual activity (i.e., they met Kinsey scale criteria of 4—*predominantly homosexual, but more than incidentally heterosexual,* or 5—*predominantly homosexual, only incidentally heterosexual*).

Lengths of treatment ranged from 3 to 18 months, and followup with four patients continued for at least five years after termination. Three of the seven cases were considered successful. In one case, a patient's successful outcome was that he avoided previous destructive homosexual activity. Another had "overcome his impotency . . . and discontinued most of his homosexual soliciting" (p. 484), while the third, at the five-year followup, told the analyst via letter that he was married, had a child, and was happy in the marriage (p. 485).

Glover (1960) discussed a series in which he treated 103 adults and 10 juveniles, with the duration of treatment varying from five months to five years. In seven cases, hormone treatment was used, either with or without psychotherapy. In terms of successful outcomes, 44 percent of the exclusively homosexual patients showed no further homosexual impulses after treatment, and 51 percent of the bisexuals lost all of their homosexual impulses.

Beukenkamp (1960) treated a homosexual man with individual and group psychoanalysis. The treatment resulted in his reorientation to heterosexuality in both behavior and experiences.

In a nine-year comprehensive study of homosexual men, Bieber et al. (1962) used an analyst team of 77 members, and provided information on two patient samples consisting of 106 homosexuals who undertook psychoanalysis. They concluded that 29 of the 106 patients (27 percent) who completed treatment became exclusively heterosexual (Kinsey score of 0). At the onset of treatment, 14 of these men were reported as exclusively homosexual and 15 were reported as predominately homosexual but with some heterosexual activity in their histories.

In a five-year followup of patients from the original study, Bieber (1967) reported that 15 of the 29 had maintained contact with their analyst. Of those 15, 12 had remained exclusively homosexual (Kinsey score of 0), and 3 reported being predominantly heterosexual with sporadic homosexual episodes under situations of stress. Bieber explained that patients who did not become heterosexual still benefited from improvements in self-esteem, social relationships, assertiveness, and work effectiveness.

As Bieber and Bieber (1979) wrote:

> A shift to heterosexuality does not mean that the potential for homosexual arousal has been totally extinguished, though in some cases this does occur. Should a post-analytic patient be faced with a recurrence of homosexual interest, he may short-circuit it by identifying the situation that has triggered anxiety about heterosexuality. (p. 419)

Bieber and Bieber (1979) also reported that since the original study (Bieber et al. 1962), they had seen more than 1,000 homosexual men and that "the data obtained [were] in accord with the [1962] research findings, thus strengthening [their] validity and reliability" (p. 417). Without giving specific numbers, the researchers reported that "we have followed patients for as long as 20 years who have remained exclusively heterosexual. Reversal rates now range from 30% to an optimistic 50%" (Bieber & Bieber, 1979, p. 416).

Coates (1962) examined 45 cases of homosexual patients who were treated at the Portman Clinic between the years of 1954 and 1960. He found that 7 of 45 cases (16 percent) were classified as "better" (p. 180), meaning that patients reported no active homosexual behaviors (but some still experienced homosexual fantasies). Unlike many other studies, this study examined the extent to which clients were exclusively homosexual at the time that therapy began. Their clients ranged from men who had same-sex fantasies, but who had never had sex with other men and had had some heterosexual experiences, to men who had had many homosexual liaisons. The group that had never had sex with men before treatment was found more likely to be classified as "better" in terms of treatment outcome.

Followup was reported in several cases. One patient was found after one year to have had no homosexual activity, and after two and a half years to be "very happy and getting married" (p. 187). Another patient, after three years of treatment, was "able to have successful heterosexual intercourse. Shortly after treatment ended, he married and all seemed to be well" (p. 188). After a four-year followup, a third patient was reported as still "better."

Ovesey, Gaylin, and Hendin (1963) reported successfully treating three men who had homosexual inclinations. After being followed for as long as five years, the men reported that they were able to maintain pleasurable heterosexual behavior, which had been the goal of their therapy.

Cappon (1965) reported treatment outcomes of his clinical work with 150 patients using psychoanalytic-based treatments (including individual, group, and combined therapy). He found a 50 percent cure rate for homosexual men and a 30 percent cure rate for homosexual women. For those identified at the onset of treatment as bisexual, Cappon reported a 90 percent cure rate. After an average 20-month followup, only 10 percent lost part of their previous level of improvement and had to be reclassified or, when possible, treated further.

Mayerson and Lief (1965) conducted a followup study of 19 patients (14 men and 5 women) who had originally presented with "homosexual problems" (p. 331). The mean duration of analytic-based therapy was 1.7 years, and the mean interval between end of therapy and followup was 4.5 years. In addition to sexual identity, the followup evaluation studied psychosomatic and psychological adjustments, social relationships, and depth of insight. At the time of followup, 47 percent of patients were found to be "apparently recovered" or "much improved" and identified themselves as "exclusively heterosexual." Twenty-two percent of them had originally identified themselves as "exclusively homosexual."

Mintz (1966) reported that after using a combination of individual and group psychoanalysis for two or more years, 3 of 10 men who had identified themselves as exclusively homosexual reported "satisfactory heterosexual adjustment" (p. 193). She described them as such: "Two are enjoying heterosexuality and report freedom of conflict" and "one [who was still in treatment at the time] has lost

interest in homosexuality and enjoys satisfying heterosexual relationships" (p. 194). Criteria for successful outcome included becoming conscious of heterosexual defenses, developing a stronger sense of personal identity through contact with heterosexual men and women, dealing with anxieties and avoidance of women, and making corrective emotional responses that led to greater self-esteem.

Kaye et al. (1967) sent 26-page surveys to more than 150 psychoanalysts who saw homosexual women in their practice, and received back 24 completed surveys. Eight of the 15 cases that were reported to be in the "homosexual range" (Kinsey scores of 4–6) at the onset of treatment had shifted to a Kinsey score of 0 (exclusively heterosexual) either at termination of treatment or when the analyst filled out the survey. Kaye et al. concluded, "Apparently at least 50% of them can be helped by psychoanalytic treatment" (p. 633).

Socarides (1978) reported that from 1967 to 1977, 20 of 44 patients (45 percent) whom he treated using "full-scale psychoanalysis" developed full "heterosexual functioning." This included having "love feelings for their heterosexual partners" (p. 406).

Jacobi (1969) reported treating 60 patients, 6 (10 percent) of whom made a satisfying transformation to heterosexuality. In another report, Lamberd (1969) reported three case studies, in which after a one-year followup, each of the patients could be considered as successfully treated.

After a followup of five or more years, Ovesey (1969) reported the case studies of three successfully treated men. According to Ovesey, "success" for men who were being treated to change sexual orientation from homosexuality to heterosexuality was not just "potency" with women, but satisfaction in the "total relationship," including marriage (pp. 123–124). Treatment focused on understanding unconscious motives that had compelled the patients to flee from women and to seek contact with men. Such insight reportedly "facilitat[ed] reversal of a homosexual pattern and . . . establish[ed] . . . heterosexuality" (p. 154).

Wallace (1969) also conducted analysis with a homosexual man who subsequently achieved heterosexual adjustment. After a six-year followup, the patient's reported *successes* included strengthened ego functions and deepened insight into both his fear of heterosexuality and his unconscious fantasies about homosexual encounters, as well as the initiation of satisfactory heterosexual activity.

Siegel (1988) reported what she described as "the most comprehensive clinical investigation [of female homosexuality] . . . derive[d] from the largest sample [12] of female homosexuals treated by a single psychoanalyst" (p. xv). As an outcome of treatment, more than half became "fully heterosexual." At the onset of treatment, these women saw themselves as exclusively homosexual (sought same-sex liaisons and had only homoerotic fantasies).

The phases of analytic therapy cited by Siegel included ideal mother transference, hypochondriacal preoccupation, denial of the need for mother, body image projections, analyst introject fantasies, homosexual actions as a defense against aggression transference, and complete working through of transference neuroses. Siegel did not set out with the goal of changing sexual orientation; therefore, no set parameters for change were identified. According to her, criteria for successful treatment were met when transference was finally resolved, whether a client's orientation had changed or not. By the end of treatment, half of her cases reported having changed their sexual orientation.

Berger (1994) described two cases of reorientation success. One "resulted in the patient marrying and fathering three children and living a heterosexually fulfilling and enjoyable life" (p. 255). The other was a "successful long-term psychodynamic psychotherapy treatment [that] helped relieve the patient of his original presenting symptoms and enabled him to become comfortably and consistently heterosexual" (p. 255).

Finally, a survey of 285 anonymous members of the American Psychoanalytic Association conducted by MacIntosh (1994) revealed that of 1,215 homosexual patients analyzed by those members, 23 percent changed from homosexuality to heterosexuality and 84 percent received significant therapeutic benefits.

Behavior and Cognitive Therapies

Behavioral-based therapists successfully treated not only unwanted homosexuality, but also a variety of sexual dysfunctions and paraphilias, including voyeurism, exhibitionism, and transvestic and other fetishism (Rachman, 1961). Aversion therapies aimed at changing the sexual behaviors of homosexuals were used as early as the 1930s (Max, 1935).

By use of *adaptational* therapy, a 40-year-old man who had practiced homosexuality for 22 years was successfully treated in the early 1950s. He ceased his homosexual behavior, married, and reported himself completely cured, evidenced by the fact that he stopped finding men attractive (Poe, 1952).

Using the process of "rational therapy," which he later developed and promoted first as Rational Emotive Therapy (RET) and then as Rational Emotive Behavior Therapy (REBT), Albert Ellis (1959) reported that a homosexual client changed to heterosexuality and that the change remained in effect after three years. More than a decade later, Shealy (1972) reported another patient who changed from homosexuality to heterosexuality with the use of RET.

Through use of assertiveness training, Stevenson and Wolpe (1960) successfully treated two homosexuals who succeeded in making a heterosexual adjustment. The treatment was still deemed successful four years later.

Mather (1966) reported that of 36 homosexuals treated with behavioral and aversion techniques, 25 were considered much improved on the Kinsey scale. MacCulloch and Feldman (1967) successfully treated 43 homosexual men with aversion therapy and dedicated their careers to the treatment of homosexuals using aversion therapy. After using an adaptation of MacCulloch and Feldman's approach to anticipatory avoidance learning, Larson (1970) also reported treatment success but did not provide specific numbers.

Kraft (1967, 1970) treated two homosexual men with a combination of systematic desensitization and psychoanalysis and found that they responded as heterosexuals after treatment.

Serban (1968) reported treatment of 25 homosexuals using *existential* therapeutic approaches. He concluded that after their erotic perceptions changed, their sexual orientation also changed.

Fookes (1969) summarized five years of clinical experience providing aversion therapy to 27 people with sexual disorders. Success ranged from 60 percent for homosexuality to 100 percent for fetishism-transvestism, and no harmful effects of aversion treatments were discernible. Fookes reported that the patients welcomed the changes, which consisted of the loss of desire for the behavior (which the patients saw as a perversion). McConaghy (1969, 1970, 1975) and McConaghy, Proctor, and Barr (1972) found successful subjective and penile plethysmography responses after applied aversion therapy was used to treat a number of homosexual men.

In Bancroft's (1970) study, 5 of 15 homosexuals (33 percent) treated with desensitization had significant shifts toward heterosexual behavior. Hatterer (1970) found in a followup of his treatment of 143 homosexuals that 49 (34 percent) achieved a satisfactory heterosexual adjustment. Using covert sensitization techniques, Cautela and Wisocki (1971) reported a 37 percent success rate one year after treatment.

Feldman and MacCulloch (1971) worked with 36 patients using anticipatory avoidance learning therapy. They found a 57 percent success rate after one year. Feldman, MacCulloch, and Orford (1971) reported followup results on research done with 63 homosexual men between 1963 and 1965. They found that 29 percent of the men who had no prior heterosexual experience had changed. "Change" was indicated by ceasing homosexual behavior, having only occasional homosexual fantasies or attractions, and developing strong heterosexual fantasy, behaviors, or both.

Van den Aardweg (1971) reported that 9 of 20 patients were completely cured through the use of exaggeration therapy. "Cure" meant that they reported no homosexual fantasies or behaviors after treatment.

Hallam and Rachman (1972) administered a course of electrical aversion therapy to seven patients complaining of "deviant sexual behavior," including homosexual impulse. Four made discernible progress, while three failed to respond. After treatment, significant changes in heart rate response to sexual stimuli were detected. Those who were successfully treated experienced a significant increase in the time required to imagine sexual material. The results were seen as providing some support for the conditioning theory of aversion therapy.

Barlow and Agras (1973) found a 30 percent decrease in homosexual behavior six months after treatment in patients who were treated with the flooding technique. Maletzky and George (1973) reported on 10 homosexual men who were treated with covert sensitization behavioral therapy. A 90 percent success rate was found at the 12-month followup assessment.

Utilizing avoidance conditioning, classical conditioning, and backward conditioning, McConaghy and Barr (1973) found that one fourth of their patients had totally ceased homosexual behavior one year after treatment. Freeman and Meyer (1975) used behavioral approaches and reported a 78 percent success rate 18 months later in patients who had been exclusively homosexual.

Cantón-Dutari (1974, 1976) used desensitization, aversion, and contraction-breathing techniques to help active homosexual men control sexual arousal in response to homosexual images. Cantón-Dutari reported that 48 of 54 patients (89 percent) were considered successfully treated because they were able to control sexual arousal in the presence of a homoerotic stimulus. Forty-four of 49 (90 percent) also performed satisfactorily during heterosexual intercourse. The researchers followed 22 of the men for an average of three and a half years. Eleven of these remained exclusively heterosexual and 4 of these 11 married; 11 masturbated to homosexual imagery but did not involve themselves in other homosexual behavior.

Using systematic desensitization, Phillips, Fischer, Groves, and Singh (1976) reported a successful behavioral outcome with a homosexual man. Their definition of "success" meant the man had no homosexual activity 18 months after treatment and was able to initiate heterosexual contact. Similar behavioral results using systemic desensitization were reported by Kraft (1967), Ramsey and van Velzen (1968), Bergin (1969), Huff (1970), and S. James (1978).

McConaghy, Armstrong, and Blaszcyzynski (1981) tried to evaluate behavior therapy for homosexuals in response to ethical objections of such treatment. Twenty people requesting behavior therapy to reduce compulsive homosexual urges were randomly assigned to receive aversive therapy, covert sensitization, or both. Both groups were studied for one year. There was no consistent trend for one therapy to be more effective than the other in reducing the strength of compulsive homosexual urges, and the successful responses to both were similar to those reported in previous studies. The researchers suggested that aversive therapies in homosexuality do not work by establishing a conditioned aversion or by altering a person's sexual orientation. The authors concluded that they reduced aversive arousal produced by behavior-completion mechanisms when people try to refrain from homosexual behavior in response to stimuli that repeatedly provoked such behavior in the past.

Using covert sensitization methods over a period of several years, Callahan, Krumboltz, and Thoresen (1976) reported that at the four-and-a-half-year followup that their client said he experienced "no problem with homosexual arousal and he has a good sexual relationship with his wife" (p. 244). As measured on the Kinsey scale, after treatment the man was considered predominantly heterosexual. Others using covert sensitization also reported successful outcomes in shifting clients from homosexual behavior to heterosexual behavior (Mandel, 1970; Kendrick & McCullough, 1972; Segal & Sims, 1972).

Herman, Barlow, and Agras (1974) studied the use of classical conditioning in three men who identified themselves as homosexual. The men were conditioned to respond to female stimuli, and slides and

films with homosexual content were also used. Critical variables in the classical conditioning procedure were systematically introduced and removed while objective and subjective measures of homosexual and heterosexual behavior were recorded (such as penile responses and self-reports of sexual urges and fantasies). Subjects completed the KSOM before and after each experimental phase. In two of the men, classical conditioning was effective for increasing heterosexual arousal. In the third man, classical conditioning was not effective.

Orwin, James, and Turner (1974) reported the effective reorientation of a homosexual man by using aversion therapy. Following pretraining assessment, Tanner (1974) assigned eight men who identified themselves as homosexuals to an automated aversive conditioning group and eight others to a waiting list control group. At the end of eight weeks, all subjects participated in a second assessment. The aversive conditioning group showed significant decreases in erectile response to slides of nude men, a decrease in the amount of arousal they felt in response to slides of nude men, and a decrease on the masculinity-femininity (MF) scale of the Minnesota Multiphasic Personality Inventory (MMPI). At the same time, they reported having significantly more sex with women, socializing with women, and sexual thoughts about women versus men.

Tanner (1975) used avoidance training on 10 men to modify homosexual behavior through either a booster or a no-booster group. Those in the booster group received five additional sessions during the year following treatment, while the others had no contact during that year. One year after the treatment was finished, the men returned for an evaluation consisting of erectile response to slides of nudes, self-report of arousal while viewing the slides, the MF scale of the MMPI, self-report of frequency of sex with men and women, frequency of thoughts about sex with men and women, frequency of socializing with men and women, and number of categories of sexual behavior engaged in with both sexes. No significant difference was found between the two groups for any of the measures. When repeated measurement tests were used, however, five of the seven tests showed significance at the .05 level or beyond, indicating that the avoidance training itself was effective but that the booster sessions did not increase the effectiveness of the initial training.

Pradhan, Ayyar, and Bagadia (1982) demonstrated that by utilizing behavioral modification techniques, 8 of 13 homosexual men showed a shift to heterosexual adaptation that was maintained at a six-month and one-year followup.

Van den Aardweg (1986a, 1986b) reported treating 101 homosexuals with cognitive approaches. About 60 percent had at least a satisfactory outcome, while one third of those changed substantially toward a heterosexual adaptation.

As Throckmorton (1998) concluded, many behaviorally trained counselors—mostly from the 1970s—advocated the use of a variety of behavioral techniques to achieve sexual shifts from homosexuality toward heterosexuality (Barlow, 1973; Barlow & Durand, 1995; Bergin, 1969; Blitch & Haynes, 1972; Freeman & Meyer, 1975; Gray, 1970; Greenspoon & Lamal, 1987; Hanson & Adesso, 1972; Marquis, 1970; Rehm & Rozensky, 1974; Tarlow, 1989; Wilson & Davison, 1974).[3]

Behavioral therapists report that their level of success in decreasing homosexuality is essentially one third or more (Birk, Huddleston, Miller, & Cohler, 1971; Bancroft, 1974). Sixty percent of 200 behavioral therapists surveyed reported that they were at least moderately successful in helping clients shift toward heterosexuality (Davison & Wilson, 1973). Even though researchers have demonstrated that behavioral therapy has been successful in assisting sexual reorientation (Byrd & Nicolosi, 2002), aversion procedures are now prohibited because of ethical considerations.

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3 References listed in alphabetical order.

Group Therapies

Eliasberg (1954) conducted group psychoanalysis by way of dream analysis with two groups of six men who were on probation and who volunteered for the study. Eliasberg wrote outcome narratives for five cases in which success was reported. Success varied for each case with no absolute criteria. Shifts from homosexual to heterosexual were reported for all five. However, these men showed bisexual behaviors from the onset of treatment and, with one exception, they had either been married or had prior sexual involvement with women. For these patients, complete shift of orientation had not been their goal and was not their outcome. Instead, the patients described positive outcomes, such as:

- I feel stronger all around, as to resistance.
- There are fewer relapses.
- I can see from my dreams that I am in a better position to reject those men.
- It comforts me that my interests are shunted away, unconsciously, from homosexuality. (p. 224)

One of the men was followed for three years, and during this time, "no trouble was reported" by the patient (p. 223).

Hadden (1958) reported in the *American Journal of Psychiatry* that he treated three homosexuals in group therapy and that one of them shifted to heterosexual adjustment. Smith and Bassin (1959) treated two men in group therapy and reported that one of the men had a marked reduction in his compulsive homosexual behavior, while the other achieved a satisfactory shift toward heterosexual adjustment.

According to Litman (1961), a homosexual man changed his sexual orientation through group therapy. Hadden (1966) reported a 38 percent success rate after treating 32 homosexuals in group therapy. The people in the group progressed to an exclusively heterosexual pattern of adjustment and showed marked improvement in or disappearance of other neurotic traits after followup. Birk, Miller, and Cohler (1970) reported a similar success rate. After two years of group therapy with male-female cotherapists, 9 (35 percent) of 26 overt homosexually identified men "shift[ed] to or towards heterosexuality" (p. 37).

Bieber (1971) reported a success rate of more than 40 percent through the use of group therapy. Hadden (1971) confirmed a one-third success rate. Pittman and DeYoung (1971) reported that two of six, or one third, of homosexuals treated in group therapy received maximum benefit and achieved their goal of a satisfactory shift toward heterosexuality.

Truax and Tourney (1971) reported that group treatment of 30 patients—compared to 20 untreated controls—resulted in increased heterosexual orientation, decreased homosexual preoccupation, reduced neurotic symptomatology, improved social relations, and increased insight into the causes and implications of their homosexuality. Changes in sexual behavior included increased heterosexual dating, decreased homosexual experiences, and increased heterosexual intercourse. While heterosexual functioning improved with further therapy, even more improvement was seen in associated neurotic symptomatology.

Birk (1974) reported that of 66 patients treated, 27 remained in treatment for 1.5 years or longer and that 85 percent experienced "at least partial heterosexual shifts," while 52 percent experienced "striking, nearly complete heterosexual shifts" as measured on the Kinsey scale (p. 41). Birk (1980) later reported that 10 of 14 (71 percent) exclusively homosexual men in treatment for more than two and a half years were married to women at followup.

Researchers reported over a 10-year period that group therapy combined with other therapies showed varied yet consistent treatment successes (Ross & Mendelsohn, 1958; Finny, 1960; Buki, 1964; Mintz, 1966; Miller, Bradley, Gross, & Wood, 1968). As with behavioral therapy, approximately one third or more of group therapy clients reported a desired shift in sexual orientation.

Hypnosis

Although Charcot and Magnan (1882) held to the theory that homosexuality was congenital, they applied hypnosis to an undisclosed number of homosexual men and reported success because those patients "became heterosexual" (as cited in Horstman, 1972, p. 5). Schrenck-Notzing (1892) had similar findings (Fine, 1987). Cafiso (1983) reported successfully treating a homosexual man by strengthening his ego through hypnosis. After the patient had developed a stronger sense of self, he was capable of approaching women sexually. This corresponds with other reports of the effective use of hypnosis to promote sexual reorientation (Regardie, 1949; Alexander, 1967; Roper, 1967).

Sex Therapies

Pomeroy (1972) noted that as early as 1940, Kinsey had reported treatment, "of more than eighty cases of men who had made a satisfactory heterosexual adaptation adjustment which either accompanied or largely replaced earlier homosexual experiences" (p. 76). Although not a sex therapist, Kinsey reportedly helped these men by training them to relate to the opposite sex and to finally begin "physical contact of the simplest kind, working up slowly to intercourse" (p. 76). Kinsey did caution, however, that homosexual fantasies were not always eradicated. According to Pomeroy, Kinsey gave this advice to one homosexually-oriented youth who wanted to change:

> Do not be discouraged if you find the male still arousing you more than the female; it may take time and abundant heterosexual experience to bring you satisfaction equal to what you have known in the homosexual. Sometimes, however, I have known the homosexual to change almost overnight, as a result of a fortunate, satisfactory heterosexual experience. (p. 77)

In Masters and Johnson's (1979) treatment of 90 homosexuals, a 28.4 percent failure rate was reported six years after treatment (Schwartz & Masters, 1984). Masters and Johnson chose to report failure rather than success rates to avoid vague, inaccurate concepts of success; however, by implication, more than 70 percent of their patients achieved some degree of success toward their self-identified goal of diminishing unwanted homosexuality and developing their heterosexual potential.

Pharmacological Interventions

Owensby (1940) reported that six patients ceased all homosexual behavior after taking the drug Metrazol (pentetrazol). Buki (1964) conducted a clinical trial using Parnate (tranylcypromine) with 36 male patients between the ages of 19 and 34 who had engaged in homosexual behavior. After expiration of the trial time periods (as many as 90 days), "the clinical examinations show[ed] an unexpected good control over homosexual activities and impulsions with 13 patients" (p. 306). Kraft (1967) reported similar findings with Brevital (methohexital), used in conjunction with Wolpe's (1964) relaxation methods.

Golwyn and Sevlie (1993) reported change in the sexual orientation of a 23-year-old homosexual man who, after taking Nardil (phenelzine) for shyness and anxiety, reported that he no longer had sexual interest in other men. The authors concluded, "Social phobia may be a hidden contributing factor in some instances of homosexual behavior" and that Nardil, "like other dopaminergic agents, might facilitate male heterosexual activity" (p. 40).

A serendipitous finding of fluoxetine-associated suppression of ego-dystonic homosexual activity in a 53-year-old man for a period of 13 years was reported by Elmore (2002). The patient's determination to remain sexually abstinent had been essential to his successful treatment.

Nicolosi (in press) found that while conducting reparative therapy, a 50-year-old male client reported a sudden and dramatic freedom from unwanted homosexual thoughts, feelings, and behaviors after taking Lexapro. The client reported that he continued to be free of these unwanted symptoms more than 18 months after starting the anti-depressant medicine.

Religiously-Mediated Reorientation

Researchers report that men and women who participate in a variety of religiously-mediated ministries based on a variety of faith traditions and/or who use spiritual activities and resources may experience intentional sexual reorientation to a greater or lesser degree. Pattison and Pattison (1980) reported successful religiously-mediated change for 11 homosexuals who participated in a Pentecostal fellowship. Researchers used both pre- and post-change surveys. On the post-change survey, 5 of the 11 participants reported no homosexual fantasies, behaviors, or impulses (0 on the Kinsey scale). Three men reported a Kinsey rating of 1, and 3 other men reported a rating of 2.

Mesmer (1992) surveyed more than 100 people participating in an ex-homosexual ministry who had reported leaving the homosexual lifestyle. He found that 41 percent of them had achieved a satisfying shift toward heterosexual adaptation.

Exodus International—a parent Christian ministry for a coalition of more than 100 ministries and Christian counselors worldwide—offers individual, group, and educational therapy. In an evaluation of religiously-mediated therapy for homosexuals, Exodus International reported that 85 percent of the people it served experienced sexual reorientation (Consiglio, 1993).

Ponticelli (1996, 1999) conducted a qualitative study examining Exodus International programs from 1992 to 1994. Taking a dual role in the study as both an observer and a participant, she interviewed 15 women and read the testimonies of 12. She found that there was more evidence for change in the women's sexual identities and social supports—along with positive changes in spiritual development—than in their actual sexual orientation. In ethnographic studies of Exodus International residential programs, Wolkomir (1996, 2006) and Erzen (2006) found that participants commonly changed their sexual identity and grew in spirituality but did not necessarily change their sexual orientation.

Robinson (1998) reported the results of interviews with seven men from Evergreen International, a Latter-day Saint (LDS) program for people struggling with unwanted homosexuality. Robinson found "positive change" in all the subjects—all married men who sought to maintain their marriages—through nine components. One important component consisted of developing a new interpretive framework concerning the causes and meaning of same-sex attraction; another consisted of the fact that the men no longer identified themselves as homosexual. The men reported strong positive benefits from therapy through the framework of these standards.

Schaeffer, Hyde, Kroencke, McCormick, and Nottebaum (2000) surveyed 248 men and women at an Exodus International Annual Conference to determine if they were experiencing success in changing their sexual orientation. The researchers found a statistically significant effect based on change over time. On both feeling and behavior scales, participants rated their current sexual orientation as significantly more heterosexual than when they were 18 years of age. The study was limited, however, because it lacked detailed sexual histories to verify the participants' self-ratings or to determine whether there were significant shifts in behavior or feeling in the periods before and after age 18.

In a followup study of 140 of the original participants that appeared in the literature before publication of the original study, Schaeffer, Nottebaum, Smith, Dech, and Krawczyk (1999) found that 61 percent of men and 71 percent of women had maintained abstinence from same-sex sexual contact in the last year of the study. Twenty-nine percent of this sample indicated they had changed their sexual

orientation to "exclusively heterosexual" (0 on the Kinsey scale) by the last year of the study, and 65 percent reported that they were still in the process of change.

Building on the previous studies, Nottebaum, Schaeffer, Rood, and Leffler (2000) compared a sample of Exodus participants with a sample of 105 people who identified themselves as homosexual. Both groups reported good mental health, but the homosexual-identified group scored higher in the mental health area. Both groups reported similar same-sex identities prior to age 18, but the Exodus group reported a higher current level of heterosexual identification.

In the prospective, longitudinal study previously described, Jones and Yarhouse (2007) assessed 73 men and women who had sought sexual reorientation help through different ministries of Exodus International. After participation in one of the various religiously-mediated, ex-gay support groups, 15 percent of the subjects reported having substantially reduced their homosexual attractions and having substantially increased their heterosexual attractions and functioning. Another 23 percent reported substantial changes in identity and behavior leading to well-adjusted celibate lives.

Byrd et al. (2008; cf. Nicolosi et al., 2000a, 2000b) surveyed 882 individuals who had experienced an intentional diminishing of unwanted homosexuality—some with the intention of enhancing of heterosexuality—through participation in therapy, pastoral counseling, and/or self-help activities, including religiously-mediated group ministry. A total of 843 (96 percent) participants reported that religion or spirituality were very important to them. Mechanisms of change highlighted by subjects included having a support group,

> an understanding, caring or nurturing . . . spiritual leader, . . . accountability to either a pastor or friend and support group [and] spirituality . . . [including] scripture study, confession to a spiritual leader, faith in God, prayer . . . conducive to inner healing, God's unconditional love, acceptance and grace, . . . and forgiveness, [and] . . . the Holy Spirit giving strength, comfort and direction. (Byrd et al., 2008, p. 23)

Spontaneous Reorientation

There have been reports in the literature of spontaneous changes in sexual orientation. In some cases, people identified as homosexual were in therapy or treatment for other conditions when they experienced spontaneous reorientation.

Kinsey et al. (1948) found that while 10 percent of a convenience sample of men had admitted to engaging in homosexual activity at some point, only 4 percent reported that they had been exclusively homosexual throughout their lives. Wolpe (1969) treated a patient with assertiveness training for an issue unrelated to homosexuality. The patient reported a spontaneous shift to heterosexual behavior, even though the focus was not on changing sexual behavior or orientation. Fluker (1976), a medical doctor treating homosexual-identified men for sexually transmitted diseases (but not for homosexuality), learned that one of his patients no longer had homosexual inclinations and was happily married to a woman.

Shechter (1992) reported spontaneous change in sexual orientation in a man whom she had treated with psychoanalysis (but not for unwanted homosexuality). She reported that the man broke up with his male lover, was no longer actively homosexual, and began to fantasize exclusively about women. After he developed a sexual relationship with a woman, he reported, "I can't keep my eyes or hands off her, and she loves it" (p. 200). Although no clear statement was made about the patient's self-identification, an implied statement was made when he asked, "Can someone like me suddenly be heterosexual?" (p. 200).

Based on a national survey, Michael, Gagnon, Laumann, and Kolata (1994) found that some people change their sexual orientation without any kind of psychotherapy—whether for unwanted

homosexuality or for any other condition. Whitehead and Whitehead's (2007) review of Michael et al. (1994) and other studies supports the finding that sexual reorientation sometimes occurs without professional or other external assistance.

Other Interventions

Woodward (1958) reported that 28 of the 48 patients who completed forensic treatment no longer had homosexual impulses. Seven of them reported having moved to the exclusively heterosexual category of the Kinsey scale. Whitener and Nikelly (1964) concluded that 30 homosexual college students treated by nonspecified interventions showed good results in about one third of selected cases.

Braaten and Darling (1965) conducted a study of college students and found that 29 of 100 "overt homosexuals" (those who engaged in homosexual behavior) and 21 of 100 "covert homosexuals" (those who did not engage in homosexual behavior but who had homosexual impulses, dreams, or fantasies) showed "movement toward heterosexuality as a result of [nonspecific interventions]" (p. 293).

Researchers at the Kinsey Institute reported that some homosexual adults allegedly have been "cured" by brain surgery to destroy "inappropriate" sexual response centers (Bell et al., 1981, p. 219).

Experiential electrode brain stimulation aimed at changing sexuality was not popular after the 1970s, and literature on the procedure is scant. Moan and Heath (1972) conducted experiential septal stimulation on a 24-year-old clinical, fixed, overt homosexual man. Their purpose was to explore whether the stimulation could be used to bring about heterosexual behavior. After the treatment protocol was finished, the patient's mood improved. He was more relaxed, and he became interested in heterosexuality (he began watching heterosexual pornography). Later he reported sexual intercourse with a woman.

Eighty-six men who attended Journey Into Manhood (JIM)—a nonclinical, experiential weekend retreat aimed at ameliorating same-sex attractions—responded to a multi-question survey initiated by its sponsoring organization (People Can Change, 2006). The men were asked to choose a response that described their sexual feelings both before and after the weekend. After the weekend retreat there was a 6 percent increase in the men who reported sexual feelings as "exclusively heterosexual, with no homosexual interest at all," and a 13 percent increase in men who reported feelings that were "primarily heterosexual, but with some slight homosexual feelings or interests." There was also a 4 percent decrease in the number of men who described themselves before the weekend as exclusively homosexual with no heterosexual feelings or interests but who shifted to another category, describing themselves as having at least slight heterosexual feelings or interests after the retreat.

Regardless of what treatment is used, being coerced to undertake reorientation therapy is not effective. Fry and Rostow (1942) found that of 16 homosexual men who were pressured by Yale University staff to consult therapists against their will, none reported changes in sexual orientation.

Anecdotal Accounts of Sexual Reorientation

A number of personal accounts of change have been published over the years (e.g., Rekers, 1995), mostly through religious channels. Aaron (1972) wrote, "For 20 years I was homosexual. . . . Today, years away from all that . . . I am functioning heterosexually and enjoying it" (p. 14). Offering spiritual guidance to others, Worthen (1984) shared his personal conversion from homosexuality, as did Konrad (1987), Comiskey (1988), and Judkins (1993).

Breedlove, Plechash, and Davis (1994) provided personal accounts of religiously-mediated change, as did Strong (1994)—who also provided an account of his personal experience. Similarly, Davies and Rentzel (1993) offered anecdotal testimonies of change in homosexuality among both men and women.

Goldberg (2008) reported testimonies of reorientation by people who participated in the Jews Offering New Alternatives to Homosexuality (JONAH) program of psychological and spiritual counseling, peer support, and self-empowerment, as well as in other religiously- and nonreligiously-mediated programs.

Assemblies of Persons Reporting That Sexual Orientation Can Be Changed

In some instances, former homosexuals have collectively protested the positions of national mental health associations that are considering whether to declare as "unethical" the offering of therapeutic help to change unwanted homosexuality. For the first time in history, on May 22, 1994, the American Psychiatric Association convention in Philadelphia was the site of one such protest—not by pro-homosexual activists, but rather by a group of ex-homosexuals reporting that change is possible (Davis, 1994). A similar protest occurred at the 2000 American Psychiatric Association convention in Chicago (Gorner, 2000). Yet another protest of this type occurred at the 2006 APA convention in New Orleans (Foust, 2006).

Meta-Analyses

Clippinger's (1974) meta-analysis of the treatment of unwanted homosexuality demonstrated that of 785 homosexuals treated, 307 (40 percent) either significantly improved in the direction of their desired goal, or had made at least some shift toward heterosexuality.

In another meta-analysis, E. C. James (1978) concluded that when the results of all research studies before 1978 were combined, approximately 35 percent of the homosexual clients had shifted to heterosexuality, 27 percent had improved, and 37 percent had neither changed nor improved. Based on this finding, she concluded that pessimistic attitudes about the prognosis for homosexuals who wanted to change their sexual orientation were not warranted. She stated, "Significant improvement and even complete recovery [from a homosexual orientation] are entirely possible" (p. 183).

Jones and Yarhouse (2000) used meta-analysis to review 30 studies conducted between the years 1954 and 1994. Of the 327 total subjects from all the studies, 108 (33 percent) were reported to have made at least some heterosexual shift.

In an analysis of 17 studies, Goetze (1997) found that a total of 44 subjects who had been exclusively or predominately homosexual had experienced a shift toward heterosexual adjustment. In this collection of studies, as in others, definitions of homosexuality and heterosexuality varied, as did definitions of successful change.

Byrd and Nicolosi (2002) used the meta-analytic technique to examine 146 studies evaluating the efficacy of treating unwanted homosexuality. Fourteen of the studies, published between 1969 and 1982, were considered appropriate for the meta-analysis. Byrd and Nicolosi concluded that the average person who received treatment was better off than 79 percent of those undergoing alternative treatments or than others in control groups, when compared to pretreatment scores on several outcome measures.

General Commentaries Supportive of the Possibility of Sexual Reorientation

A number of general commentaries supportive of the possibility of sexual reorientation were published in the 1950s. In a review of treatment successes, Karpman (1954) concluded, "Every psychotherapist of experience must have in his records at least a few cases of analysis of homosexuality, exhibitionism, transvestitism that he has treated and cured or improved" (p. 390). Johnson (1955) reported that

change of sexual orientation from homosexual to heterosexual is possible and that the best prospects for change are the younger and more motivated patients. Mendelsohn and Ross (1959) made similar reports. Bergler (1956) wrote, "The homosexual's real enemy is his ignorance of the possibility that he can be helped" (p. 176).

In a review of 10 years of providing psychoanalysis aimed at diminishing homosexuality, Rubinstein (1958) reported that a number of his patients were helped and improved well beyond original expectations. Fried's (1960) report likewise supported the conclusion of previous analytical studies that homosexual patients can and have been treated successfully.

Tarail (1961) asserted that homosexuals could change through reconditioning therapy, physical and environmental withdrawal psychotherapy, and motivation therapy. Hastings (1963) speculated that homosexuals treated with psychoanalysis may very well be cured of unwanted homosexuality. Albert Ellis (1965) wrote, "Fixed homosexuality is definitely curable. . . . Every homophile who truly wants to learn how to enjoy (and not merely tolerate) heterosexual relations can, with the help of a good therapist, do so" (p. 265).

Some authorities have predicted that change in orientation may follow a client's use of existential analysis to discover and refute any faulty assumptions or distorted views that might be associated with the client's orientation (Benda, 1963; Wolman, 1967). Doyle (1967) concluded that treatment can be successful if the patient does not resist change and willingly works with an analyst for a sufficient period of time. According to Frank (1972), homosexuals can be appreciably helped through psychotherapeutic techniques. Mohr and Turner (1967) concluded that treatment of homosexuality was possible, but would be unsuccessful if the patient was not motivated to change. Hadden (1966) found that homosexual patients "give every indication of progressing toward a reversal pattern" (p. 15).

Janov (1970) validated the success of behavioral treatment of homosexuality and found that by offering reality and educational therapies, homosexuals could be helped to change. Newman, Berkowitz, and Owen (1971) concluded, "We've found that a homosexual who really wants to change has a very good chance of doing so" (p. 22).

From a Lacanian analytic perspective, Dor (2001) asked, "What happens when certain analysts make the disappearance of the patient's homosexuality the primary aim of treatment?" (p. 70). His answer:

> Only an ideological argument implicitly based in sexual norms can underlie such a practice; . . . [however,] the only norms that exist in clinical psychoanalysis are those that govern the space of the treatment. . . . This being the case, heterosexuality is a possible outcome of the treatment of a homosexual patient. (p. 70)

In a paper presented to the National Institute of Mental Health (NIMH), Frank (1972) wrote, "A large number of case reports and systematic studies report that some homosexuals can be successfully treated" (p. 63).

West (1977) observed that many studies of change from homosexual to heterosexual orientation have shown some degree of success—no less than 30 percent for behavioral therapies and about 25 percent for psychoanalysis. West speculated that if facilities were more practical and available, and if social and moral climates allowed it, statistics on treatment success would improve.

Marmor (1975) declared, "There is little doubt that a genuine shift in preferential sex object can and does take place in somewhere between 20 and 50 percent of patients with homosexual behavior who seek psychotherapy with this end in mind" (p. 151). Marmor later reported:

> The general view in the gay community that treatment is never successful is without foundation. The fact that most homosexual preferences are probably learned and not inborn means that, in the presence of strong motivation to change, they are open to modification, and clinical experience confirms this. (1980, pp. 276–277)

According to Kronemeyer (1980), approximately 80 percent of homosexual men and women in his practice achieved a healthy and satisfying shift toward heterosexuality. Sexologist Helen Singer Kaplan found that, with effective therapy, "very often a man's latent heterosexuality will blossom" (in an interview with Klein, 1981, p. 92). Kaplan concluded that with modern methods, "many homosexuals can change to a heterosexual orientation if they want to do so" (p. 92). Behaviorist Wolpe (1982) reported in a 20-year retrospective study that he had successfully treated several conditions, including homosexuality, with behavioral therapy.

Barnhouse (1984) asserted that psychiatrists and psychologists falsify scientific data when they report that changing orientation is impossible. Fine (1987) concluded that regardless of the type of treatment for homosexuality, a motivated and willing patient will yield a useful degree of success.

Nicolosi (1991, 1993, in press) gives practical methods for treating homosexual men and cites his and others' evidence of treatment success. Nicolosi reports that about a third of his long-term clients achieve a satisfactory diminishment of unwanted homosexuality and a significant increase in heterosexual attraction, although he cautions that some degree of homosexual attraction remains in the majority of clients throughout their lives. Also, another third of his clients satisfactorily diminish unwanted homosexuality but do not develop significant heterosexual attraction, while the remaining third appear to achieve no significant change, but report that their efforts were nonetheless beneficial in other ways.

Throckmorton (1998) reviewed the outcome literature through 1998 and concluded that change in sexual orientation was possible—but then opined that he was uncertain about how to *define* successful change in orientation. Throckmorton reported that clients whom he had treated and who initially were attracted primarily to persons of the same sex later declared that they were primarily attracted to persons of the opposite sex. More recently, Throckmorton (2002) reported additional empirical support for the possibility of beneficial change in orientation.

Within the religious domain, Wilson (1979) concluded:

> Treatment using dynamic individual psychotherapy, group therapy, aversion therapy, or psychotherapy with an integration of Christian principles will produce object-choice reorientation and successful heterosexual relationships in a high percentage of persons. . . . Homosexuals can change their orientation. (p. 167)

Moberly (1983) concluded that change was possible with the help of religious motivation. Consiglio (1991), who worked with homosexuals for more than 15 years, also supported religiously-mediated change in his work. Keefe (1987) reported, "I have seen some homosexuals in treatment and have met more former homosexuals (including those who were exclusively so) . . . who now respond physically and emotionally as heterosexuals in successful marriages" (p. 76). Courage, an apostolate of the Roman Catholic Church, follows a simplistic yet concrete view of success where celibacy (which he defines as serene sexual abstinence) is an acceptable outcome. "By developing an interior life of chastity, which is the universal call to all Christians, one can move beyond the confines of the homosexual identity to a more complete one in Christ" (Courage, 2006, ¶ 2).

General Commentaries Critical of the Possibility of Sexual Reorientation

While claiming that homosexuality is untreatable, Hemphill, Leitch, and Stuart (1958) did not offer scientific data as to why they made that claim. They based their findings on the Curran and Parr (1957) study, which failed to define what specific approach was used. Ironically, Curran and Parr reported one case of successful sexual reorientation.

Critics of sexual reorientation success allege that reports of such success lack conclusive evidence (Acosta, 1975); that such evidence is not confirmed (Tripp, 1975); that treatments are unethical (Davison, 1976), immoral (Davison, 1978), and unconvincing (Coleman, 1978); that studies have methodological flaws (Haldeman, 1991); and that studies have high failure rates (Murphy, 1991). The Kinsey Institute once endorsed interventions aimed at changing sexual orientation but withdrew that endorsement, saying that studies reported "varying success rates" (Reinisch, 1990, p. 181) and that sexual reorientation was not socially acceptable (Bell et al., 1981). Lasser and Gottlieb (2004) speculate—with apparent reluctance—"that in some isolated and rare circumstances, conversion therapy might be effective" (p. 198).

McConaghy (2000), who published many behavioral therapy outcome reports, opines that predominantly homosexual men do not seek change. He speculates that those who seek professional help are mostly anxious, socially intimidated men at the fringe of heterosexual orientation who adopt a black-versus-white posture.

Bancroft (1970) found that 5 of 15 (33 percent) desensitized, treated homosexuals experienced a change in orientation and behavior. But Bancroft later asserted that homosexuality did not need to be cured (Bancroft, 1975).

Beckstead (2001) opines, "Hopes of experiencing heterosexual attractions and eradicating homosexual attractions may turn into disappointments" (p. 106). For those who fail therapy, Beckstead says, the time spent in therapy is often perceived as painful. However, this draws from partisan opinion verses empirical data.

Drescher (2001) criticizes reorientation therapists, opining that they only reinforce the stigma of homosexuality that existed before homosexuality was removed from the *Diagnostic and Statistical Manual* (*DSM*) in the 1970s. He suggests that these therapists have embraced conservative religious dogma in their attempts to change homosexuals, therefore "stifling dissent" (p. 22). Schneider et al. (2002) assert that mental health professionals who diagnose homosexuality as pathological have "promulgated risky and often harmful 'treatments' aimed at creating sexual conformity" (p. 273).

Forstein (2001) opines that it is unnecessary to change a person's sexual orientation, but concludes that there is no scientific proof that reorientation therapies necessarily are harmful and unethical. He offers methodological questions for therapists to consider and basic guidelines for ethical intervention.

Shidlo and Schroeder (2002) studied homosexuals who had attempted but failed to achieve sexual reorientation via therapeutic and/or religiously-mediated assistance in order to document the harm caused by such attempts. Shidlo and Schroeder learned from several people who had received reorientation therapies "that they were plagued by serious psychological and interpersonal problems during the therapy and after its termination" (p. 254). The researchers criticized therapies aimed at sexual reorientation as ethically unsound and poor practice, even though a number of their subjects did report either successful reorientation or that their attempts to reorient had been helpful, regardless of whether they had successfully reoriented.

A number of general commentaries critical of the possibility of change also raise concerns about the potential harm of participating in therapy to change one's sexual orientation (Duberman, 1991, 2001; Haldeman, 1991, 1994, 2001; Beckstead, 2001; Drescher, 2001; Schroeder & Shidlo, 2001; Shidlo et al.,

2001; Schneider et al., 2002; Shidlo & Schroeder; 2002). Literature concerning the potential harmfulness of reorientation therapy is discussed in Section II.

Limitations of the Reorientation Literature

Like all clinical reports and scientific studies, those reported here have limitations. Single-case studies are especially limited because data is not objective; rather, it is based on an individual therapist's reports and is not generalized to a larger body of clients or therapists. Anecdotal accounts are not sufficient when more scientific means of study are available. Studies that use larger, more representative samples and multiple therapists nevertheless may have methodological limitations, such as self-reported data, nonrandomization, and retrospective reporting. Many studies are limited because of the absence of control groups, robust measurement, and adequate longitudinal and replicable research designs.

The results of studies also may be difficult to interpret because sexual orientation is generally not clearly defined or understood (Gonsiorek, Sell, & Weinrich, 1995; Sell, 1997) and is realistically characterized by multiple factors (Schneider et al., 2002). A person's self-identified sexual orientation may not be congruent with his or her sexual behavior, thoughts, or feelings.

At present, sexual orientation is perhaps best conceptualized and measured as a continuum rather than a discrete category. For example, two people may both define themselves as heterosexual, even though one person has some homosexual tendencies and the other does not. While the two actually have different orientations when viewed on a scale, they may report themselves in the same category. This type of difference complicates the reporting and interpreting of success and failure rates.

This treatise assumes a common understanding of what is meant by *reorientation therapy,* the goals of reorientation therapy, what is meant by *homosexuality,* and which aspects of homosexuality clients may attempt to change or may succeed in changing. The most controversial issue seems to be the assertion that genuine, lasting, and substantial change of sexual orientation is possible. Reports that people have successfully and permanently changed their sexual orientation may be discounted because the definitions of sexual orientation vary and because recidivism is a possible outcome in this, as in any, course of psychotherapy (Lambert & Ogles, 2004).

In the absence of a commonly held understanding about these topics, client satisfaction with the process and outcomes of reorientation therapy may be an unavoidable benchmark for determining help or harm. Further, even though self-reported outcomes and (dis)satisfaction with them are subjective, assessment of clients' perceived satisfaction and perceived results remains a practical way to measure the harm and benefits of therapeutic approaches at this time.

Measurement of treatment failure also depends on the definition of *sexual orientation*—something for which there is no universal definition. Unless sexual orientation is seen on a continuum, someone who retains an occasional homosexual thought, feeling, or action could be incorrectly labeled as "homosexual." Further, some clients reported that while their participation in reorientation therapy did not lead to a change in their orientation, they nevertheless were satisfied with the changes they did achieve through therapy (Nicolosi et al., 2000b; Spitzer, 2003). Even Shidlo and Schroeder (2002), who wrote that they had intended to study people who reported that they were harmed by reorientation therapies, found positive support for such therapies. Not only did 13 percent of their 202 subjects report being "successful," but also many of those who were not successful nevertheless reported that their experience of therapy had been at least somewhat helpful.

This section is a compilation of 125 years of clinical reports and research studies documenting that change in sexual orientation is possible. We offer this narrative, chronological review of the literature, but also recognize that we do *not* discuss in depth the particular weaknesses and strengths of the reports and

studies mentioned. Although the research literature discussed was considered acceptable by the clinical or research standards of the day, we acknowledge that older research has limitations as a body when evaluated using current standards for scientific research (such as methods of sampling, control groups, assessment, and post-treatment followup.). Despite the historical, methodological limitations of individual studies, we conclude that a fair consideration of all of the literature reveals consistent and compelling evidence that some individuals can change sexual identity—as well as affective, cognitive, and behavioral components of their sexual orientation—through participation in competent, therapeutic intervention.

In the 1970s, homosexuality was formally declassified as a mental disorder or illness. The American Psychiatric Association (1972) formally removed homosexuality from its list of mental disorders during the sixth printing of the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-II*). In support of this decision, the APA likewise declared that homosexuality was not a "mental illness" (Conger, 1975, p. 633). Since then, there has been a dearth of research on the identity development and treatment of homosexuals who seek reorientation.

Byrd's comments on the responses of homosexual activists—especially activist-professionals—to Spitzer's (2003) study also address the political-scientific context of this dearth of research:

> Activists suggest that there is no need to study change from homosexuality, and that even research on this subject will cause harm to self-identified homosexuals. In spite of a political climate where activism often trumps science, and where activist claims go uncritically examined, there is no rational basis for the speculation that studying homosexuality will harm gay-identified individuals. . . . When sociopolitical agendas prevent scientists from studying even controversial topics like homosexuality, no one wins. In fact science can only progress by asking questions and seeking answers. When research is discouraged and scientists are intimidated, we begin down a slippery slope that approximates the censorship of scientific investigation, a very dangerous slope indeed. (Byrd, 2008; cf. 2006)

Finally, we note that research studies and reports commonly cited by—and apparently conducted in order to provide evidence to support—gay-rights activists hardly meet the methodological standards used as the basis for criticizing the empirical evidence for assisted sexual reorientation. For example, Schumm's (2008) analysis of 12 doctoral dissertations over two decades (late 1970s to the late 1990s) offers an excellent critique of the methodological weaknesses of studies commonly used to support legislative and political efforts to promote homosexual parenting and adoption rights.

Overall, most of the research has been conducted on men, but a number of theorists have argued that the sexuality of women is more fluid and situationally influenced than that of men. Gold-standard studies on the development of sexual orientation and the effects of interventions on change of orientation—for both men and women—are needed and must necessarily include better randomized and longitudinal research designs. Until then, with so much historically state-of-the-art clinical evidence and empirical research documenting that sexual reorientation is possible, and without a preponderance of quality research evidence demonstrating definitively that such change is *not* possible, we cannot deny a client's right to self-determination and professionally assisted reorientation.

Conclusion

Section I of this treatise is a brief overview of 125 years of clinical and scientific reports documenting that volitional change from homosexuality toward heterosexuality is possible. Many advocates of

these therapies have reported that they are helpful and, that in some cases, changes in orientation are maintained. Many researchers and theorists agree that sexuality is fluid, which critics claim could affect reported outcomes of studies. General critics of reorientation therapies claim that they can be harmful, and anecdotal accounts of being harmed have been reported (Duberman, 1991; Shidlo et al., 2001; Shidlo & Schroeder, 2002). But as Forstein (2001) concluded, no existing studies document that such therapies *are* in fact harmful (p. 177).

A broad range of treatment modes and attitudes toward homosexuality have been demonstrated across various disciplines (Lamberd, 1971). There are two principal premises underlying the treatment of homosexuality: First, it is primarily developmental or adaptational in nature, with other contributing factors (such as predisposing constitutional/biological factors or learning through nonconsensual sexual activity). Second, people with a homosexual adaptation can be helped to experience a more heterosexual adjustment, at least in some cases and to some degree.

The outcomes of interventions aimed at changing sexual orientation vary. Success rates have been generally defined by a decrease in homosexual attraction and a shift in sexual desire toward heterosexuality, as determined by self-reports, therapist reports, or specific measurements—such as penile plethysmography, the 7-point Kinsey scale, and the multi-item KSOG.

Various paradigms and approaches have been used to treat homosexuality, including psychoanalysis, hypnosis, behavior therapies (including aversion), cognitive therapies, sex therapies, group therapies, religiously-mediated interventions, and pharmacology. In many cases, combinations of therapies have been used. There have also been reports of spontaneous change. A limitation of many reports is the failure to clearly define *sexual orientation, homosexuality, heterosexuality,* and what *change* means. Reports of psychoanalytic treatments have shown that outcomes vary. A consistent one-third success rate is synthesized from older reports of behavior, cognitive, and group therapies, but no systematic sampling of representative patient populations exists in the literature, so it must be acknowledged that overall success rates are unknown.

After homosexuality was removed from diagnostic manual as a mental illness, the shift in the treatment of homosexuality largely evolved from amelioration toward acceptance and, finally, normalization. The topic of sexual reorientation has been reduced largely to a social debate, with media outlets like *People* magazine, the *Montel Williams Show,* and CNN making it a public forum—conducting discussions that are confusing, biased, and unscientific. Nonscientific advocacy groups such as the Human Rights Campaign have also attempted to discredit reorientation therapies—without the credentials to do so (Human Rights Campaign, 1998).

But even homosexually-identified scholars recognize the need to serve the psychological needs of homosexuals. One such scholar wrote that clinicians "have the ethical obligation . . . [that] regardless of pathology, cultural trends, or current political rhetoric, mental health issues for homosexuals remain clinically significant and, like all others, must be addressed by the clinician with competence" (Monachello, 2006, p. 56). NARTH asserts that this "ethical obligation" to offer competent care must extend to the dissatisfied homosexually-oriented client whose values and sense of self convince him that he was designed for heterosexuality and for a gender-complementary partner.

Underscoring this same principle, the APA code of ethics requires that "psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination" (APA, 2002, General Principles, Principle E). While homosexuality itself was declared no longer to be a mental disorder according to the *Diagnostic and Statistical Manual II,* distress concerning sexual orientation is still considered a *DSM-IV* subcategory, labeled as "Sexual Disorders Not Otherwise Specified." Therefore, "the developmental issues that contribute to 'the persistent and marked distress' about one's sexual orientation are valid areas of investigation" (Morin & Rothblum, 1991, p. 3).

To quote Monachello (2006):

> We should defend the homosexual client's right to choose professional support and assistance toward fulfilling his/her goals in therapy according to the client's own values and tradition. We should be committed to protecting our homosexual client's right to autonomy and self-determination in therapy. (p. 57)

We acknowledge that change in sexual orientation may be difficult to attain. As with other deeply ingrained psychological conditions and behavioral patterns—such as low-self-esteem, alcohol abuse, social phobias, eating disorders, or borderline personality disorder—change through therapy does not come easily, and there is a substantial therapeutic failure rate, as well as a need for ongoing maintenance of any success that is attained. Relapses to old forms of thinking and behaving are, as is the case with most forms of psychotherapy for most psychological conditions, fairly common. But even when clients have failed to change sexual orientation, other benefits commonly have resulted from their attempts. We conclude that the documented benefits of reorientation therapy support its continued availability to clients who exercise their right of therapeutic autonomy and self-determination through ethically informed consent.