II. Response to APA Claim: Efforts to Change Sexual Orientation Are Harmful and Can Lead to Greater Self-Hatred, Depression, and Other Self-Destructive Behaviors

The APA claims that efforts to change sexual orientation should be avoided because persons who participate in them may be harmed by the experience (DeLeon, 1998; Just the Facts Coalition, 2008). Are therapies for the resolution of unwanted homosexual feelings, thoughts, or behaviors *never* helpful? And are they *always* harmful to those who receive such services? If such therapies are ever helpful—even to a single client—then claims of being *always harmful* and *never helpful* are not supported. Numerous reports by therapists and clients of reorientation therapies document significant resolution of unwanted homosexual feelings, thoughts, and behaviors, so reorientation therapy is *not* always harmful to those who attempt sexual reorientation.

But what evidence is there that reorientation therapy is *usually* or *ever* harmful? And, would it be harmful *not* to offer such therapy to those dissatisfied with their homosexuality? In the Introduction, we point out that the APA cites the work of various authors (Davison, 1991; Gonsiorek & Weinrich, 1991; Haldeman, 1994; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002) in support of its claim that reorientation therapy is (at least potentially) harmful. In this section, we discuss literature and perspectives relevant to answering these questions.

Before discussing specific reports, we acknowledge that the evaluation of the helpfulness and harmfulness of reorientation therapies is limited by methodological difficulties. In the last few decades of the 20th century, therapies for unwanted homosexual attractions and behaviors diversified to the extent that proper evaluations of their efficacy were very difficult to implement. The typically modest numbers of clients for each therapy made it impossible for most tests to have adequate statistical power, and the few studies conducted either lumped together various therapeutic approaches or failed to operationalize and measure adequately the unique features of a given approach.

In addition, clinical approaches commonly have been evaluated using convenience samples and the individual or pooled testimonies of clients and/or clinicians. As a result, both positive and negative stories about therapy processes and outcomes have been reported without an objective means of resolving conflicting accounts. Also, most of the mental health professionals who have offered reorientation therapy have been private practitioners without the time or resources to engage in systematic outcome research on their therapeutic approaches.

Reports of the Harmfulness of Efforts to Change Sexual Orientation

Certain writers speculate on the potential harmfulness of efforts to treat homosexuality and/or offer anecdotal reports of such harm (see "General Commentaries Critical of the Possibility of Sexual Reorientation" in Section I). Duberman (1991, 2001), a self-identified homosexual, wrote about his own negative experiences in reorientation therapy and generalized that it is impossible for anyone to pursue successful change. In much the same way, Ford (2001) and Moor (2001) told their own stories of unsuccessful attempts and self-perceived harm.

Brown (1996) declared reorientation therapies to be "clear violations of the ethic of doing no harm" (p. 905), but the only authority for this claim was the anecdotal Haldeman (1991) paper and others written predominantly by noted gay activists with an apparent ideological stake in the outcome.

As Beckstead (2001) opines, "Hopes of experiencing heterosexual attractions and eradicating homosexual attractions may turn into disappointments" (p. 106). He mentions that those who fail to change as intended often perceive that their time spent in therapy was painful. However, this conclusion appears to be based on opinion rather than empirical data.

Drescher (2001) opined that reorientation therapists only reinforce the stigma of homosexuality that existed before homosexuality was removed from the *DSM* in the 1970s. He suggests that these therapists are embracing conservative religious dogma in their attempts to change homosexuals, therefore "stifling dissent" (p. 22) about whether sexual orientation ought to be changed. 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).

The authors of the most recent study cited as supporting the harmfulness of reorientation therapies, Shidlo and Schroeder (2002), reported that several people who had received reorientation therapy claimed "that they were plagued by serious psychological and interpersonal problems during the therapy and after its termination" (p. 254). Ironically, this study (discussed in detail below) is commonly misrepresented. Along with the preceding and other assertions of harm, the authors were clear about the obvious limitations of their study. Given the methodological limitations of the study, they clarify that the "data presented in this article do not provide information on the incidence and the prevalence of failure, success, harm, help or ethical violations in conversion therapy" (p. 250).

In their survey of 882 clients, Nicolosi et al. (2000b) offered participants a 70-item list of potentially negative consequences of therapy. Only 7.1 percent reported that they were worse on three or more of the list items, which suggested minor negative effects for those who stayed in therapy.

Finally, in the most methodically rigorous study to date, Jones and Yarhouse (2007) found empirical evidence that change—in sexual orientation for some participants, in sexual identity for others—through their involvement in the religiously-mediated ministries of Exodus was possible, but that no evidence was found to support the claim that attempts to change sexual orientation caused harm to participants. This study is significant because of its longitudinal design and its use of a mix of standard and developed assessment instruments for measuring sexual orientation, as well as actual psychological and spiritual functioning before, during, and after participation. Jones and Yarhouse's research design offers a standard for future studies of the harmfulness—and helpfulness—of therapeutic, as well as religiously-mediated efforts to change unwanted sexual orientation.

Suicidality

The presence of depression and the corresponding risk of suicide are greater in any population of mental health clients than in nonclient populations. The prevalence of depression and suicidal thoughts and attempts is even greater for those dealing with homosexuality (see Section III). Although Shidlo and

Schroeder (2002) speculate that the most significant harm resulting from the therapies under discussion might be suicide, an examination of their work suggests a statistical trend that long-term suicidality among their subjects reduced by 50 percent after therapy (Whitehead, 2008). A better analysis of suicide risk would involve better controls and use detailed suicidality rates in matched homosexuals who did not undergo any therapies of the type described by Shidlo and Schroeder (2002).

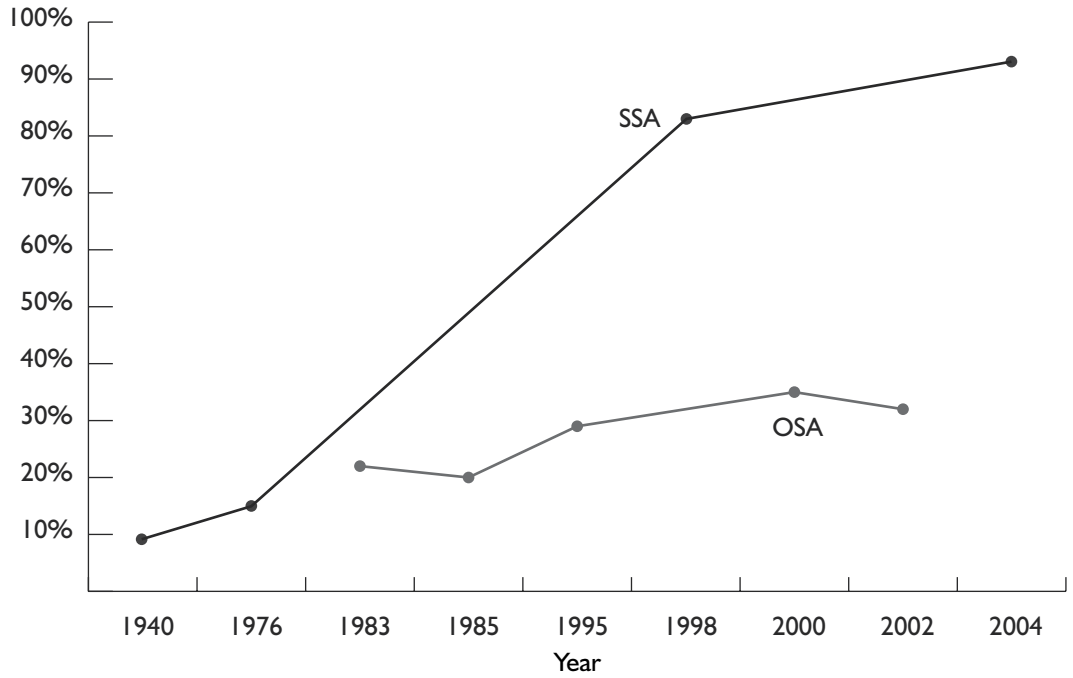
Greater Homophobia

Critics like Haldeman (1994) suggest that reorientation therapy results in a negative attitude toward homosexuality, saying, "Conversion therapies by their very existence exacerbate . . . homophobia" (p. 225). This vague criticism doesn't specify who it is—clients, the general public, professional bodies, or all three—that develops this type of negative attitude.

If the statement is intended to mean that those who have selected therapy gain more negative attitudes toward homosexuality and/or toward themselves for being homosexual, the criticism would be valid only if it could be proved that such attitudes were caused specifically by reorientation therapy. In what follows, we examine opinions over time as revealed by surveys and show that the existence of reorientation therapies had no significant negative impact on homosexuals or on how society views or treats them.

Figure 1 shows that opinions about origins of same-sex attractions have changed far faster within the homosexual community than among the public at large. Many homosexual men and women believe they were born that way and are not to be blamed. This suggests that the existence of therapy had no significant, negative effect on the self-understanding of homosexuals.

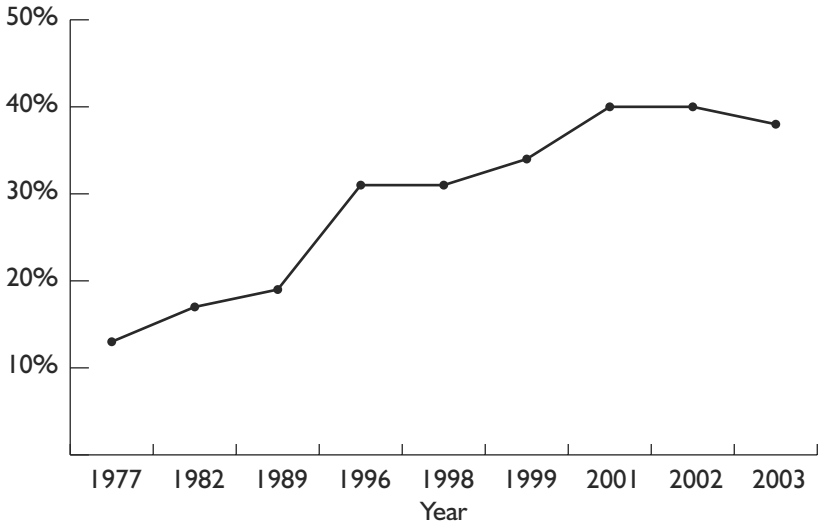
Figure 1. Belief in Genetics as a Source of SSA



Changes in how same-sex attraction (SSA) individuals have viewed the origins of their trait with time. A few opposite-sex attraction (OSA) points are inserted for comparison (Bell, 1976; Herek, 2002; Kryzan & Walsh, 1998; Otis & Skinner, 2004; Harris Poll 2000 as cited in Schneider, 2006).

As shown in Figure 2, over the past few decades there has been a clear trend toward the belief that homosexuals are born that way—a belief that is increasing among the general public, as well as in the homosexual community. This trend indicates a growing belief in all communities that those with same-sex attraction are acting out an attraction that is normal and natural for them and that they cannot change. The availability of various reorientation therapies has had an immeasurably small effect on general opinion, which has become much more accepting toward homosexuality.

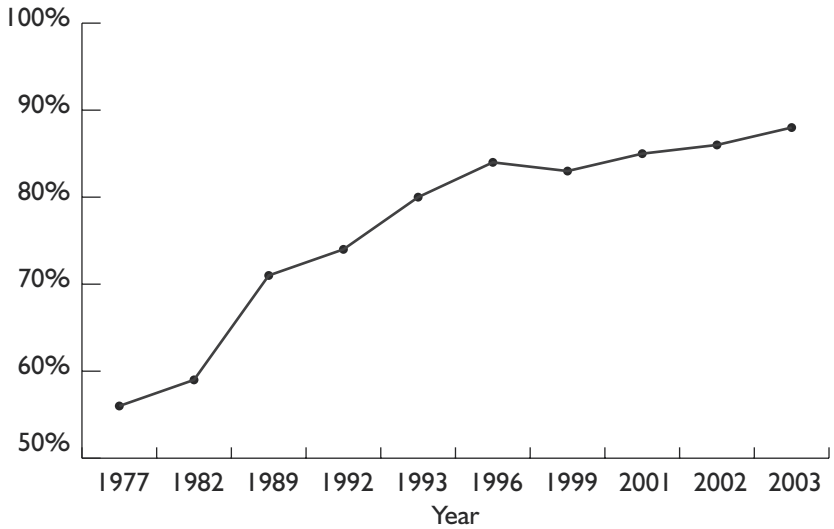
Figure 2. Gallup Poll: People With SSA Born That Way?



Changes in opinions of the general population about origins of SSA with time (Robinson, 2006).

Figure 3 shows the increase of positive attitudes toward those with same-sex attraction, as measured by the belief that they should have equal access under the law—a belief that generally indicates at least some degree of acceptance of homosexuality.

Figure 3. Should SSA People Have Equal Access?



Changing opinions about whether social discrimination against people with SSA should be permitted (Robinson, 2006).

As shown in the preceding graphs, researchers indicate that over the past 30 years, offering reorientation therapy and religiously-mediated ministries to persons to help them to resolve unwanted homosexuality did *not* coincide with an increase in social discrimination toward homosexuals. As the Kaiser Family Foundation (2001) random telephone survey of households in the United States found, "The public is increasingly accepting of gays and lesbians and supports anti-discrimination measures and expanded rights and benefits for domestic partners" (p. 11).

The Hunter College Poll (Egan, Edelman, & Sherrill, 2008)—a random, nationally representative, telephone-initiated, online-completed survey of homosexual and bisexual men and women—found a parallel finding. Among self-reported members of the lesbian, gay, and bisexual (LGB) community:

> While the oldest generation of LGB's [those age 65 and over] places a high priority on obtaining *freedom from* discrimination and bias, the youngest generation [those aged 18–25] instead believes it is more important to win the *freedom to* live their lives in ways no different than heterosexual Americans [e.g., via "the securing of marriage rights and the rights to parent and adopt children"]. (p. 25; emphasis in original)

Presumably, younger members of the LGB community are more concerned about lacking the rights to live as heterosexual couples do than about past or anticipated experiences of workplace discrimination, anti-gay bias crimes, etc. (see Egan & Sherrill, 2005).

What if critics mean that therapy causes homophobia not among the general public, but among those who have actually participated in it? Such a statement would be a valid criticism only if such attitudes were always caused by therapy and if those attitudes were shown by objective evidence to be an inevitable side effect of therapy. Researchers report otherwise. We believe that the informed consent of consumers of reorientation therapies should be based on the documented average participation—and nonparticipation—benefits and risks, which reorientation therapists give to potential clients.

Reports of the Helpfulness of Efforts to Change Sexual Orientation

Significantly, clinicians who are opposed to reorientation therapy and who caution that it may be harmful nonetheless may recognize that such therapy does not always cause harm. For example, Haldeman (2001), a gay-activist clinician who reports that he has treated dissatisfied former consumers of such therapy, writes:

> Not all individuals appear to be harmed by conversion therapy. It is not uncommon, in fact, for some to report that a failed attempt at conversion therapy had an odd, indirectly beneficial effect [such as] an individual's final "letting go" of the denial surrounding his sexual orientation. (pp. 119–120)

Subsequent to describing the risks to which he believes reorientation therapy clients are subjected, Haldeman qualifies his risk assessment by asserting, "This is not to suggest that all conversion therapies are harmful, or that the mental health professions should try to stop them" (p. 128).

Another body of research documents that even when consumers of reorientation therapies have not found that therapy was successful, the clients nevertheless found therapy to be helpful in other ways (Nicolosi et al., 2000b; Shidlo & Schroeder, 2002; Spitzer, 2003). While the Shidlo and Schroeder study was initially designed for "documenting the damage" done by "homophobic therapies" in order "to inform the public about the often harmful effects of such therapies" (as written in the participant

recruitment section of their paper), unexpected reports of helpful change led to recruiting and including "both self-perceived successes and self-perceived treatment failures" in the study (p. 259).

Four consumer satisfaction survey studies were reported by Nicolosi et al. (2000b), Shidlo and Schroeder (2002), Spitzer (2003), and Karten (2006). Shidlo and Schroeder (2002) collected predominantly negative reports for five years, while the authors of the other studies assembled positive reports over much shorter time periods. This suggests a possible trend: reports of harm may be much harder to find.

Shidlo and Schroeder (2002) chiefly collected stories of harm from therapy reported by individuals, presenting many descriptive statistics. The other researchers assembled stories of varying degrees of success of therapy, offering similar statistics. For all that these studies do show, another important limitation is that none of them offers evidence about the number of people who were temporarily in therapy but did not continue. From a methodological point of view, the value of these papers (as attested by the authors themselves) is restricted to saying that some people report positive results while others report negative results.

In their survey of 882 clients, Nicolosi et al. (2000b) gave subjects a list of potentially negative consequences of therapy. Only 7.1 percent reported that they were "worse" on three or more items on the list, which suggests minor negative effects for those who stayed in therapy, at least within this sample (see Section I for further discussion of this study).

Shidlo and Schroeder (2002) recruited subjects by advertising on homosexually-oriented Web sites, using email lists and newspapers, advertising in nonhomosexual newspapers, and using direct mailings to homosexual and ex-homosexual organizations. The initial ad in homosexual publications cited the specific request, "Help Us Document the Harm!" After some respondents reported finding therapy at least somewhat helpful, the researchers advertised for additional subjects in a more neutral manner. Since the researchers specifically sought subjects who thought that they had been harmed and who would help the researchers make a case against such therapies, the sample clearly was nonrepresentative of the therapy population as a whole.

Of the 202 participants, including 182 men and 20 women, 176 reported that they had failed conversion therapy and 26 reported that they had actually been successful. Twelve of the self-reported "successes" were still struggling with "slips" (some incidents of homosexuality following treatment), and 6 were not struggling with same-sex attractions because they were managing those attractions. Eight were termed to be in a "heterosexual shift period" (p. 253)—they were rated at 3 (equally heterosexual and homosexual) or less (more heterosexual) on the 7-point Kinsey scale, labeled themselves as heterosexual, reported having heterosexual behaviors and being in a heterosexual relationship, and denied homosexual behavior.

Shidlo and Schroeder found that among the "self-perceived successes" who participated in clinical treatment courses—defined as "any therapy administered by a licensed psychologist, psychiatrist, social worker, family and marriage therapist, or counselor" (other subjects had participated in religiously-mediated ministries)—a total of 22 viewed treatment as not harmful, but in fact "helpful only." The other "successes" reported that treatment had been "both helpful and harmful." Of the remaining 168 self-perceived treatment "failures," 9 reported that treatment was "helpful only"; 72 that treatment was "both helpful and harmful"; 85 that treatment was "harmful only"; and 2 that treatment was "neither harmful nor helpful."

Spitzer (2003) reported that there was no evidence of any form of harm experienced by the participants in his study. "To the contrary," he writes, "they reported that it was helpful in a variety of ways beyond changing sexual orientation itself" (p. 413). And because his study found considerable benefit and no harm, Spitzer says that the American Psychiatric Association should stop applying a double

standard in its discouragement of reorientation therapy and its active encouragement of only therapy that confirms and solidifies a homosexual identity ("gay-affirmative" therapy)—a therapy, he concludes, that has no "rigorous scientific evidence of effectiveness" (p. 413).

These studies share a common limitation. Like other reports, none of these studies reports the number of persons who were temporarily in therapy but dropped out before sufficient time was allowed to assess the eventual outcome. From a methodological point of view, the value of these three papers (as attested by their authors) is restricted to saying that "some people report positive results while others report negative results." This is what an objective observer with no ideological stake in the outcome would conclude from these findings. An accurate rate of either harmfulness or helpfulness is not attainable from these studies, and both rates might conceivably be either extremely small or quite substantial.

Finally, using a longitudinal research design with multiple assessment measures, Jones and Yarhouse (2007) found not only that many participants in religiously-mediated intervention experienced effective reorientation, but also that participants, including those who failed to reorient, did not experience the interventions as harmful.

Overall, the present literature does not support the conclusion that predominant harm is a regular result of reorientation therapy. Future efforts to understand the potential and avoidable harmfulness—as well as the helpfulness—of therapy to treat unwanted homosexuality ought to replicate the design of the Jones and Yarhouse (2007) study. In addition, future research on the process and outcomes of psychological care for persons seeking sexual reorientation must use as the criteria for valid therapy standards that are clear, universally agreed upon, and commonly used for evaluating psychological care for any client goals.

Avoidance of Even Greater Harm

The APA has warned that efforts to change sexual orientation may be harmful and lead consumers to experience greater self-hatred, depression, and other self-destructive behaviors (APA, 2008; DeLeon, 1998; Just the Facts Coalition, 2008). That claim is not supported by existing research, since no randomized study has ever assessed harm rates. Further, this warning is misleading to consumers who otherwise might benefit from such therapy.

The logic of APA and like-minded professionals appears to be that since some clients have reported that they were harmed by reorientation therapies, all people should avoid providing it or taking advantage of it. More rigorous research already documents that therapy *in general* "has been shown to be harmful" to some of its consumers (Lambert & Ogles, 2004). Applying the same logic to therapy in general would have all people avoid any (or every) approach to therapy—and would have therapists pursue different professions.

It is worth considering that a given therapeutic approach to help someone resolve or cope with any specific difficulty might succeed brilliantly for a few individuals but fail completely for others. The generalizations that a specific type of therapy "does not work" or "is harmful" cannot be made based on limited anecdotal evidence. On the basis of such evidence, it would be highly unethical to deny therapy to all informed clients who seek it.

To use an extreme example, a drug that cured cancer in only 1 percent of those who took it—but that failed in 99 percent of patients, and that caused short-term nausea as well—would not be taken off the market; in fact, it would be ethically endorsed as at least worth a try, as long as the patient understood the risks and benefits and had provided informed consent. As previously discussed in Section I, mental health professionals providing therapy for unwanted homosexuality commonly report much higher success rates than 1 percent.

The prospect of banning therapy for those who want it would potentially create much greater harm. No one can accurately predict future swings in public opinion. It is quite conceivable that refusal to offer reorientation therapies to a client or class of clients—a large minority of whom will subsequently die of AIDS—could be the subject of extremely damaging class-action suits in the future. Precedents are found among institutional inmates who have sued parent organizations many decades later for defective care.

The APA or other professional organizations could be sued in the future by relatives of ego-dystonic homosexuals who were told that they were "born that way," that change was not possible, and that they will only be "true to themselves" if they claim a homosexual identity and reject their "homophobia" (their values and viewpoints about human nature and human sexuality). The APA could be sued for not providing the desired service—and, therefore, for not preventing the very grave medical risks inherent in the male homosexual lifestyle.

Many who seek reorientation therapy do so because they are afraid of the medical risks of continuing the lifestyle. Statistically the risk of life-threatening disease in the homosexual community is greater than the medical risk of any activity for any comparable group (see Section III). Someone who wishes to avoid the risk of death should be helped to avoid the activities that expose him to life-threatening disease; it is unethical for a therapist *not* to provide—or not to refer a client for—such help.

Probably the most unfortunate counseling/therapy failure in history, resulting in the death of tens of thousands, is that associated with safe-sex counseling. Rates of human immunodeficiency virus (HIV) infection have been resurgent in recent years, and in many countries they are as high as before safe-sex counseling started. Although this resurgence may be due to people becoming weary of overexposure to the safe-sex message, it is inaccurate to say that this counseling led to harm. Another example is that counseling to avoid teen pregnancy did not prevent the emergence of a large group of teenage mothers who are often near or below the poverty level. No one would argue that such counseling should stop because it did not entirely fulfill its ultimate aim.

Similarly, reorientation therapies, which have been trying to prevent the greatest long-term harm imaginable to clients—death from AIDS—must not be unfairly characterized as generally leading to harm. Various professional organizations have issued position statements disapproving of reorientation therapies, but as yet no formal ban on such therapy is in force.

It should be recognized that failure to offer therapeutic help to persons who are "dissatisfied" with their homosexuality on religious grounds would be violating their rights not only to autonomy and self-determination, but also to religious freedom. APA guidelines challenge psychologists to not only aspire to "respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination," but also to be "aware of and respect cultural, individual, and role differences, including those based on . . . religion," and to "consider these factors when working with members of such groups" (APA, 2002). For many, the desire to diminish homosexuality and to develop heterosexual potential is intrinsic to their value system. This may include a religious background that values gender complementarity and traditional understandings of family and sexuality—sources that no psychotherapist has the ethical right to attempt to change.

As Byrd et al. (2008) found, many participants in therapeutic, pastoral, or religiously-mediated efforts to diminish unwanted homosexuality have a "world view [that] preclude[s] homosexuality as an identity or lifestyle. A deeply felt religious or spiritual identity seem[s] to be a primary motivator in seeking treatment in the first place" (p. 26). Byrd et al.'s quote of gay-activist researcher Haldeman bears repeating:

> A corollary issue for man is a sense of religious or spiritual identity that is sometimes as deeply felt as is sexual orientation. For some it is easier and less emotionally disruptive

> to contemplate change in sexual orientation than to disengage from a religious way of life that is seen as completely central to the individual's sense of self and purpose. . . . However we may view this choice or the psychological underpinnings thereof, do we have a right to deny such an individual treatment that may help him to adapt in the way he has decided is right for him? I would say we do not. (Haldeman, 2000, p. 3)

Principles for Ethical Therapy

While Shidlo and Schroeder (2002) criticize therapies aimed at changing sexual orientation as being ethically unsound and poor practice, Forstein (2001) opines differently. Forstein wrote that although he does not believe it is necessary to change a person's sexual orientation, there is no scientific proof that reorientation therapies are necessarily harmful and unethical. Further, Forstein offered methodological questions for therapists to consider and suggested basic guidelines for ethical intervention.

The ethics of clinical reorientation-based interventions have been a primary concern of major mental health organizations and professionals (Throckmorton, 1998; Yarhouse, 1998). In terms of ethical alternatives, Lasser and Gottlieb (2004), who otherwise voice concern about the risks and skepticism about the helpfulness of conversion (i.e., reorientation) therapy, nevertheless offer the following perspective:

> Despite the obvious risks associated with conversion therapy, there are two possible advantages to treating the patients in this manner. First, . . . we must accept that in some isolated and rare circumstances, conversion therapy might be effective. Second, even if the treatment is not successful, the patient may benefit in at least three ways. First, a genuine failed attempt may help the patient accept his or her sexual orientation. Second, the treatment may foster gains in other areas as a by-product. Third, the patient-therapist relationship is maintained, whereas a refusal to consider conversion therapy has the potential to prematurely terminate the patient-therapist relationship. (p. 198)

Even when therapies have failed in changing sexual orientation, other psychological benefits have resulted, such as the discovery of sexual identity, increased social supports, spiritual awakening, and decreased anxiety (Byrd et al. 2008; Erzen, 2006; Karten, 2006; Lasser & Gottlieb, 2004; Nicolosi et al., 2000b; Schroeder & Shidlo, 2001).

We agree that professional standards should apply to all therapies, including those used in the psychological care of persons with an unwanted sexual orientation. Even before the obligation to do good is the principle, "First, do no harm." Therapy should not lead to significant, immediate, or avoidable harm; thus, it would be highly unprofessional to approve therapies that create significant and immediate self-hatred, depression, and other self-destructive results. We also believe that any known significant negative effect of therapy should be a matter of prior informed client consent, and that any long-term negative effects of therapy that might be revealed by future research should be disclosed and forestalled as far as is practical. Of course, all therapies (including those trying to change sexual orientation) may—and sometimes do—lead to unintended or indirect harm (Lambert & Ogles, 2004; Mohr, 1995).

Given the intensely political nature of the subject, we argue that published literature contains very few accounts of harm resulting from reorientation therapies. If such therapies were usually harmful, one would expect a flood of such reports. Based on the current literature, the claim of overwhelming harmfulness is simply not supported empirically and is simply untrue in a quantitative sense.

If this claim of harmfulness means that the therapies being discussed have produced some harm, then all therapies in the entire field of psychology are equally guilty—all will have led some clients to

a perception of harm, or at least disappointed hopes, at some time, usually inadvertently (Lambert & Ogles, 2004; Mohr, 1995). Reorientation therapy—like any therapy for which the clinical and scientific literature shows no obvious ill effects, some obvious (at least anecdotal) benefits, and over a century of multi-theoretical, multi-professional, and multi-disciplinary support—deserves to be recognized for the degree of nonmaleficence (nonmalfeasance, or lack of harmfulness), as well as beneficence (helpfulness) already demonstrated. Reorientation therapy should be considered as generally beneficial and should continue to be made available to those seeking sexual reorientation, unless and until proven otherwise.

Conclusion

While client dissatisfaction is a possible and unfortunate consequence of any therapy, efforts to help persons change unwanted homosexual orientation have not been shown to be generally harmful, nor to usually lead to psychological harm. In fact, in many cases there have been reports of psychological benefits of reorientation therapy independent of those benefits associated with changing sexual orientation, and accruing to the client, whether or not they succeed in changing unwanted sexual attractions. Even when they were not able to change their homosexual thoughts, feelings, fantasies, or behaviors as (much as) they had hoped, clients tend to report satisfaction with the changes they did achieve.

Significantly, clinicians who are clearly opposed to reorientation therapy and who caution that it may be harmful have recognized that such therapy does not always cause harm. For example, Haldeman (2001), a gay-activist clinician who reports that he has treated dissatisfied former consumers of such therapy, remarks:

> Not all individuals appear to be harmed by conversion therapy. It is not uncommon, in fact, for some to report that a failed attempt at conversion therapy had an odd, indirectly beneficial effect [such as] an individual's final "letting go" of the denial surrounding his sexual orientation. (pp. 119–120)

Subsequently, after describing the risks to which he believes reorientation therapy clients were subject, Haldeman qualifies his risk assessment by saying, "This is not to suggest that all conversion therapies are harmful or that the mental health professions should try to stop them" (p. 128).

Spitzer (2003) writes in his conclusion, "The mental health professions should stop moving in the direction of banning therapy that has, as a goal, a change in sexual orientation. Many patients, provided with informed consent about the possibility that they will be disappointed if the therapy does not succeed, can make a rational choice to work toward developing their heterosexual potential and minimizing their unwanted homosexual attractions" (p. 413).

Is reorientation therapy chosen only by clients who are driven by guilt—in other words, an attitude popularly known as *homophobia*? To the contrary, Spitzer concludes. In fact, "the ability to make such a choice should be considered fundamental to client autonomy and self-determination" (p. 413). In any therapeutic process, the reinforcement of "self-hatred already experienced by the patient" (American Psychiatric Association, 2000; quoted in Just the Facts Coalition, 2008, p. 7) must be considered, as well as the assertion, "The potential risks of reparative therapy are great, including depression, anxiety, and self-destructive behavior."

It is not uncommon for clients who terminate any therapy before effectively resolving underlying emotional issues or compulsive behavior patterns to feel worse than when they began. For example, short-term, dynamic psychotherapy often leads clients to become aware of depression, anxiety, and

other emotions that already existed. In the short term, clients may experience an increased feeling of depression as they try to practice sexual or other forms of sobriety (e.g., substance use). An increase in unpleasant feelings may not be an indication of "harm," but an opportunity to deal with feelings formerly numbed either by intrapsychic repression or by mood-suppressing behaviors (e.g., fantasy and forms of sexual gratification), substances (e.g., alcohol or drugs), or paraphernalia (e.g., pornography and gambling).

Regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences will inevitably occur for a small percentage of clients, especially those who begin therapy with a severe initial level of disturbance, such as borderline personality disorder (Lambert & Ogles, 2004, p 177). Clients whose therapists may lack empathy, who may underestimate the severity of the clients' problems, or who experience significant negative countertransference may also be at greater risk for deterioration (Mohr, 1995, p. 157). Also, as with therapy in general for compulsive or addicted behaviors (Lambert & Ogles, 2004), it would not be unusual to see recidivism during or following the treatment of compulsive or addictive sexual and/or other disorders co-occurring with unwanted homosexuality (see Section III).

We conclude that the continuing availability of reorientation therapy over the past several decades had a negligible effect on promoting or maintaining negative attitudes toward the homosexual community—either by homosexuals themselves or by the public as a whole. On the contrary, studies cited above demonstrate a clear societal trend toward a greater belief that homosexuality is innate, that those experiencing homosexuality are not to be blamed, and that unjust discrimination against homosexuals should not be permitted. This trend is seen both among homosexuals and among the general public.

Overall, researchers found that clients participating in efforts to change unwanted homosexual attractions or behaviors are not generally harmed by doing so. Furthermore, any negative consequences attributed to experiencing reorientation therapy have not proven to outweigh the benefits reported by those who have found the therapies helpful, even when reorientation did not occur. Reports in the literature concerning the potential of being harmed by participating in reorientation therapy suffer from limitations on the methods of research. Autobiographical case studies, third-person case studies, and nonrandom samples undergird the most often cited—and relatively few—references that reorientation therapy is harmful to some people.

The research on "successful" reorientation therapy is more robust, even though it largely falls short of the "gold standard" of research (i.e., a prospective, longitudinal design with representative and randomly assigned groups of subjects). While a small number of studies claim that reorientation therapy causes harm, far greater numbers of controlled clinical case studies and other research support the conclusion that reorientation therapy is beneficial to some persons with unwanted homosexuality who seek its assistance.

We agree with Haldeman's (2001) assertion, "Clearly, all of the potential outcomes of conversion therapy need to be further documented and assessed" (p. 119). Further assessment will lead to better understanding of when and how the process of reorientation therapy is most helpful or could cause avoidable distress. Further studies must take into account that not all "reorientation therapists" practice the same way. Such therapists use many, if not most of the general therapeutic approaches practiced to help clients with depression, anxiety, shame, unresolved family-of-origin distress, sexual and emotional abuse, relationship difficulties, lack of assertiveness, compulsive and addictive habits, and so on (Nicolosi et al., 2000a).

We conclude that overall the mental-health professions have no empirical basis for denying a client's right to treatment in resolving unwanted homosexuality based on concerns about "potential harm." Spitzer's (2003) conclusion, cited above, bears repeating in context:

The mental health professionals should stop moving in the direction of banning therapy that has, as a goal, a change in sexual orientation. Many patients, provided with informed consent about the possibility that they will be disappointed if the therapy does not succeed, can make a rational choice to work toward developing their heterosexual potential and minimizing their unwanted homosexual attractions. The ability to make such a choice [of reorientation therapies for homosexuality] should be considered fundamental to client autonomy and self-determination. (p. 413)