

# **JOURNAL OF HUMAN SEXUALITY**

**(Volume I)**

**What Research Shows:  
NARTH's Response to the APA Claims  
on Homosexuality**

A Report of the Scientific Advisory Committee  
of the National Association for Research  
and Therapy of Homosexuality

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## Background

This document was prepared in response to certain statements and resolutions of the American Psychological Association (APA) that are inaccurate and not grounded in science, in direct violation of the APA's own "Leona Tyler Principle" (Fowler, 1993; Tyler 1969). As members of NARTH's Scientific Advisory Committee, we feel obligated to inform both the scientific and lay communities about the plethora of studies that lead to a singular conclusion: *Homosexuality is not innate, immutable, or without significant risk to medical, psychological, and relational health.*

We wrote a reasonably comprehensive, historical review of more than 100 years of clinical and research literature. The literature we reviewed includes older, less methodologically sophisticated studies as well as more recent, representative, and methodologically rigorous studies. We acknowledge in advance the methodological limitations of the earlier studies, but include them because these earlier reports for the most part met acceptable research and publication standards at the time they were written, and because their conclusions are supported by the most current, methodologically sound studies available.

We are aware that there will be those in both the public and private domains who will disagree and take issue with our presentation of specific reports or studies. Research by its very nature invites verification, critique, commentary and interpretation, as well as a willingness to see the overall picture portrayed by many decades of empirical research, clinical studies, and experiential evidence.

Overall, we believe this monograph offers convincing evidence that there is hope and help for those men and women who find their unwanted homosexual attractions to be distressing. In a spirit of client autonomy, self-determination, and diversity, NARTH strongly supports the freedom and rights of individuals to seek psychological care for unwanted homosexual attractions and the rights of licensed professionals to provide that care.



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## Introduction

In the policy statement Resolution on Appropriate Therapeutic Responses to Sexual Orientation (DeLeon, 1998), the American Psychological Association (APA) voiced its concern about “the ethics, efficacy, benefits, and potential for harm of therapies that seek to reduce or eliminate same-gender sexual orientation.” The statement also indicates that “some gay, lesbian, bisexual and questioning individuals [are] . . . at risk for presenting for ‘conversion’ treatment.” A decade later, the APA continues to voice these concerns. (Here and below, quotations in bold are for emphasis, while quotes in italics are present in the original.)

In *Answers to Your Questions for a Better Understanding of Sexual Orientation and Homosexuality*, the APA states the following about the treatment of homosexuality:

### **Is homosexuality a mental disorder?**

No, lesbian, gay, and bisexual orientations are not disorders. **Research has found no inherent association between any of these sexual orientations and psychopathology.** Both heterosexual behavior and homosexual behavior are normal aspects of human sexuality. Both have been documented in many different cultures and historical eras. Despite the persistence of stereotypes that portray lesbian, gay, and bisexual people as disturbed, several decades of research and clinical experience have led all mainstream medical and mental health organizations in this country to conclude that these orientations represent normal forms of human experience. Lesbian, gay, and bisexual relationships are normal forms of human bonding. Therefore, these mainstream organizations long ago abandoned classifications of homosexuality as a mental disorder. (APA, 2008, p. 3)

### **What about therapy intended to change sexual orientation from gay to straight?**

All major national mental health organizations have officially expressed concerns about therapies promoted to modify sexual orientation. To date, **there has been no scientifically adequate research to show that therapy aimed at changing sexual ori-**

**entation (sometimes called reparative or conversion therapy)<sup>1</sup> is safe or effective.** Furthermore, it seems likely that the promotion of change therapies reinforces stereotypes and contributes to a negative climate for lesbian, gay, and bisexual persons. This appears to be especially likely for lesbian, gay, and bisexual individuals who grow up in more conservative religious settings.

Helpful responses of a therapist treating an individual who is troubled about her or his same-sex attractions include helping that person actively cope with social prejudices against homosexuality, successfully resolve issues associated with and resulting from internal conflicts, and actively lead a happy and satisfying life. Mental health professional organizations call on their members to respect a person's (client's) right to self-determination; be sensitive to the client's race, culture, ethnicity, age, gender, gender identity, sexual orientation, religion, socioeconomic status, language, and disability status when working with that client; and eliminate biases based on these factors. (APA, 2008, p. 3)

In *Just the Facts About Sexual Orientation and Youth* (Just the Facts Coalition, 2008), the APA voices similar concerns. *Just the Facts* is a revised, updated, and republished edition of the original 1999 publication by the same name and, like the 1999 publication, it was produced by a coalition of national education, health, and mental health organizations. Both the 1999 and 2008 editions were responses to the “**negative implications**” of initiatives “encouraging the promotion of **‘reparative therapy’ programs** in public schools . . . and **the potential threat** [such initiatives] **posed to the health and well-being of lesbian, gay, and bisexual students**” (Just the Facts Coalition, 2008, p. 20). Just the Facts also claims:

Despite the general consensus of major medical, health, and mental health professions that both heterosexuality and homosexuality are normal expressions of human sexuality, **efforts to change sexual orientation through therapy** have been adopted by some political and religious organizations and aggressively promoted to the public. However, such efforts **have serious potential to harm** young people because they present the view that the sexual orientation of **lesbian, gay, and bisexual youth** is a mental illness or disorder, and they often frame the inability to change one's sexual orientation as a personal and moral failure. Because of the aggressive promotion of efforts to change sexual orientation through therapy, **a number of medical, health, and mental health professional organizations have issued public statements about the dangers of this approach.** The American Academy of Pediatrics, the American Counseling Association, the American Psychiatric Association, the American Psychological Association, the American School Counselor Association, the National Association of School Psychologists, and the National Association of Social Workers, together representing more than 480,000 mental health professionals, have taken the position that **homosexuality is not a mental disorder and thus is not something that needs to or can be “cured.”** (pp. 5–6)

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1 The terms *reparative*, *conversion*, and *reorientation* are often used interchangeably in the literature. Practitioners of reparative therapy are typically trained in a psychodynamic, if not psychoanalytic, model. Conversion therapy is used commonly, but not exclusively, by critics of assisted sexual reorientation to refer to religiously- as well as professionally-mediated change efforts. Practitioners of reorientation therapies may be trained in one or more of the full spectrum of theoretical and practical approaches to psychotherapy (Nicolosi, Byrd, & Potts, 2000a). In the text—other than in direct quotes—we use *reorientation therapy* as the general term for all professional, therapeutic approaches to assisted change in unwanted sexual orientation.

Just the Facts offers quotes from public statements of each of the professional organizations cited above. Notably, the American Counseling Association (ACA) code of ethics (ACA, 2005) alerts counselors to their need to “**explain the potential risks** and ethical considerations of using [“unproven” or “developing”] techniques/procedures and take steps to **protect clients from possible harm**” (Just the Facts Coalition, 2008, p. 6). The National Association of Social Workers (NASW) policy statement on lesbian, gay, and bisexual issues (NASW, 2006) asserts, “**No data demonstrate that reparative or conversion therapies are effective, and in fact they may be harmful**” (Just the Facts Coalition, 2008, p. 9).

In addition, a portion of the quoted American Psychiatric Association’s (2000) position statement on reparative therapy includes the following:

Psychotherapeutic modalities to convert or “repair” homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, **anecdotal reports of “cures” are counterbalanced by anecdotal claims of psychological harm.** In the past four decades, “**reparative” therapists have not produced any rigorous scientific research to substantiate their claims of cure. . . . The potential risks of reparative therapy are great, including depression, anxiety, and self-destructive behavior,** since therapist alignment with societal prejudices against homosexuality **may reinforce self-hatred already experienced by the patient.** (Just the Facts Coalition, 2008, pp. 6–7)

Just the Facts precedes the NASW quotation with the assertion:

As these statements make clear, the nation’s leading professional medical, health, and mental health organizations do not support efforts to change young people’s sexual orientation through therapy and have raised serious concern about the potential harm from such efforts. (p. 8)

Repeating its assertion, Just the Facts concludes with a warning to public school officials about “**the risk that these treatments** [to change sexual orientation through therapy and religious ministry] **may cause harm to young people . . . [i.e.,] their lesbian, gay and bisexual students**” (p. 20).

In its 1997 and 2008 publications, the APA also cites in support of its concerns the work of authors whose writings both speculate on the potential “harmfulness” of efforts to treat homosexuality and offer anecdotal reports of such harm (Davison, 1991; Gonsiorek & Weinrich, 1991; Haldeman, 1994; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002).

### **Three Claims by the APA**

There appear to be three major claims underlying the APA’s objections to the treatment of homosexuality.<sup>2</sup>

1. There is no conclusive or convincing evidence that sexual orientation may be changed through reorientation therapy.

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2 The terms *homosexuality* and *homosexual* are used throughout this report as per their historical and scientific usage. The authors are aware that the terms *lesbian* and *gay* are often preferred when referring to specific homosexual groups. Terms like *gay* are used only to describe lifestyle locations (e.g., bars or baths) or in direct quotes from researchers.

2. Efforts to change sexual orientation are shown to be harmful and can lead to greater self-hatred, depression, and other self-destructive behaviors.
3. There is no greater pathology in the homosexual population than the general population.

In this scientific report, we review more than 100 years of experiential evidence, clinical studies, and research that demonstrate that it is possible for some men and women to change from homosexuality to heterosexuality; that efforts to change do not invariably result in harm; and that homosexual men and women do indeed have greater risk factors for pathology than do the general population. Based on our review of the reports of reorienters, clinicians and researchers, we conclude that reorientation treatment should continue to be available to those homosexuals who seek it.

# 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),<sup>1</sup> 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

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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).<sup>2</sup>

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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 I. COMPILATION AND OVERALL AVERAGE OUTCOME OF RECENT SURVEYS OF REORIENTATION THERAPY CONSUMERS

<i>Survey</i>	<i>N</i>	<i>Number and percent reporting exclusive opposite-sex attraction shift fully successful</i>
Nicolosi et al. (2000b) <sup>1</sup>	318	114 (36%)
Shidlo & Schroeder (2002)	202	8 (4%)
Spitzer (2003) <sup>2</sup>	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 re-orientation 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 woman 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 Blaszczynski (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).<sup>3</sup>

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 Tournay (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 impulses 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 Kronmeyer (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 versus 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 (Lambers, 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.



## 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).

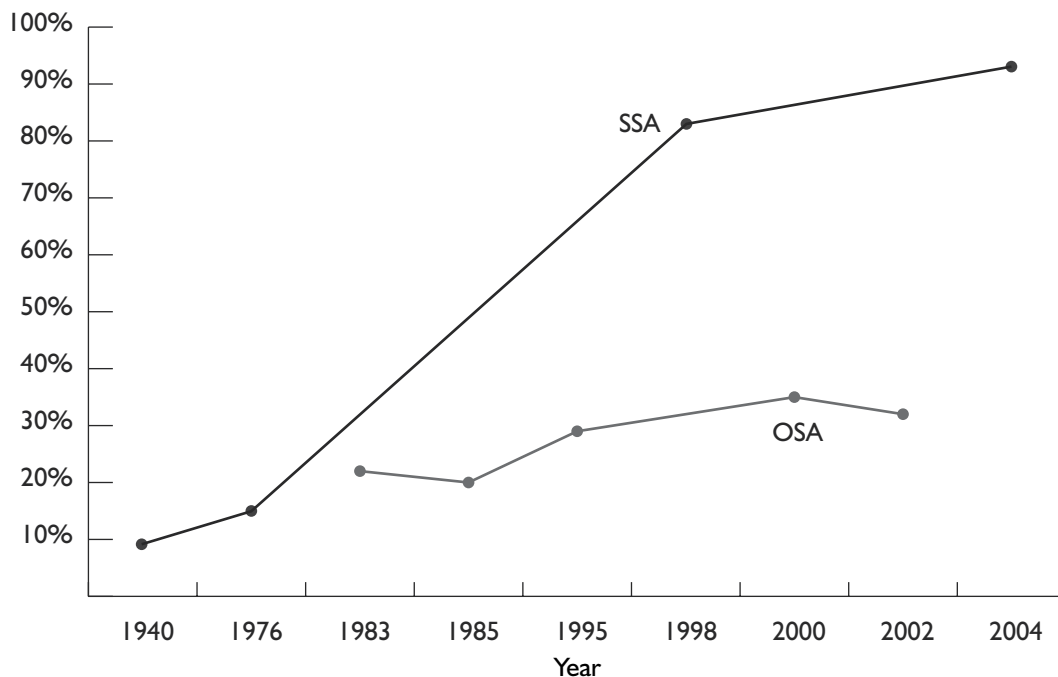
### Greater Homophobia

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.

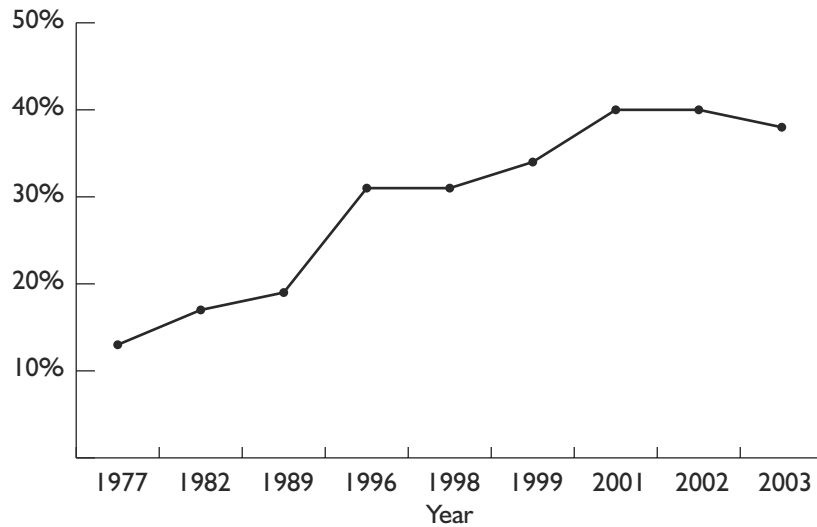
FIGURE 1. BELIEF IN GENETICS AS A SOURCE OF SSA



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.

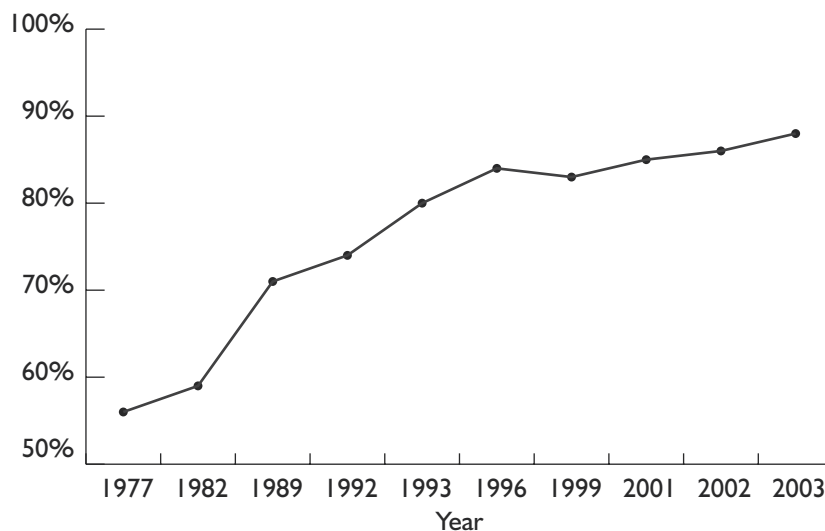
FIGURE 2. GALLUP POLL: PEOPLE WITH SSA BORN THAT WAY?



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)

### **III. Response to APA Claim: There Is No Greater Pathology in the Homosexual Population Than in the General Population**

There is a general consensus in the scientific literature that greater pathology exists among homosexually-oriented people than among heterosexuals. In fact, it is difficult to find another group in society with such high risks for experiencing such a wide range of medical, psychological, and relational dysfunctions.

Recent research using methodologically current quantitative survey criteria confirms the results of less rigorous studies from several decades ago. The pathology is not of a single kind; rather, it has many individual manifestations. It consists of a strikingly greater incidence of a wide range of mental health disorders—specifically substance abuse, depression, and suicidality; but also extending to pathological risk-taking, high breakup rates of relationships, and sexual addiction. No empirical study has ever documented that these higher rates of pathology may be explained solely (or even primarily) by society's disapproval of homosexuality.

#### **Higher Levels of Mental Health Problems**

Preeminent reports on the question of the relationship between homosexuality and psychopathology among both young people and adults were written by Herrell et al. (1999) and Fergusson, Horwood, and Beautrais (1999), and were published in the *Archives of General Psychiatry*. In his commentary on these meta-analytic studies, Bailey (1999) concludes:

These studies contain arguably the best published data on the association between homosexuality and psychopathology, and both converge on the same unhappy conclusion: homosexual people are at substantially higher risk for some forms of emotional problems, including suicidality, major depression, and anxiety disorder. (p. 883)

The findings of Herrell et al. (1999) and Fergusson et al. (1999) are summarized as follows:

- Reports of lifetime measures of suicidality are strongly associated with a same-gender sexual orientation (Herrell et al., p. 873).
- The substantially increased lifetime risk of suicidal behaviors in homosexual men is unlikely to be due solely to substance abuse or other psychiatric comorbidity (p. 867).

- Findings support recent evidence suggesting that homosexual and bisexual young people are at increased risk of mental health problems, with these associations being particularly evident for measures of suicidal behavior and multiple disorders (Fergusson et al., 1999, p. 876).
- Emerging consensus from recent studies is that young people who disclose homosexual behaviors or attraction are at increased risk of suicidal behaviors and mental health problems (p. 880).
- Homosexual and bisexual young people are at increased risk of major depression, generalized anxiety disorder, conduct disorder, nicotine dependence, other substance abuse and/or dependence, multiple disorders, suicidal ideation, and suicide attempts (p. 876).

One should ask whether the results of these studies may be unique to a country and culture that is considered intolerant of homosexual behavior, such as the United States. To the contrary, Bailey (1999) concludes that “results from a large, equally as well-conducted Dutch study [Sandfort, de Graaf, Bijl, & Schnabel, 1999] generally corroborate these findings” (p. 883). The Dutch society is well-known for its great tolerance and acceptance of homosexuals (Sandfort, de Graaf, Bijl, & Schnabel, 2001).

Bailey (1999) opines further that possible reasons for the higher level of mental health problems in the homosexual population include not only the usual hypothesis about social discrimination, but also the following:

Homosexuality represents a deviation from normal development and is associated with other such deviations that may lead to mental illness.

Increased psychopathology among homosexual people is a consequence of lifestyle differences associated with sexual orientation, . . . such as behavioral risk factors associated with male homosexuality, . . . [including] receptive anal sex and promiscuity. (p. 884)

Bailey concludes, “It would be a shame if sociopolitical concerns prevented researchers from conscientious consideration of any reasonable hypothesis” (p.884).

Gilman et al. (2001) studied a random, nationally representative household survey of the general U.S. population. The sample consisted of 125 men and women reporting any homosexual behavior in the past five years and 4,785 men and women reporting exclusively opposite-sex sexual partners. The participation rate was 82.4 percent. These researchers found the following *12-month prevalences* (P) and *lifetime risk or odds ratios* (LOR) of homosexual (same sex-attracted or SSA) *women* to heterosexual (opposite sex-attracted or OSA) *women* for the following disorders:

- *Post-Traumatic Stress Disorder*—P: 20.9% SSA vs. 5.9% OSA; LOR = 2.7 (SSA > OSA).
- *Anxiety Disorder*—P: 40% SSA vs. 22.4% OSA; LOR = 1.8 (SSA > OSA).
- *Major Depression*—P: 34.5% SSA vs. 12.9% OSA; LOR = 1.9 (SSA > OSA).
- *Thoughts of Suicide*—LOR = 2.0 (SSA > OSA).
- *Any Mood Disorder*—P: 35.1% SSA vs. 13.9% OSA; LOR = 2.0 (SSA > OSA).
- *Any Substance Use Disorder*—P: 19.5% SSA vs. 7.2% OSA; LOR = 2.4 (SSA > OSA).

Among *men*, these researchers found the following *lifetime risk or odds ratios* (LOR) comparing homosexual (SSA) with heterosexual (OSA) *men*:

- *Drug Abuse Disorder*—LOR = 2.8 (SSA > OSA).
- *Drug Dependence Disorder*—LOR = 2.4 (SSA > OSA).
- *Thoughts of Suicide*—LOR = 2.2 (SSA > OSA).

Similarly, Jorm, Korten, Rodgers, Jacomb, and Christensen (2002) conducted a random, nationally representative household survey of the general Australia population. The participation rate was 58.6 percent, and the sample consisted of 149 men and women identifying themselves as homosexual or bisexual and 4,675 men and women identifying themselves as heterosexual. The homosexual and bisexual groups reported significantly poorer mental health in terms of anxiety, depression, suicidality, and negative affect than the heterosexual group.

Research from a different country also documents that homosexuals have a lower overall quality of life compared to heterosexuals. Sandfort, de Graaf, and Bijl (2003) studied a random, nationally representative household survey of the general population in the Netherlands. The sample consisted of 125 men and women reporting homosexual behavior and 5,873 men and women reporting only heterosexual behavior, and the participation rate was 69.7 percent. Homosexual men were found to have a significantly lower quality of life compared to heterosexual men in terms of general health, mental health, emotional role functioning, social functioning, and vitality. Sandfort et al. (2003) concluded:

Compared to heterosexual men, homosexual men evaluated their general level of health and their mental health as less positive, reported that emotional problems more often interfered with work or other daily activities, that physical health or emotional problems interfered with normal social activities, and felt less energetic. (p. 18)

Conron, Mimiaga, and Landers (2008) conducted a population-based telephone survey of Massachusetts adults for the Massachusetts Department of Public Health (MDPH). From 2001 to 2006, 38,910 adult residents of Massachusetts were administered the Behavioral Risk Factor Surveillance System, which is a collaborative effort between the U.S. Centers for Disease Control and Prevention (CDC) and state departments of public health. The MDPH added questions to assess differences in self-reported adult health behavior and status by sexual orientation for adults ages 18–64. During the years surveyed, most (97.1 percent) participants self-identified as straight or heterosexual, while 1.9 percent identified as gay, lesbian, or homosexual, and 1 percent as bisexual. The authors reported comparisons of health behavior and status between straight/heterosexual and gay/lesbian/homosexual residents and between straight/heterosexual and bisexual residents separately.

*Gay/lesbian/homosexual* residents reported having a poorer health profile than straight/heterosexual residents on:

- Self-reported health as fair/poor (odds ratio [OR] 1.45)
- Physical, mental, or emotional disability-related activity limitation (OR 1.78)
- Asthma (OR 1.51)
- Current (OR 2.47) and past tobacco smoking (OR 1.67)
- Anxious mood; feeling tense or worried for more than 14 of the last 30 days (OR 1.4)
- Binge drinking in the last 30 days (OR 1.29\*)
- Illicit drug use in the last 30 days (OR 2.98)
- Lifetime having ever been sexually assaulted (OR 2.91)

\* *Statistically significant but potentially unstable estimate due to high relative standard error.*

*Bisexual* residents reported having a *poorer* health profile than heterosexual/straight residents on:

- Self-reported health (OR 4.44)
- Anxious (OR 3.10) and depressed (feeling sad or blue for more than 14 of the last 30 days) moods (OR 2.6)
- Suicide ideation in the prior 12 months (OR 9.16)
- Current tobacco smoking (OR 2.96, women; OR 2.10, men\*)
- Having ever been sexually assaulted (3.68), in the prior 12 months (OR 4.02\*)

\* *Statistically significant but potentially unstable estimate due to high relative standard error.*

In addition, compared with heterosexual/straight women, *bisexual women* were more likely to report:

- Disability-related activity limitation (OR 5.26)
- Illicit drug use in the last 30 days (OR 8.8)
- Lifetime threat of or actual physical assault by intimate partner (OR 7.98\*)

\* *Statistically significant but potentially unstable estimate due to high relative standard error.*

No significant differences were found when comparing the reported incidence of these three health issues between bisexual and heterosexual *men*.

Other sex differences were found concerning weight. While lesbian/homosexual *women* were *more* likely to be *obese* (OR 2.23) than heterosexual/straight women, gay/homosexual *men* were *less* likely to be *obese* (OR 0.42) or *overweight* (OR 0.57) than were straight/heterosexual men. No differences were found when comparing the weight of straight/heterosexuals and bisexuals of either sex. Also, bisexual *women* were more likely than straight/heterosexual women to report illicit drug use (OR 8.80), while no statistically significant difference was found between the incidence of substance use by bisexual and straight/heterosexual men.

Overall, gay/lesbian/homosexual adults reported poorer health and greater risks than straight/heterosexuals across several health domains, and bisexual adults reported even more. The researchers reported no statistical comparisons of health behavior and status between gay/lesbian/homosexual and bisexual residents. Further analysis and additional research would help explain any clinical significance about what led bisexual (but *not* gay/lesbian/homosexual) residents of Massachusetts to experience more *depressed mood*, *heart disease*, *suicidal ideation*, and *sexual assault in the prior 12 months*, and less *health insurance* and access to a *regular health care provider* and *dental care* than heterosexual men; and gay/homosexual (but *not* bisexual) men to have had statistically greater odds of *colorectal cancer screening* (sigmoidoscopy/colonoscopy), *condom use*, *asthma*, *binge drinking*, having been a *former (vs. never) smoker*, and *disability-related activity limitation* than heterosexual men.

A recent meta-analysis supports the general results of the studies reported above. King et al. (2008) located 13,706 scholarly publications between 1966 and April 2005 on the prevalence of mental disorder, substance misuse, suicide, and deliberate self-harm among homosexuals. Of those publications, 28 met at least one or more of four methodological quality criteria for inclusion in a meta-analysis: random sampling, 60 percent or greater participation rate, sampling from the general population instead of a selected group, and sample size equal to or greater than 100 research subjects. A comprehensive systematic meta-analysis of these 28 highest-quality studies, reporting research on a combined 214,344 heterosexual and 11,971 homosexual subjects, found the following:

### *Risk Comparisons for Men*

- Homosexual men demonstrated 2.58 times increased risk of lifetime prevalence of depression compared to heterosexuals (p. 77).
- Homosexual men demonstrated 4.28 times increased risk of lifetime prevalence of suicidal attempts compared to heterosexuals (p. 74).
- Homosexual men demonstrated 2.30 times increased risk of lifetime prevalence of deliberate self-harm compared to heterosexuals (p. 75).
- Homosexual men demonstrated 1.88 times increased risk of 12-month prevalence of anxiety disorders compared to heterosexuals (p. 78).
- Homosexual men demonstrated 2.41 times increased risk of 12-month prevalence of drug dependence compared to heterosexuals (p. 80).

### *Risk Comparisons for Women*

- Homosexual women demonstrated 2.05 times increased risk of lifetime prevalence of depression compared to heterosexuals (p. 77).
- Homosexual women demonstrated 1.82 times increased risk of lifetime prevalence of suicidal attempts compared to heterosexuals (p. 74).
- Homosexual women demonstrated 4.00 times increased risk of 12-month prevalence of alcohol dependence compared to heterosexuals (p. 79).
- Homosexual women demonstrated 3.50 times increased risk of 12-month prevalence of drug dependence compared to heterosexuals (p. 80).
- Homosexual women demonstrated 3.42 times increased risk of 12-month prevalence of any substance use disorder compared to heterosexuals (p. 81).

The results of this meta-analytic study by King et al. (2008)—as well as those reported above from Herrell et al. (1999), Fergusson et al. (1999), Gilman et al. (2001), Jorm et al. (2002), Sandfort et al. (2003), and Conron et al. (2008)—offer clear evidence that people who are homosexually-oriented are at significantly greater risk for experiencing serious medical and mental health problems than are heterosexually-oriented persons.

## **Discussion of Specific Areas of Medical and Mental Health Risk**

### **Substance Abuse**

#### *Alcohol*

Homosexual men in the United States report being afflicted with drug and alcohol dependencies at rates that are much higher than that of the general population. Studies since 1975 show that these rates are as high as double those of the heterosexual population (Craig, 1987; Fenwick & Pillard, 1978; Fifield, 1975; Fifield, Latham, & Phillips, 1977; Gruskin & Gordon, 2006; Hatzenbuehler, Corbin, & Fromme, 2008; Lewis, Saghir, & Robins, 1982; Lohrenz, Donnelly, Coyne, & Spare, 1978; Meissner & Morton, 1977; Saghir & Robins, 1973; Sandfort et al., 2001; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006; Saunders, 1984; Skinner, 1994; Weinberg & Williams, 1975; Ziebold, 1979). A few researchers have reported lower prevalences; Stall and Wiley (1988) reported only 19 percent higher, and Smith (1979) reported rates among homosexuals as being only 10 percent higher.

In the Stall et al. (2001) study of a household-based probability telephone sample of 2,172 urban men who had sex with men in the previous five years in selected zip codes of Chicago, Los Angeles, New York, and San Francisco, 85 percent of homosexually behaving men reported alcohol use. Researchers report that binge drinking among homosexuals occurs more frequently than in society at large (Ostrow, 1990; Ostrow, Beltran, & Joseph, 1994).

Similar findings exist for homosexual women, whose alcohol consumption is on average three times that of heterosexual women (Anderson & Henderson, 1985; Burke, 1982; Diamond & Wilsnack, 1978; Hughes & Wilsnack, 1994; Johnson & Palermo, 1992; King & Nazareth, 2006; Meads, Buckley, & Sanderson, 2007; Nardi, 1982; Sandfort et al., 2001, 2006; Valanis et al., 2000; Weathers, 1980; Wilsnack et al., 2008; Ziebold & Mongeon, 1982).

Cochran, Keenan, Schober, and Mays (2000) reported a nationally representative household survey of the general U.S. population in which the participation rate was 79 percent. The sample consisted of 194 men and women reporting at least one same-gender sexual partner in the past year, and 2,844 men and women reporting only opposite-gender sexual partners. Cochran et al. found:

Homosexually active women reported using alcohol more frequently and in greater amounts and experienced greater alcohol-related morbidity than exclusively heterosexually active women. Findings suggest higher risk for alcohol-related problems among lesbians as compared with other women. (p. 1062)

Cochran et al. reported the following comparisons:

- 30.3 percent of homosexually active women were “very high or drunk 3 or more days” in the past year compared to 16.6 percent of heterosexual women (p. 1066).
- 8.4 percent of homosexually active women were “very high or drunk an average of once per week or more” in the past year compared to 2.3 percent of heterosexual women (p. 1066).
- 7 percent of homosexually active women reported heavy drinking in the past month compared to 2.7 percent of heterosexual women (p. 1066).

Drabble and Trocki (2005) reported a nationally representative household telephone interview survey of the general U.S. population. This female sample consisted of 36 who identified themselves as lesbian, 71 who reported themselves as heterosexual and having had same-sex partners, 50 who reported themselves as bisexual, and 3,723 who reported themselves as heterosexual. Overall, 41.8 percent of lesbians and 45.6 percent of bisexuals reported they were heavy alcohol drinkers, compared with 12.7 percent of heterosexuals. Alcoholism among homosexual women is evidently so problematic that even with a support system such as Alcoholics Anonymous (AA), they do not respond as well to counseling as their heterosexual counterparts (Hall, 1994).

The message that homosexuals were heavier drinkers was so clear in the 20th century that it inspired advertising strategies. For example, Earl Nissen of the Coors Brewing Company told *Advertising Age* that homosexual men drank twice as much as heterosexual men, so they developed ads that would appeal more to homosexuals in order to yield more sales for the company (Pruzan, 1996).

Leukefeld, Battjes, and Armsel (1990) and Wang, Häusermann, Ajdacic-Gross, Aggleton, and Weiss (2007) report that homosexual youth have an unusually high prevalence of alcoholism when compared with heterosexual youth. A meta-analysis combining the data of 18 studies concluded that the risk of alcohol abuse among homosexual youth is 3.4 times that for heterosexual teens (Marshal et al., 2008).



Bisexuals have been shown to have varying rates of alcoholism, and the specific rates vary depending on the study. Regardless, the incidence of alcoholism among bisexuals is generally higher than that among heterosexuals (Bostwick et al., 2007; Jorm et al., 2002; King & Nazareth, 2006; Wilsnack et al., 2008).

### **Drug Use**

A representative study of the U.S. population that compared the rates of illicit drug use among homosexuals to the National Household Survey on Drug Abuse found that homosexuals had a higher rate of such use than heterosexuals (Skinner, 1994).

An earlier longitudinal study in Boston conducted between 1985 and 1988 on a convenience sample of more than 400 homosexuals found that 80 percent used marijuana, 70 percent used amyl nitrate (also known as “poppers”), 60 percent used cocaine, 30 percent used amphetamines, and 20 percent used LSD. No control group of comparable heterosexuals was studied (Seage, 1992). In another convenience sample of 1,000 homosexual men who were not compared with a control group of heterosexuals, the use of drugs—such as marijuana, cocaine, and amyl nitrite—was widely reported, as was binge drinking (Ostrow et al., 1994).

Amyl nitrite is used for its euphoric effects, but also because it relaxes the anal muscles. Fifty-seven percent of 150 homosexual men interviewed admitted to using amyl nitrite at least once in the six months prior to the interview (Goode & Troiden, 1979). In another study, 86 percent of 250 homosexual men had inhaled amyl nitrite within the last five years—a proportion similar to the 86.4 percent reported in STD clinics in Atlanta, New York, and San Francisco (McManus, Starrett, & Harris, 1982). That level of usage is not common among heterosexuals (Newmeyer, 1992).

Among homosexual men, there is heavy use of both injected and noninjected drugs, with 17 percent reporting the use of intravenous drugs (Lauritsen, 1993). In most studies, substance abuse is higher among homosexual than heterosexual men, and even higher among homosexual women than among both homosexual men and heterosexual women. Although DeBord, Wood, Sher, and Good (1998) found that substance abuse among homosexuals is equal to abuse rates among heterosexuals, higher prevalence among homosexuals was found in more recent studies (Gilman et al., 2001; Sandfort et al., 2001, 2006; Wang et al., 2007). A meta-analysis by Marshal et al. (2008) showed that drug abuse among homosexuals is 2.89 times higher than general substance abuse among heterosexuals.

In a nationally representative household telephone interview survey of the general United States female population, Drabble and Trocki (2005) found that compared with exclusively heterosexual women, the odds of THC use—marijuana, hash, THC, or “grass”—was 4.70 (odds ratio) for homosexual women and 6.09 for bisexual women.

Stall et al.’s (2001) household-based probability telephone study found not only that 85 percent of homosexually behaving men reported alcohol use, but also that 52 percent reported recreational drug use of any kind.

Cochran, Ackerman, Mays, and Ross (2004) assessed and compared drug use of a nationally representative sample of 194 homosexually experienced and 2,844 heterosexually experienced men and women. The following results were reported:

- 37.2 percent of *homosexually active men* reported lifetime use of *cocaine*, compared to 19.5 percent of heterosexual men.
- 34.7 percent of *homosexually active men* reported lifetime use of *hallucinogens*, compared to 18.0 percent of heterosexual men.
- 30.8 percent of *homosexually active men* reported lifetime use of *inhalants*, compared to 9.8 percent of heterosexual men.

- 38.5 percent of *homosexually active women* reported lifetime use of *cocaine*, compared to 12.1 percent of heterosexual women.
- 22.9 percent of *homosexually active women* reported lifetime use of *hallucinogens*, compared to 9.9 percent of heterosexual women.
- 14.3 percent of *homosexually active women* reported lifetime use of *inhalants*, compared to 5.0 percent of heterosexual women.

Cochran et al. (2004) concluded, “Across studies, lesbians and gay men evidence higher prevalence of use and problems with illicit drug use” (p. 994).

Thiede et al. (2003) reported a cross-sectional sampling survey that was conducted in seven major urban centers in the United States. The sample included 3,492 young men who had sex with men. The survey revealed that 66 percent of the homosexual men reported using illicit drugs; 28 percent had used three or more drugs, and 29 percent had used drugs frequently (once a week or more).

Concerning whether substance use begins before or after the realization that one experiences homosexual attraction, Craig (1987) stated, “One question not answered by prevalence data is whether homosexuality preceded drug abuse, or whether drug abuse preceded homosexuality” (p. 1145). However, since initial homosexual attraction occurs at a mean age of 10 years (Whitam & Mathy, 1986), it appears likely that for many the experience of homosexuality precedes substance abuse.

Do societal pressures place homosexuals at high risk for substance abuse, as suggested by Weinberg (1972)? The U.S. Department of Health and Human Services (DHHS) concluded that while factors such as social stigma and discrimination are widely believed to place homosexual men and women at higher risk for developing substance abuse and other difficulties, existing research fails to document this belief (DHHS, 1994).

### ***Summary of Substance Abuse Among Homosexuals***

Twentieth-century research revealed that homosexuals are about three times more likely to abuse or be dependent on drugs or alcohol than the general population. Studies have shown that nearly two thirds of homosexual teens abuse alcohol. In the female homosexual community, alcohol use is even more widespread and is often used as a gateway to sexual activity.

## **Undue Risk-Taking, Particularly With Life or Health**

### ***HIV/AIDS Risk***

The prevalence, consistency, and relapse risk-taking behavior for HIV and AIDS is much higher among homosexuals than among heterosexuals. Risky sexual behaviors are so widespread in the homosexual community that risk education programs over the past two decades have clearly failed, with seroconversion rates now approaching those before the programs started.

The incidence of apparent heterosexual transmission of HIV/AIDS in the United States was rather low during the 20th century, making up approximately 10 percent of the total cases (Huether & McCance, 1996). However, the *risk* of HIV/AIDS among homosexuals at that time was approximately 430 times greater than among heterosexuals (Odets, 1994a) because of the higher infection rate present in the homosexual population, the larger number of partners among homosexuals, and the greater likelihood of transmission through anal as opposed to vaginal sex. Homosexuals consistently represent the highest rates of HIV/AIDS cases in the United States. For example, in a 1990 report, close to 96 percent of San Francisco’s AIDS cases were homosexual men (Ekstrand & Coates, 1990). In another cohort of 508 homosexual men in San Francisco, 50 percent tested positive for HIV antibodies (Hays, Turner, & Coates, 1992).

There is no significant difference between HIV-positive and HIV-negative homosexual groups in the way they express their sexuality. A sample of 121 from each group showed a similar variety in sexual partners and behaviors, and both place themselves in the same types of risk-related situations (Meyer-Bahlburg et al., 1991).

One of the most significant risks in the 1990s was unprotected anal intercourse: one third of male bisexuals had engaged in unprotected anal intercourse in the previous 6 months (McKirnan, Stokes, & Doll, 1995), two thirds in the previous 18 months (Signorile, 1995), and 23 percent in the period just before the study (Myers, Godin, Lambert, Calzavara, & Locker, 1996). Only about 12 percent reported that they had never engaged in unprotected anal intercourse (Myers, Godin, Calzavara, Lambert, & Locker, 1993).

In a study of Canadian men, the proportions of those who participated in unprotected anal intercourse varied by city: 57.1 percent in Montreal, 73.3 percent in Ontario, and 56.3 percent in Vancouver (Myers et al., 1993). Researchers found varied rates of unprotected anal intercourse:

- 64 percent (Linn et al., 1989)
- More than 70 percent (McKusick, Coates, Morin, Pollack, & Hoff, 1990)
- 25 percent (D'Augelli, 1992)
- 41 percent (Osmond, Page, & Wiley, 1994)
- 27 percent in the last two months (Kelly, Sikkema, Winett, & Solomon, 1995)
- 95 percent reporting at least one incidence (Offir, Fisher, Williams, & Fisher, 1993)
- 52 percent, inconsistently or never (Rotheram-Borus, Hunter, & Rosario, 1994)

In one summary, Satinover (1996) calculated that 40 percent of homosexual men never used a condom during anal intercourse.

AIDS education, argued by pro-homosexual advocates to be essential in decreasing AIDS risk, essentially failed (Odets, 1994b). The vast majority of homosexual men with higher levels of AIDS education do not practice safer sex behavior. Canada's Talking Sex Project found that education did not increase behaviors to limit the risk of contracting HIV through anal sex (Myers, Godin, Calzavara, Lambert, & Locker, 1992). The researchers concluded that homosexual men repeatedly engage in unprotected anal intercourse despite known consequences.

Although previous studies gave some encouragement that the AIDS risk behaviors among homosexuals had decreased (Ekstrand & Coates, 1990; Martin, 1987), other researchers found that inconsistent condom use remained high (McCombs & White, 1990). Even when high-risk activities were reduced, this occurred among only a small percentage—and there was an especially small reduction in risky behavior for those participating in anal intercourse (McKusick, Horstman, & Coates, 1985).

Near the beginning of the AIDS epidemic, researchers found that while a large percentage of homosexuals adopted safer behaviors, a similar percentage continued to engage in risky behaviors (Siegel, Bauman, Christ, & Krown, 1988). And even though homosexuals practiced “safer sex” during some periods after AIDS became prevalent, they eventually relapsed from these safer practices to riskier, more common practices (Kelly et al., 1991; CDC, 1991). In longitudinal behavioral studies (1984–1991), more than one third of a sample of 310 homosexual men relapsed to risky sex behaviors, while fewer than 9 percent reported consistent no-risk behaviors (deWit, van den Hoek, Sandfort, & van Griensven, 1993).

When a dozen risk-reduction studies were reviewed, the researchers concluded, “Even using cross-sectional designs, the efficacy of health education interventions in reducing sexual risk for HIV infections [among homosexuals] have not been consistently demonstrated” (Stall, Coates, & Hoff, 1988, p. 883).

Sadly, HIV/AIDS education findings suggest that there is little or no observable benefit to educating homosexual men about their health risk (Pryor & Reeder, 1993). While risk knowledge is typically high among sexually active homosexual men, they also typically fail to reduce their high-risk activities (Kelly et al., 1990). Consistency is what matters: it only takes one incident of risk relapse to acquire AIDS. Because the actual transmission of a virus is not visible to the human eye, some homosexuals never fully see the risk of their behaviors. In addition, persons infected with HIV may be asymptomatic for many years. While erroneously thinking that they are disease-free, they may nonetheless spread the disease.

Even homosexual and bisexual men who know that they are infected with HIV continue to be promiscuous and seldom notify their partners of their HIV status. When researchers studied 111 men infected with HIV—93 percent of them identified as homosexual—the men collectively reported 929 individual sexual partners. Fewer than 6 percent of those partners were informed of their risk by these men, who knew they were infected with HIV yet carelessly infected others—in a few cases, deliberately—or at least put others at grave risk (Marks, Richardson, Ruiz, & Maldonado, 1992).

In another survey, 823 homosexual or bisexual men were interviewed on their knowledge about AIDS. They reported having many sexual partners and frequently using drugs. They were also unlikely to discuss safer sex with their partners. Only 1 percent reported that they exclusively practiced safer sex. In the six months before the study, the average number of sex partners for each was 11.4 (Linn et al., 1989).

While receptive anal sex with ejaculation poses the most common risk for HIV infection among homosexuals, evidence shows that oral transmission of HIV is also possible (Keet, 1992). Researchers document the presence of HIV seroconversion in homosexual men who received oral sex (Lifson et al., 1990).

Even with a condom, sex is not completely safe, since condoms can fail as often as 10 percent of the time (Goldsmith, 1987, as cited by Martin, 1990). Failure rates are also caused by errors in use (Martin, 1990). In addition, condoms are more likely to break during anal intercourse because it creates greater friction than vaginal sex, and other mechanical stresses are involved (DHHS, 1990) as the anus is used for a purpose for which it was not biologically designed.

By the early 1990s, approximately 60 percent of AIDS cases on the east coast and 90 percent on the west coast were related to homosexuality. Twenty-seven percent of the AIDS cases in the United States occurred in three cities with high homosexual populations: Los Angeles, New York, and San Francisco. At the time of the study, these cities had approximately 20 to 50 percent of the nation's total homosexual population (Kelly, St. Lawrence, & Brasfield, 1991). Specific homosexual neighborhoods were severely infected; San Francisco's Castro neighborhood and New York City's Chelsea Village were found to have an especially large number of AIDS cases (Bartlett, 1994). Although Los Angeles, New York, and San Francisco were considered "AIDS epicenters," homosexuals in smaller and less homosexually populated cities were also infected with HIV because of the potential and actual spread of disease from such epicenters to smaller communities (Ruefli, Yu, & Barton, 1992).

In 1988, the sexual behavior of homosexuals was studied among patrons of four Seattle gay bars; more than 400 surveys were completed. In the surveys, 29 percent of the respondents reported engaging in unprotected anal intercourse at least once in the two months prior to the survey. In 1994, the authors concluded that the rate of unprotected anal intercourse had not changed much since the findings of the 1988 study, despite increased knowledge about AIDS (Steiner, Lemke, & Roffman, 1994).

In a sample of 526 homosexual men from midsized cities, 37 percent admitted to engaging in unprotected anal intercourse in the three months before the study (Kelly et al., 1990). While those in the study were well educated and aware of the AIDS risk, risk-taking behavior was still commonplace—suggesting

that deeper psychological phenomena, not lack of education, motivate the high-risk behavior of homosexual men. A homosexual orientation predicts vulnerability to AIDS risk and relapse behaviors (Kelly, St. Lawrence, & Brasfield, 1991).

The San Francisco Young Men's Health Study, a household study of 380 unmarried men 18 to 29 years of age, revealed that 68 percent of homosexual and bisexual men had tested HIV seropositive. The researchers reported that even after they knew they were HIV positive, homosexuals continued to practice risky behavior and thus widened the epidemic (Osmond et al., 1994). Another researcher reported that homosexuals likely participated in unsafe sex because subconsciously they did not want to survive or because it gave them a way to more strongly identify with the homosexual community (San Francisco Department of Health, 1993).

In a sample survey of 6,000 men entering gay bars in 16 small American cities, researchers assessed sexual behaviors and predictors of risky sexual practices. Researchers also included in their definition of risky behavior a number of different male partners. These researchers documented that the men had a weak intention to use protection and believed that safer sex practices were not the norm in the homosexual community (Kelly et al., 1995). Lack of concern about the risk of "unprotected" homosexual sex persists in spite of the real dangers of its practice. One single act of unprotected anal intercourse with a 20- to 30-year-old homosexual man carries with it a transmission risk of about 1 in 165 (Satinover, 1996).

According to Dr. Linda Valleroy of the CDC, HIV rates are very high among young homosexual men, compared with the general population of youth in the United States (Russell, 2001). This is not surprising given that homosexual youth report a high incidence of unprotected anal intercourse (Lemp, Hirozawa, & Givertz, 1994).

Messina (1992) found that among street youth, 50 percent in New York and 40 percent in Seattle identified themselves as homosexual, and close to 10 percent were already infected with HIV. It is estimated that even more cases of infection were undetected or unreported, while the majority remained at risk. These youth represented fewer than 4 percent of the population at the time (Messina, 1992). Researchers in London also found that half of young male street sex workers were homosexual and that 21 percent of a sample of 50 reported that they had been diagnosed as HIV positive (West, 1993).

In another study, New York City homosexual and bisexual adolescent men reportedly used protection, such as condoms, only during the first year after they became sexually active (Rotheram-Borus, Rosario, et al., 1994).

Offir et al. (1993) conducted a qualitative exploratory research project consisting of open discussions with 41 homosexual men about the increase of AIDS-prevention behaviors. For many, the use of actual safer-sex practices was erratic, and "respondents did not express motivation to initiate further behavior change" (p. 62). One third reported unprotected insertive sex, and more than half "indicated a general reluctance to use condoms during oral sex" (p. 64). The respondents apparently thought that their risky behaviors were merely atypical, situationally based, and not a true health risk.

In some studies, homosexual men have been found to be apathetic about their HIV test results. Two thirds of those who volunteered for HIV testing did not even want to learn the results (Ostrow et al., 1994). This phenomenon was found in a multicenter AIDS cohort study of more than 1,000 homosexual men in Chicago from 1984 to 1990. The majority of homosexuals had unprotected intercourse and did not perceive their behavior as risky (McLean, Boulton, Brooks, & Lakani, 1994).

Anal intercourse and fellatio carry significant risk with or without a condom. In fact, the DHHS issued a warning from the Surgeon General in its publication, *Condoms and Sexually Transmitted Diseases . . . Especially AIDS* (1990), which states:

Condoms provide some protection, but anal intercourse is simply too dangerous a practice. . . . Even if a condom doesn't break, anal intercourse is very risky because it can cause tissue in the rectum to tear and bleed. These tears allow disease to pass more easily from one partner to the other. (p. 7)

In another study of homosexual men who used condoms, 26 percent reported at least one condom breakage during usage (D'Augelli, 1992). The risk of condom failure (such as breakage or slippage) in a single episode is high for those who use condoms during anal intercourse (Thompson, Yager, & Martin, 1993).

In spite of realizing the health risks, some homosexuals argue for and attempt to justify unsafe sex, as in this example:

Unsafe sex can emerge from good and honorable motives. Although dismissed by hard-line scientists, statements such as, "I want to please you," or "It seemed like the right thing to do," are not wimpish excuses but potential reasons. Unsafe sex is not irrational, but a different sort of rationality. (Davies, Hickson, Weatherburn, & Hunt, 1993)

In his article "Sodomy and Stigma," Bruce Parnell wrote, "We need to acknowledge that it is reasonable for people to want to f—k without condoms," and the most appropriate strategy is to encourage individuals to "consider for themselves what is and what is not appropriate behavior for themselves" (as cited in Molenaar, 1994, p. 2). This type of rhetoric was prevalent in the mainstream homosexual literature of the 20th century. The extreme phenomenon of deliberate anal intercourse without protection (now known as *barebacking*) is an illustration of this almost unprecedented attitude to risk (Parsons & Bimbi, 2007; Parsons, Kelly, Bimbi, Muench, & Mergenstern, 2007).

A review of qualitative data revealed that many homosexuals were not even concerned with the risk—for them, having unprotected sex outweighed any risk of disease, even though at the time AIDS had a virtually 100 percent mortality rate. Failure to protect oneself from disease goes beyond apathy, lack of information, cognitive distortion, or perception—rather, such failure suggests, at least in some cases, a pathological lack of self-care.

Homosexual men regularly reported that they practiced unsafe sex out of boredom or despair (Kirp, 1995). They maintained that condoms were a barrier to intimacy and that their risky behaviors played "an important role in their lives" (Brendstrup & Schmidt, 1990). But the consequence of this pathological thinking is the probability that within 20 years—even assuming the development of antiviral therapy (Yazdanpanah et al., 2002)—a third or more of all homosexual men now at age 20 would be dead from AIDS (Kirp, 1995).

A significant number of homosexually active people, aware of the risk and despite their knowledge, continue to engage in unsafe sexual practices. This is highly pathological. Some argue that risk-taking homosexuals are not representative of the whole, and this is a potentially valid point that could only be addressed by research studies using random sampling or some other method of representative sampling. However, it is also possible that the risk-taking of the homosexuals in the above studies is fairly representative of the majority of homosexual males. More rigorous research is needed to resolve this research question. Because research to date fails to show a psychological difference between homosexual men practicing safer sex and those practicing risky sex (Siegel, Mesagno, Krown, & Christ, 1989), it is possible and perhaps likely that even a majority of those who practice safer sex at one point in time will subsequently lapse into practicing riskier sex.

Some researchers suggest that cognitive distortion may be a causal explanation for risk-taking sexual behaviors among male homosexuals. When homosexual men interpreted the riskiness of their behaviors, they were found to evade the facts, using a variety of misconceptions (Bauman & Siegel, 1987). In a different but perhaps parallel finding, Brenner (1991) found in psychoanalytic work with homosexual men that some appear to have an unconscious wish to develop AIDS.

Researchers have found that homosexual men differ cognitively from heterosexual men. Typically, they have more feminine traits. In a discussion of cognitive research, researchers concluded that in three groups of 38 subjects each (heterosexual men, heterosexual women, and homosexual men), the cognitive pattern of homosexual men was significantly different from that of heterosexual men, but not significantly different from that of heterosexual women (McCormick & Witelson, 1991).

Some of this disregard for one's own well-being may be attributed to social isolation. Many homosexuals with AIDS have been left alone and estranged from family. Ethnographic fieldwork in Houston between 1984 and 1991 revealed that of the examined individual cases of homosexual men with HIV/AIDS, all but one lived alone. But AIDS alone does not appear to cause social estrangement. In the first part of the ethnographic work, a high level of family estrangement was found independent of the AIDS phenomenon among 64 of the men who were studied (Lang, 1991).

Have there been reductions in sexual risk-taking among heterosexual males over time? It appears not. Sexually risky behavior among HIV-positive homosexuals in the 21st century continues to be highly problematic for individuals and society, despite education and decreased social stigma. Van Kesteren, Hospers, and Kok (2007) reviewed research on sexual risk behavior among HIV-positive men who had homosexual sex after the year 2000. The review included 53 published studies that reported on unprotected anal intercourse in cross-sectional and longitudinal surveys of HIV-positive men who had sex with men (MSM), and MSM with mixed HIV status. The men in the studies were self-identified as homosexual, bisexual, or just men who have sex with other men.

Van Kesteren et al.'s (2007) findings indicated high levels of unprotected anal intercourse among HIV-positive MSM, particularly those whose partners were HIV-negative or who had unknown HIV status. Studies of MSM of mixed HIV status found that the rate of unprotected anal intercourse among HIV-positive MSM was much higher than that of HIV-negative MSM. Furthermore, the prevalence of unprotected anal intercourse among HIV-positive MSM had increased in recent years. Although studies indicated that HIV-positive MSM had adopted some risk-reduction strategies, roughly two in five HIV-positive MSM continued to engage in unprotected anal intercourse, for which the risks and consequences are well known. Schackman et al. (2008) recently reported similar results.

An international survey of increased risk for many countries showed increased risk of HIV infection for homosexual men compared with heterosexual men in all countries/regions, even in Africa, where there is a high incidence of HIV infection among heterosexuals (Baral, Sifakis, Cleghorn, & Beyrer, 2007). Even with retroviral therapy, the mean life expectancy among those who are HIV positive seemed to increase only from about 10 years to perhaps rather more than 15 years (Yazdanpanah et al., 2002).

### *Homosexual Women and HIV/AIDS*

At a New York City STD clinic, 17 percent of homosexual women were HIV positive compared with 11 percent of exclusively heterosexual women, a difference that was statistically significant (Bevier, Chiasson, Heffernan, & Castro, 1995). Women who were classified as homosexual were mostly bisexual, rather than exclusively homosexual.

In a study of homosexual and bisexual women in the San Francisco and Berkeley area, 6 of the 498 surveyed had tested positive for HIV. That rate of 1.2 percent exceeded the rate of 0.35 percent among

women in general (Lemp, Hirozawa, & Givertz, 1995). These figures may be suspect, however, since all contact was on the street and because the sample may not have been representative.

Another California survey of homosexual women by the San Francisco Department of Health (1993) found that 22 percent reported that they had sex with a man during the previous three years, and 47 percent of those reported that they did not always use a condom. As written in *Newsline*:

Over 10% of the women surveyed were injection drug users, and of this group, 71% have shared needles. It also appears that lesbians and bisexual women were much more likely to have sex and share needles with gay or bisexual men than heterosexual women [were]. (LaBarbera, 1994, p. 9)

### **Summary of HIV/AIDS Risk**

In the 20th century, HIV/AIDS risk was approximately 430 times greater among homosexuals than among heterosexuals. There was a significant decrease in the numbers who became HIV positive only for a brief time after the onset of the AIDS epidemic. Empirical evidence indicates that the numbers rose again as homosexual men relapsed into higher-risk sexual behavior patterns. Having HIV/AIDS did not curtail the sexual behaviors of a large percentage of homosexual men. Researchers found very little practical difference between the sexual risk-taking behaviors of the HIV-positive and HIV-negative homosexual groups.

Unprotected anal sex among homosexual men was found to be commonplace. Homosexual youth reported a high incidence of unprotected anal intercourse, and HIV was very prevalent among young homosexuals compared to the general population of youth in the United States. Despite increased knowledge regarding the health risks of specific homosexual behaviors and decreased social stigma for homosexually-identified individuals, the situation regarding HIV/AIDS among homosexuals remains life-threatening to individuals and problematic for society.

In 2005 the risks of acquiring HIV from a single act of unprotected sex within the male homosexual community in the United States remained about 500 times greater than within the heterosexual community. (Data assumptions: 25 percent of the male homosexual population is HIV positive [CDC, 2005], compared with 0.2 percent of the heterosexual population [UNAIDS/WHO (2005)]; and 66 percent of HIV-positive cases are among the male homosexual community.)

Homosexual men have three times the median number of partners compared with heterosexual men (Laumann, Gagnon, Michael, & Michaels, 1994). No other group of comparable size in the population routinely and knowingly exposes itself to such life-threatening health risks in spite of educational campaigns.

### **Sexually Transmitted Diseases/Health Risks**

Homosexuals have been found to be at particular risk of infectious diseases and other related health issues because of their sexual practices (Fluker, 1983).

Fluker (1976) and Fluker and Cross (1981) reported that homosexuals accounted for a large and disproportionate percentage of STD cases, and that they have long flooded medical centers with STD-related conditions.

Lifetime prevalence for STDs in homosexual men was 75 percent compared with 16.9 percent for heterosexual men (Laumann et al., 1994). In one independent study of more than 4,000 homosexual men, 78 percent had had at least one STD (Handsfield, 1981). In *The Spada Report*, two thirds of the respondents reported STDs (Spada, 1979).

Various researchers have concluded that homosexual men incur a greater risk of contracting STDs when compared with heterosexual men. Researchers report a greater risk among homosexuals for:



- Syphilis and gonorrhea (CDC, 1979; Darrow, Barrett, Jay, & Young, 1981; Fluker, 1983)
- Gonorrhea, syphilis, and human papillomavirus (HPV) infections (Handsfield & Schwebke, 1990)
- Gonorrhea, syphilis, and anal warts (Judson, Penley, Robinson, & Smith, 1980)
- HPV and anal cancers (Surawicz et al., 1995)

In a comparison study, anti-HIV antibodies were found in 30 percent of homosexual men but in only 12 percent of heterosexual men (Corey & Holmes, 1980). In another study conducted in Seattle in 1980, Handsfield (1981) found that at least 43 percent of a sample of 102 cases of hepatitis B virus (HBV) were homosexual men. This prevalence was disproportionately high because numerous population studies have documented that homosexually behaving men constitute only 2 to 3 percent of adult males (Laumann et al., 1994; Whitehead & Whitehead, 2007).

Gastrointestinal symptoms were found to be high among homosexual men and were often associated with STDs (Rompalo, 1990). Enteric bacterial pathogens that affect the intestines and cause complications—including shigellosis, giardiasis, amebiasis, infestations, and threadworms—were particularly prevalent among homosexual men (Fluker, 1983; Quinn, 1986; Smith & Singer, 1994), but were much rarer among heterosexual men.

Of men attending an STD clinic in Houston, a significantly higher frequency of human cytomegalovirus (HCMV) was found in the urine of homosexual men: 18 percent compared to 4 percent in heterosexual men (Greenberg et al., 1984).

Homosexuals are also more frequently exposed to ectoparasites, such as pubic lice (*Phthirus pubis*). One researcher found that 69 percent of homosexual men reported a history of these ectoparasites (Billstein, 1989). A history of scabies was also reported in 22 percent of homosexuals in the study by Jay and Young (1979). Another researcher found that anal intercourse often produces acute and chronic *pruritis ani* (anal itching) (MacAlpine, 1953).

Homosexual men also expose themselves to biological hazards more often than the general population. For example, common activities such as fisting, scat play (*coprophilia*, or sex involving feces), and sadistic and masochistic sexual practices expose homosexual men to blood and open wounds—often with multiple partners.

Anal intercourse is in fact maladaptive to human biological design. While the vagina has natural lubrication and a wide opening, the anal canal is small and dry, resulting in injury if sexually penetrated (Ketterer, 1983). In addition to its natural lubrication, the vaginal wall is relatively tenacious and cleaner than the rectum. In terms of unprotected intercourse, vaginal sex is safer than anal sex. Not only can the anus tear, but there is a possibility feces will enter the insertive partner's bloodstream (Satinover, 1996).

Anal intercourse readily damages the upper rectum and ruptures the peritoneum. Continued stretching and displacement of the anus leads to problems in control of gas and feces, and anal penetration puts the anal sphincter muscle at risk, causing chronic incontinence or urgency of defecation (Miles, Allen-Mersh, & Wastell, 1993). Homosexual men have a disproportionate rate of anal fissures, rectosigmoid tears, penile edema, and hemorrhoids (Owen, 1985). Kaposi's sarcoma, a lethal skin cancer, is disproportionately found in homosexuals (*Lancet*, 1981, as cited by West, 1983) and is considered an opportunistic infection related to AIDS.

Induced immune dysregulation not related to AIDS can be brought about by contact between homosexual men—the exchange of sperm antibodies alone are most likely responsible for marked suppression of the immune system (Mavligit, 1984). Even in the absence of symptoms, homosexuals have been found to have a surprisingly high level of immune dysfunction (Greenberg et al., 1984).

Homosexual women were also found to be at higher risk for STDs and other health problems. For example, the rate of bacterial vaginosis is 2.45 times higher among homosexual women than among heterosexual women (Evans, Scally, Wellard, & Wilson, 2007). Oral-genital sex common to homosexual women puts them at risk for herpes. Since heterosexual contact is also common among homosexual women (80 percent of homosexual women reported heterosexual contact in the past), they are at a dual risk for STDs (Johnson & Palermo, 1992). Homosexual women who report heterosexual histories are also more likely to report a history of gonorrhea or syphilis (Ernst & Houts, 1984). The men with whom homosexual women have sex are frequently drawn from the homosexual community, which they consider less psychologically threatening but which also exposes them to higher medical risks.

### **Analingus**

According to Corey and Holmes (1980), "Diaries concerning sexual behavior kept by homosexual men showed that the acquisition of hepatitis A virus infection was correlated with frequent oral-anal contact" (p. 435). In the 1991 Canadian Men's Survey, 33.7 percent of men who have sex with men reported practicing insertive analingus and 40 percent practiced receptive analingus in the three months prior to the study (Myers et al., 1993). The act of analingus is not found among heterosexuals (McWhirter & Mattison, 1984).

### **Suicide**

Researchers using methodologically strong studies document that suicidality is more strongly associated with homosexual orientation and behavior than with heterosexual orientation and behavior (Fergusson et al., 1999; Herrell et al., 1999; King et al., 2008). This finding is consistent with the results of older studies.

In a systematic study of 57 homosexual women and 43 single heterosexual women, researchers found that 23 percent of the homosexuals had attempted suicide compared to 5 percent of the heterosexuals (Saghir, Robins, Walbran, & Gentry, 1970). When homosexual and heterosexual women in prison were matched and compared, the homosexual women reported significantly more suicidal attempts (Climent, Ervin, Rollins, Plutchik, & Batinelli, 1977). DHHS reported that more than one third of suicides in the total population were committed by homosexual men—figures that put them at least two to three times more likely to commit suicide than the general population. Researchers conclude, "Increased receptive anal sex behavior may in itself be considered a form of avoidant coping or suicidal behavior" (Ostrow et al., 1994, p. 550).

In a study of 52 homosexual college men, researchers found that 55 percent reported a history of suicidal ideation (Schneider, Farberow, & Kruks, 1989). A review of three large, well-designed studies found that homosexual men and women attempted suicide two to seven times more often than heterosexual comparison groups (Saunders & Valente, 1987). While attempts of or ideas about suicide did not necessarily mean completion of suicide, such attempts do increase the risk factors, leading to the conclusion that homosexuals are at greater risk for suicide completion.

The results of more recent methodologically stronger studies confirm and expand these earlier findings. De Graaf, Sandfort, and Ten Have (2006) conducted a random, nationally representative household survey of the general population in the Netherlands, which has a tolerant social climate toward homosexuality (Sandfort et al., 2001). The participation rate was 69.7 percent and the sample consisted of 125 men and women reporting homosexual behavior and 5,873 men and women reporting only heterosexual behavior. De Graaf et al. reported the following at risk odds ratios (OR):

- Lifetime death wishes (OR 5.93): 26.8 percent of homosexual men showed a lifetime risk of experiencing death wishes vs. 5.8 percent of heterosexual men.
- Lifetime suicide contemplation (OR 7.74): 40.2 percent of homosexual men showed a lifetime risk for contemplating suicide vs. 7.8 percent of heterosexual men.
- Lifetime deliberate self-harm (OR 10.23): 14.6 percent of homosexual men showed a lifetime risk for deliberate self-harm vs. 2.0 percent of heterosexual men.
- Lifetime suicide contemplation (OR 2.12): 23.3 percent of homosexual women showed a lifetime risk for contemplating suicide vs. 2.3 percent of heterosexual women.

Herrell et al. (1999) reported a study from the population-based Vietnam Era Twins Registry of a sample of 103 middle-aged male-male twin pairs “in which one member of the pair reported male sexual partners after age 18 years while the other did not.” Some 6,434 pairs were concordant for no adult same-gender partners, and 16 pairs were concordant for any adult same-gender partners. Herrell et al. found, “There is more than a 4-fold increase in *suicidal ideation* (OR, 4.1) among the twins reporting a same-gender sexual orientation compared with their co-twins discordant on this measure” (p. 871). Also, “Twins reporting a same-gender sexual orientation are 6.5 times more likely to report having *at-tempted suicide* than their co-twins” (p. 871).

### Suicide among homosexual youth

Studies of youth who have attempted suicide have revealed that a disproportionately high number are homosexual (D’Augelli & Hershberger, 1993; Hendin, 1992; Prenzlauer, Drescher, & Winchel, 1992; Rich, Fowler, Young, & Benkush, 1986). Gibson (1986) concluded that homosexual and bisexual youth are three times more likely to attempt suicide than are heterosexual youth. Findings from other studies are remarkably similar (D’Augelli & Hershberger, 1993; Proctor & Groze, 1994; Remafedi, Farrow, & Deisher, 1991; Rotheram-Borus, Rosario, et al., 1994; Tielman, Carballo, & Hendricks, 1991).

Recent studies with better methodological control (i.e., randomized sampling and better control groups) continue to report much the same results: suicide is significantly more prevalent among homosexuals than heterosexuals (de Graaf et al., 2006; Fleming, Merry, Robinson, Denny, & Watson, 2007; Hegna & Wichstrøm, 2007; Lester, 2006; Meads et al., 2007; Safren & Heimberg, 1999; Sandfort et al., 2001, 2006; Silenzio, Pena, Duberstein, Cerel, & Knox, 2007; Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003; Warner et al., 2004). Among homosexual men the prevalence of suicide is close to three times higher than among heterosexual men. The suicidality among homosexual women was almost entirely connected to their increased mental illness (such as depression), but it was not related to mental illness in homosexual men.

In one Netherlands study (de Graaf et al., 2006) involving 7,000 participants, younger homosexually-oriented people were found to be at greater risk of suicidality than older homosexually-oriented people. This suggests that liberalization of social mores in the Netherlands has not lowered the risk of suicidality in the younger generation.

Much information is now available about motivations for suicide, and this data shows that the predominant motives for homosexual people are relationship breakup and self-hatred. No young person ever welcomes the discovery that he or she is attracted to the same sex, a discovery that makes them feel very different at the precise time when they are trying to conform to the standards and motivations of their peers. According to D’Augelli (as cited in Paul et al., 2002), the time of greatest suicide risk for youth is when they believe they are homosexual but have not yet told anyone. At that point, overt

discrimination issues or the other issues we touch on later are on average much less important, and the dominant motive is self-hatred.

The precipitating problems found in most of the studies were the breakup of romantic relationships, other relationship difficulties, hatred of being homosexual, depression, substance addiction, and social discrimination. Various studies ask homosexuals who attempt suicide about the most common motives in their suicidal attempts. It's difficult to interpret the data—the factors are interrelated and there are classification difficulties. Because the studies span almost 30 years, there may have been some relative changes with time. Notable are the sparse numerical estimates of the significance of social discrimination as a motivator for suicide. Indeed, there is much skepticism about whether discrimination is real or only perceived, and whether it is a primary or secondary motivating factor.

### **Romantic relationship difficulties**

Bell and Weinberg (1978) found that 43 percent of suicide attempts among white homosexual men and 67 percent among white homosexual women involve the distress involved in ending a romantic relationship. Perhaps reflecting this, Bradford, Ryan, and Rothblum (1994) found that 44 percent of nonsuicidal people in their study reported problems with lovers as the most common complaint. Hendin (1995), whose specialty is the study of suicide, found that among whites, homosexual rejection by a same-sex person was the usual precipitating event for the suicidal attempt. However, this also included nonromantic rejection. "Suicidal homosexuals typically attributed all their unhappiness to rejection," Hendin concluded, "but it was clear that unhappiness and rejection formed intrinsic parts of their relationships" (p.137).

The researchers note the life-or-death, "I can't live without you" quality that suicidal homosexual youth give their relationships. Hillier, Turner, and Mitchell (2005) found that "given the hostility of their environment, having someone who cared was particularly important and breakups were particularly devastating" (p. 44). Bartholow et al. (1994) found that 17 to 20 percent of their suicidal sample had ended a primary relationship in the previous four months. Among homosexual youth, Remafedi et al. (1991) found that 19 percent cited romantic problems as the reason for their suicidal attempts.

Since there are approximately three to four times as many partners among members of the homosexual community as there are in the heterosexual community (Laumann et al., 1994), it is tempting to think that having so many more partners could be an important factor explaining the higher level of suicidal attempts. However, the research findings for the following variables show that an adequate explanation is not so simple.

General relationship difficulties (with family, peers, etc.) of a rather variable nature were cited as significant suicidal ideation motivators by 44 percent of Remafedi et al.'s (1991) group. Bradford et al. (1994) studied a group in which 34 percent mentioned family problems and 10 percent mentioned problems with friends. D'Augelli et al. (2005) found that parental disapproval was a factor. Other researchers recorded that homosexual teens reported relationship-related reasons for attempting suicide (Buhrich & Loke, 1988; Dubé & Savin-Williams, 1999; Safren & Heimberg, 1999).

### **Self-hatred and depression**

Thirty-seven percent of Bell and Weinberg's (1978) convenience sample of suicidal homosexual adults "could not accept themselves"; 21 percent of Bradford et al.'s (1994) group could not deal with being homosexual; and one third of Remafedi et al.'s (1991) group cited the same problem. About half of the youth in D'Augelli et al.'s (2005) group reported that they attempted suicide because they hated being homosexual. Hammelman (1993) placed the figure as high as 75 percent. Buhrich and Loke (1988) and Dubé and Savin-Williams (1999) also reported discontent with being homosexual as a suicidal risk factor.

We admit that some researchers opine that if society put its stamp of approval on homosexual behavior, such self-hatred would be removed. However, we think this view is unrealistic, because suicidality figures for countries more tolerant of alternative lifestyles than the United States (such as the Netherlands) do not, in fact, support this assumption (Sandfort et al., 2001). Also, depression itself is associated with suicide (Dubé & Savin-Williams, 1999). Depression experienced by homosexuals could originate from factors other than lack of self-acceptance of, or self-hatred for, being homosexual, but the above researchers, if they studied other depression risk factors, do not report them.

### **Substance abuse**

Substance abuse is independently associated with suicide and was certainly high in the homosexual groups studied. Remafedi et al. (1991) found that 15 percent of their young group reported this as a variable that may have influenced their attempting suicide. Five studies (de Graaf et al., 2006; Eisenberg & Resnick, 2006; Herrell et al., 1999; Lester, 2006; Safren & Heimberg, 1999) report that when substance abuse and depression are factored out, there is still an influence uniquely attributable to sexual orientation. By contrast, de Graaf et al. (2006) found that suicidal attempts by homosexual women—but not by homosexual men—were entirely accounted for by increased mental illness, presumably depression.

### **Discrimination**

Friedman, Koeske, Silvestre, Korr, and Sites (2006) reported that bullying is a suicide risk factor for homosexual youth. However, the hypothesis that social discrimination and bullying can explain all suicidality in homosexually-oriented youth is not supported by the research.

For both homosexual teens of both genders, Shaffer, Fisher, Hicks, Parides, and Gould (1995) reported that suicidal attempts are not subsequent to a social stigmatization episode. Remafedi et al. (1991) found that both those who attempted suicide and those who did not had similar experiences of discrimination, and concluded that discrimination must have only a minor effect on subsequent suicidal behavior. Hendin (1995) found no evidence that discrimination was a significant factor in suicidal attempts. Likewise, Hershberger, Scott, and D'Augelli (1995) found that victimization was not directly related to suicide and that an incident of social discrimination toward a homosexual youth could be ameliorated by the youth's self-acceptance and family support. The researchers concluded that independent suicidal thinking was a more important suicidal risk factor than prior victimization.

Significantly, Paul et al. (2002) found that suicide risk remains constant in spite of changing social attitudes and greater social tolerance—meaning that factors other than societal discrimination are prompting suicidal attempts. Warner et al. (2004) found that among suicidal homosexual youth, physical attacks were 70 percent greater and bullying was 40 percent higher than for a nonsuicidal homosexual group, suggesting that physical attacks and bullying were significant factors. However, these have much smaller effects than other factors already discussed, implying that the effects of direct discrimination are not numerically overwhelming.

Hillier et al. (2005) did not separate suicide from other self-harm, including self-mutilation, but the physical and mental abuse group could have had as high as two times the suicidal attempts as the nonabused group. Homophobia was cited by 35 percent of their group as the reason for suicidal attempts or ideation—but no separate figures were given for suicidal attempts, and the majority of their sample probably experienced ideation. Friedman et al. (2006) also cited bullying as a suicide factor for young people.

In the relatively homosexual-friendly Netherlands, de Graaf et al. (2006) thought *perceived* discrimination might have been a greater factor, because the lesser discrimination than in other countries did not lead to lower suicide prevalence. Sandfort, Bakker, Schellevis, and Vanwesenbeeck (2009) found

homosexual suicidality was entirely accounted for by coping style, leaving no room for influence of societal stigma. Fitzpatrick, Euton, Jones, and Schmidt (2005) found that atypical gender role was more tightly correlated with suicidality than actual sexual orientation.

### Summary regarding suicide rates

Overall, the preceding studies suggest that homosexuals encounter an unusually high rate of intimate relationship difficulties, which lead them to attempt suicide. Depression and substance abuse are causal variables for suicidal attempts, but discrimination—far from being a universal explanation—seems to have relatively and absolutely less influence than hypothesized. Self-hatred appears to be another important factor in itself, but the development of self-hatred among homosexuals is not shown to be due solely—or primarily—to social discrimination either. Researchers have documented that societal discrimination itself accounts directly or indirectly for at most a small part of the higher incidence of suicidality among homosexuals. As Bailey (1999) states, “It would indeed be surprising if anti-homosexual attitudes were not part of the explanation of increased suicidality among homosexual people, but this remains to be demonstrated” (p. 884).

Life and health are uniquely attacked by and among homosexuals, producing increased medical and mental health problems and mortality. This phenomenon does not seem to be primarily connected with discrimination issues in society at large. Instead, the greatest factors contributing to an increased suicide rate seem to be attitudes among homosexuals themselves and their responses to the breakup of the relationships that they enter so intensely.

We must also consider the existence of as-yet-unidentified factors, about which some prominent writers have theorized—including the possibility of a developmental disorder, either biological, psychological, or both—and problematic lifestyle factors common to the homosexual community.

We again quote Bailey (1999), writing in the *Archives of General Psychiatry*, “Homosexuality represents a deviation from normal development, and is associated with other such deviations that may lead to mental illness” (p. 884). Bailey proposes several possible interpretations of the findings. Bailey concludes that while social oppression is a likely stressor, researchers have not demonstrated that social oppression is the sole or primary source of the greater prevalence of mental illness among homosexuals.

A second possibility, Bailey speculates, is that since evolution naturally selects for heterosexuality, “homosexuality may represent developmental error” (p. 884). While he does not fully elaborate on this suggestion, he says some research links homosexuality to “developmental instability” (p. 884) similar to minor physical anomalies such as left-handedness. A third possibility concerns the gender-atypicality of homosexuals as a group; homosexual men, being as a group more feminine, may be exhibiting more female-like types of neuroticism.

A fourth possibility is that the increased psychopathology experienced by homosexuals may be due to “lifestyle differences” (particularly promiscuity and fear of sexually transmitted diseases). Lifestyle differences—including the homosexual community’s great stress on physical attractiveness and thinness—might also explain the much higher rate of homosexual men with eating disorders.

To understand why homosexuality is linked with psychopathology, Bailey calls for more research—particularly research that is free of politicization and that does not avoid exploring unpopular hypotheses (cf. Byrd, 2006, 2008).

### Psychological Maladjustment Studies

We recognize that the older literature in this section is less academically rigorous than more recent studies. None of these tests was sufficient to unequivocally identify homosexually-oriented people without

a personal interview about their sexuality. We discuss these older findings because newer researchers using more methodologically rigorous methods draw similar conclusions.

Hooker's (1957) research is frequently cited as "proving" there is no greater pathology in homosexual men—something which her research was not designed to do. She compared small, select samples of homosexual and heterosexual men, and independent judges found no differences in overall adjustments on Rorschach protocols; in fact, the judges could not distinguish the homosexuals from the heterosexuals. Although Hooker's study showed little difference between the two groups, this was at least partially due to sampling bias. The study excluded from participation homosexuals with obvious pathology. Although no differences in overall adjustment were found within the select group and through the study's limited projective testing method, it still was possible to distinguish the two groups from results of the Thematic Apperception Test (TAT) protocols, which were designed to assess the subject's unconscious, repressed motives, among other things.

Numerous studies after Hooker have failed to support Hooker's finding of no difference in overall adjustment. A number of different studies using a variety of psychological tests have found significant differences in psychological adjustment scores between heterosexuals and homosexuals. Overall, the outcomes of research using psychological tests reveal a trend that correlates homosexuality to high neuroticism (van den Aardweg, 1985). A number of these studies are discussed below.

### *Minnesota Multiphasic Personality Inventory (MMPI)*

After administering the Minnesota Multiphasic Personality Inventory (MMPI) to a group of reportedly "normal homosexuals," Loney (1971) found that the F-scale score—a deviant, or rare, response scale—was greater among homosexuals than heterosexuals. This meant that the homosexual group in Loney's study sample responded to items in ways that are rarely endorsed by individuals who are free from serious psychopathology.

Manosevitz (1971) administered MMPIs to nonclinical samples of homosexuals and heterosexuals and found that the profiles of homosexuals appeared more depressed, sociopathic deviant, feminine (for men), paranoid, anxious, and schizophrenic, and less skilled socially than did the profiles of the heterosexuals. Cubitt and Gendreau (1972) compared the MMPI scores of homosexual and heterosexual prisoners and found that the profiles of homosexuals were more histrionic (theatrical) and suggested more somatic concerns (such as undue concern with body appearance).

Braaten and Darling (1965) found that the MMPI profiles of overt homosexuals appeared more sociopathic deviant, and that those of covert homosexuals suggested lower social skills. Among both groups, the profiles of homosexual men appeared more feminine than the profiles of heterosexual men.

Doidge and Holtzman (1960) rated Air Force trainees for their degree of homosexuality. The researchers found that homosexual men were more feminine, hysterical, sociopathic deviant, paranoid schizophrenic, histrionic, and depressed, and that they had lower social skills and higher anxiety levels than did heterosexual men.

Oliver and Mosher (1968) compared both homosexual and heterosexual youth housed in a reformatory. They concluded, "The data suggests [sic] greater maladjustment on the part of homosexuals" (p. 101).

### *MMPI MF (masculinity/femininity) Scale*

Lester (1975) found that five of seven studies reported that homosexual men had higher MF scores, meaning they were more feminine than the heterosexual men. Friberg (1967) concluded after his review that "in general, it appears that homosexuals do obtain higher femininity scores than heterosexuals" (p. 102).

### ***California Psychological Inventory (CPI)***

Compared with 66 heterosexual men, 60 homosexual men scored lower on the California Psychological Inventory scales of Wb (sense of well-being) and Sc (self-control), but higher on Scale 5 (sensitivity) (Hiatt & Hargrave, 1994).

### ***Personality Factor Questionnaire (16PF)***

In a community sample, Evans (1970) found that the scores of homosexuals who completed the 16PF were less emotionally stable, conscientious, and self-controlled, and more tense, tender-minded, suspicious, imaginative, apprehensive, and self-sufficient than the scores of heterosexuals. Evans observed that overall, the homosexual group resembled typical heterosexuals more than they resembled diagnosed anxiety neurotics, and that they appeared to be "mildly neurotic."

Using a forensic sample, Cubitt and Gendreau (1972) found that the homosexuals had less emotional stability and were less experimenting and more shrewd. After reviewing these studies, Lester (1975) concluded, "Again, although differences are not consistent, the trends are for greater maladjustment or neurosis in the homosexual" (p. 103).

### ***Gough Adjective Checklist***

Evans (1971) compared homosexuals and heterosexuals on the Gough Adjective Checklist. The homosexual group endorsed items associated with being less self-confident, less dominant, and more succorant, having less endurance, less need for achievement and order, more need for abasement, and more counseling readiness. On the MF scale, the homosexual men scored as more feminine. The homosexual group checked more unfavorable adjectives and fewer personal adjectives (suggesting a lower degree of emotional connectedness and less self-knowledge). The two groups did not differ on the number of favorable adjectives checked, including self-control, labiality, intraception, nurturance, affiliation, heterosexuality, exhibitionism, autonomy, aggression, change, and deference. On the MF scale, the homosexual men scored as more feminine. Evans concluded that homosexuals appeared more neurotic overall.

### ***Other Tests***

Grygier (1958) compared neurotic men on the Dynamic Personality Inventory. The homosexuals in the group scored higher on the questions related to passivity and the need for comfort/support, feminine narcissism, and feminine identification, and lower on questions related to masculine identification.

Siegelman (1972) administered the Scheier and Cattell's Neuroticism Scale Questionnaire (NSQ) to samples of homosexuals and heterosexuals. For the total sample, the homosexuals were more tender-minded, more submissive, more anxious, and had a higher total score. Siegelman then compared those respondents who had low femininity scores, and found that the homosexuals were more tender-minded than the heterosexuals. In general, the homosexuals were assessed as more neurotic and less well-adjusted. Siegelman also compared those homosexuals who belonged to a homosexual organization to those who did not and found that those in the organization were more depressed, more submissive, and had a higher total score.

Kendrick and Clarke (1967) compared homosexual psychiatric patients with nonpsychiatric heterosexuals and found differences in their self-concept on both the Semantic Differential and George Kelly's repertory grid. On the whole, the homosexuals had less favorable attitudes toward themselves, but they also had less favorable attitudes toward other concepts, such as justice, sex, and being normal.



### *Summary of Psychological Maladjustment Studies*

The outcomes of research using formal, well-controlled, and validated psychological tests show a trend that correlates homosexuality to high neuroticism, such as emotional difficulties and disorders. After presenting the findings of various psychological tests comparing homosexuals and heterosexuals, Lester (1975) concluded that “homosexuals do seem to be less well-adjusted than heterosexuals” (p. 108).

### **Mental Health and Psychological Disorders**

The current scientific consensus is that homosexuals have much greater psychopathology than the general population (Fergusson et al., 1999; Herrell et al., 1999; King et al., 2008; Sandfort et al., 2001).

While homosexual advocates agree that homosexual men and women display higher rates of drug and alcohol abuse and have higher risk of suicide, they argue that victimization and societal nonacceptance of homosexuality is responsible for these trends. However, researchers have not demonstrated a causal correlation between social victimization of homosexuals and the development of these disorders. For example, Hershberger et al. (1995) found that victimization does not directly relate to suicide in homosexuals. Savin-Williams (1994) concluded that there was no evidence of a causal link between stressors such as verbal and physical abuse and negative outcomes of homosexual youth, such as school problems, running away, substance abuse, prostitution, and suicide.

Notably, in a cross-cultural comparison of mental health in the Netherlands, Denmark, and the United States, Ross, Paulsen, and Stalstrom (1988) found no significant differences between the incidence of mental and emotional disorders reported by homosexuals in those countries. The lower level of social hostility toward homosexuals in the Netherlands and Denmark compared with the United States was not associated with a lower level of psychiatric problems among homosexuals in those European countries.

### *Results from the U.S. National Lesbian Health Care Survey and Canadian Surveys*

The National Lesbian Health Care Survey (NLHCS)—conducted between 1984 and 1985—provided information on the mental health of 1,925 homosexual women from all 50 states and was considered the most comprehensive study at the time. Despite the fact that homosexual women were socially connected and had support systems, the researchers reported significant problems.

More than half of the women thought about suicide at some time, and 18 percent had attempted suicide. Forty-one percent had been raped or sexually attacked at least once, the overwhelming majority by men. Nineteen percent were victims of incest during childhood. This suggests that at least some of the mental health problems were caused by very negative life experiences rather than by societal stigma (Bradford et al., 1994; Ryan & Bradford, 1993).

### *Anxiety and Depression*

Atkinson et al. (1988) found that regardless of whether a homosexual man is HIV-positive, he still reports significantly higher lifetime rates of anxiety disorder than does a heterosexual man.

Saghir and Robins (1971) found that homosexuals reported more depression than did heterosexuals. Pillard (1988) found that bipolar depression (including bipolar I, II, and cyclothymic types) occurred significantly more frequently in his sample of 51 homosexual men compared to a sample of 50 heterosexual men.

In a sample of HIV-positive homosexual men, Siegel et al. (1989) found significant levels of depression—even among those who reported positive socialization. While it could be argued that distress about developing AIDS may have caused this depression, other research suggests an alternative

explanation. Several samples of homosexual and bisexual men in HIV studies suggest that depression and anxiety are high in these populations and that their psychiatric morbidity began before the AIDS epidemic (Weinrich, Atkinson, McCutchan, Grant, & HNRC, 1995).

Cazzullo et al. (1990) found a higher psychopathological risk for homosexuals who were HIV-positive but symptom-free—but they concluded that the “major risk for HIV infection consists of subjects whose personal histories contain clear indications of psychopathological traits” (p. 290). Therefore, not only the HIV-positive homosexuals, but also those who were at risk before they were infected with HIV, showed psychopathology.

Homosexual men report significantly higher rates of major depression than the general population, with or without HIV infection (Atkinson et al., 1988). In a comparison study of 28 HIV-positive, symptom-free homosexual men and 68 HIV-negative homosexual men, the two groups did not differ significantly in levels of depression, both at the beginning of the study and again at the followup (Jadresic, Riccio, Hawkins, & Wilson, 1994). In other words, receiving an HIV diagnosis had little effect on a man’s level of depression. A diagnosis of fatal illness would normally be a crushing blow. The fact that it had no effect in raising depression levels suggests the extent of the depression with which many homosexual men may routinely struggle—and for which help should be available.

A study of HIV-negative homosexual African-American women showed that they were just as distressed as HIV-positive homosexual African-American men, and were even more distressed than HIV-negative men (Cochran & Mays, 1994). Although race and gender could be an argument here, researchers found that both homosexual men and homosexual women reported distress levels in excess of those previously reported in studies of both African-American and Caucasian men and women.

Nurius (1983) found that homosexuals experienced more depression than heterosexuals. Although the study revealed an “unmistakable, statistically significant relationship between depression and sexual orientation” (p. 133), the researcher denied that sexual orientation was an explanation for the depression.

During a community health survey at the Millennium March on Washington in 2000, the issue of depression and mental health was the number-one concern for homosexual women and the number-one concern for homosexual men after HIV/AIDS (“Depression and Mental Health,” n.d.).

### *Eating Disorders and Standards of Attractiveness*

In a nonclinical study of 250 college students—53 homosexual women, 59 homosexual men, 62 heterosexual women, and 63 heterosexual men—researchers found that the homosexual men and heterosexual women were most dissatisfied with their bodies and were vulnerable to eating disorders. They suggested that homosexual men and heterosexual women both place a high level of importance on physical attractiveness. In comparison, they found that homosexual women and heterosexual men were less concerned with their own physical attractiveness, and were therefore less dissatisfied with their bodies and less vulnerable to eating disorders (Siever, 1994).

Siever’s results support the findings of earlier studies (Berscheid, Walster, & Bornstedt, 1973; Silberstein, Mishkind, Striegel-Moore, Timko, & Rodin, 1989), and are supported by more recent studies (Ackard, Fedio, Neumark-Sztainer, & Britt, 2008; Carlat, Camargo, & Herzog, 1997).

Clinical studies of men with eating disorders found that one third were homosexual (Robinson & Holden, 1986; Schneider & Agras, 1987). In an eating disorders group, researchers confirmed that one third of the men were reportedly homosexual (Herzog, Bradburn, & Newman, 1990). Both percentages were disproportionately high compared with the percentages of homosexual men in the population.

A clinical study of men diagnosed with bulimia nervosa found that 82 percent considered themselves to be homosexual (Fichter & Hoffman, 1990).

In a nonclinical sample, after comparing heterosexual and homosexual men who were college students, researchers concluded that the homosexual men were significantly more likely to report past or current binge eating at the time of the study (Yager, Kurtzman, Landsverk, & Weismeier, 1988).

Homosexual women were found to be less invested in conventional standards of attractiveness (Brown, 1987). Instead, homosexual women placed more emphasis on physical strength as a positive physical characteristic (Striegel-Moore, Tucker, & Hsu, 1990).

Overall, homosexual men appear to have a disproportionately higher rate of eating disorders compared to heterosexual men, but homosexual women, compared with heterosexual women, do not.

### *Psychiatric Disorders*

In a 1979 review of 53 cases of male genital self-mutilation, homosexual feelings were common in both the psychotic (87 percent) and nonpsychotic patients (Fisch, 1987).

Current sociological studies support the Fisch study, as well as the suggestive results of older, methodologically weaker studies (Ellis, 1959, 1965; Lester, 1975). In particular, the results of six independent surveys reported in the last decade are noteworthy:

- A study of Vietnam veterans (Herrell et al., 1999)
- A study of participants in the New Zealand Longitudinal Survey (Fergusson et al., 1999)
- A population-based Netherlands study (Sandfort et al., 2001)
- A separate Netherlands study (Sandfort et al., 2006)
- A U.K. Midlands survey (Meads et al., 2007)
- A survey of Massachusetts residents (Conron et al., 2008)

The Herrell et al. (1999) study of Vietnam veterans found approximately three times greater suicidality in homosexual men, a rate that was higher than would be expected even after allowing for depression and psychiatric comorbidity.

In the New Zealand study (Fergusson et al., 1999), several statistically significant odds ratios indicating the prevalence of psychological disorders in homosexuals compared with that in heterosexuals shows by what factor the occurrence was higher among homosexuals:

- depression, 4
- generalized anxiety disorder, 2.8
- conduct disorder, 3.8
- nicotine dependence, 5
- other substance abuse or addiction, 1.9
- multiple disorders, 5.9
- suicidal ideation, 5.4
- suicidal attempts, 6.2

After adjusting for other factors, the association between homosexuality and the psychological disorders remained. Followup with the same group confirmed these findings (Fergusson, Horwood, Ridder, & Beauvais, 2005).

Besides the usual hypothesis that social discrimination accounts for the association between homosexuality and increased risks for psychological disorders, Fergusson et al. (1999, 2005) propose two novel explanatory hypotheses:

- People more prone to psychiatric disorder may be more likely to become homosexual.
- Lifestyle choices by nonheterosexuals more often produce negative outcomes and mental health problems.

In their study of homosexuals in the Netherlands, Sandfort et al. (2001) found that homosexuals had statistically greater odds than heterosexuals for experiencing the following: mood disorders, 2.93; anxiety disorders among homosexual men, 2.61; and substance abuse among homosexual women, 4.05. More homosexuals than heterosexuals had two or more disorders—i.e., comorbidity—giving odds ratios of 2.70 for men and 2.09 for women. Ratios for specific disorders were:

- Bipolar: 5.02 men, 1.80 women
- Agoraphobia: 6.32 men, 1.85 women
- Obsessive-compulsive disorder (OCD): 7.18 men (women absent)

For lifetime prevalence (men and women respectively), the ratios were:

- Bipolar: 7.27, 0.92
- Panic disorder: 4.21, 0.75
- Agoraphobia: 4.54, 1.36\*
- Simple phobia: 3.61, 1.27\*
- OCD: 6.2, absent
- Alcohol abuse: 0.48, 2.01
- Alcohol dependence: 1.23, 3.59
- Drug abuse: 1.34, 1.88
- Drug dependence: 2.47, 8.04

*\* Odds ratio not significantly different statistically.*

Researchers found that the presence of HIV infection was not a significant factor affecting these prevalences and odds ratios. Overall, homosexual men showed higher levels of types of disorders that are more typical of women, and homosexual women showed higher levels of disorders more typical of men.

Using a population-based estimate of sexual orientation, Conron et al. (2008) found that among Massachusetts (U.S.) residents:

Sexual orientation differences exist with respect to access to health care, overall health status, cancer screening, chronic health conditions, mental health, substance use including tobacco smoking, sexual health, and violence victimization. While gay/lesbian/homosexual adults evidenced poorer health and greater risk than straight/heterosexuals across several health domains, poorer health was observed most often for bisexuals. (p. 2)

King and McKeown (2003) found that two thirds of homosexual and bisexual adults in the United Kingdom are likely to have mental health problems compared to one third of heterosexuals. Warner et al. (2004) surveyed homosexual men and women in the United Kingdom; combined, 43 percent had a mental disorder as defined by the revised *Clinical Interview Schedule (CIS-R)*. Similarly, Wang et al. (2007) found that 44 percent of the Swiss homosexual population had a *DSM-III* condition when surveyed.

Drawing from appropriate studies already referenced, Rekers (2006) shows that the lifetime prevalence of mental illness among homosexuals is 50 to 60 percent for the Netherlands and more than 70 percent for New Zealand. As Sandfort et al. (2001) report, the Netherlands has a “social climate toward homosexuality [that] has long been and remains considerably more tolerant” (p. 89). Both the Netherlands and New Zealand are known to have cultures tolerant of homosexuality and intolerant of social discrimination based on sexual orientation or sexual lifestyle.

In a study in the United States, 48 percent of homosexual men and women believed they currently needed mental health treatment, while only 22 percent of heterosexuals felt they needed treatment. Ten percent of homosexual, bisexual, and transgendered men had been hospitalized for psychopathology compared to 4.4 percent of heterosexual men. Among women, corresponding figures were 8.7 percent of homosexuals and 6.8 percent of heterosexuals (Cochran & Cauce, 2006).

Hatzenbuehler et al. (2008) found that homosexual youth under the age of 18 had 30 to 50 percent more depression and anxiety than heterosexual youth in the same age group, and that this could be entirely accounted for by emotional regulation deficits—the sexual orientation did not contribute to their model. They hypothesized that social stigma related to sexual orientation might account for emotional regulation deficits, but that this influence was indirect.

It would be difficult to find another group of people in society of comparable size to those with same-sex attraction that have such a high level of psychopathology that expresses itself in such varied forms. The case could be made that some of the most self-destructive attitudes—especially this group’s willingness to engage in high-risk sex—must be related to deeper psychological issues rather than solely the person’s experience of social discrimination. If social discrimination and “internalized homophobia” are solely—or primarily—to blame for the higher level of pathology, no research to date demonstrates this.

### ***Summary of Research on Mental Health and Psychological Disorders***

We think that Bailey’s (1999) conclusions about the Herrell et al. (1999) and Fergusson et al. (1999) studies offer a relevant summary of the conclusions of all of the researchers investigating the relative prevalence of mental health difficulties and psychological disorders between the homosexual and heterosexual population.

These studies contain arguably the best published data on the association between homosexuality and psychopathology, and . . . converge on the same unhappy conclusion: homosexual people are at substantially higher risk for some forms of emotional problems, including suicidality, major depression, and anxiety disorder. . . . Some mental health professionals who opposed the successful 1973 referendum to remove homosexuality from DSM-III will feel vindicated. Second, some social conservatives will attribute the findings to the inevitable consequences of the choice of a homosexual lifestyle. Third, and in stark contrast to the other two positions, many people will conclude that widespread prejudice against homosexual people causes them to be unhappy, or worse, mentally ill. Commitment to any of these positions would be premature, however, and should be discouraged. It would indeed be surprising if anti-homosexual attitudes were not part of the explanation of increased suicidality among homosexual people, but this remains to be demonstrated. (p. 884)

In summary, there are now so many relevant studies that have been so carefully controlled methodologically and that have used such adequate sample sizes, the evidence is clear: *compared with the*

*heterosexual population, significantly higher levels of psychological adjustment problems do exist within the homosexual population.*

## **Interpersonal Relationships**

In the case of homosexual men, homosexual relationships are considerably more unstable and less likely to be sexually monogamous than are heterosexual relationships. Many studies of homosexual men reveal this characteristic instability. The Male Couple—a study by a homosexual couple, one a psychologist and the other a psychiatrist—reported that of the 156 couples studied, only 7 maintained sexual fidelity. Those couples who had been in a relationship for more than five years were unable to maintain sexual fidelity. While the study found that close to a third of the sample lived together longer than 10 years, the author reported, “The majority of couples . . . and all the couples together longer than 5 years, were not continuously sexually exclusive with each other” (McWhirter & Mattison, 1984, p. 285).

As Kurdek and Schmitt (1986) found, while some homosexual relationships seem to last, those relationships eventually become open when a homosexual couple lives together for longer periods of time. Saghir and Robins (1973) found that 75 percent of homosexual men over the age of 40 had not experienced a relationship that lasted longer than one year. Only 8 percent of the homosexual men and 7 percent of the homosexual women ever had relationships that lasted longer than three years.

*The Gay Report* included findings from a study of 5,000 homosexual men and women who reported details about themselves and their relationships in both open-ended and closed-end questioning. The authors concluded that “for gay men, the process of forming a couple and staying together is by no means the same as it is for a man and a woman, married or not” (Jay & Young, 1979, p. 339). The researchers found that the average length of a homosexual relationship is about two years. Two years is also the estimate in a more recent study by Pollak (1985).

As with *The Gay Report*, *The Spada Report* offered survey respondents the opportunity to talk at length about their unconventional sexuality and relationships. The survey was completed by more than 1,000 homosexual men representing every state in the nation. More than half reported that they had a lover, and 74 percent of the men with lovers reported that they, their lover, or both had engaged in sex outside the relationship. One subject responded, “If anything, having sex with others [made] our love for each other stronger” (Spada, 1979, p. 190). Another reported, “Those who impose monogamy must be so terribly unsure of themselves as persons of value.” He further opined that people, “sexually or otherwise, do not generate from a closed unit” (p. 190). These findings and the studies discussed above clearly show that attitudes about monogamy are very different in male homosexual relationships than in heterosexual relationships.

Harry (1984) found that while 50 percent of homosexuals report they are involved in a relationship at any given time, such involvement does not mean that they are committed or monogamous. As Henslin and Sagarin (1978) have concluded, “Many [homosexual] couples who stay together for a long time become roommates bound chiefly by companionship and domestic ties, ceasing to be bed partners and finding sex outside the relationship” (p. 229).

Researchers in Los Angeles during the late 1980s found that homosexuals averaged more than 20 partners a year (Linn et al., 1989). This number is particularly high considering the risks associated with homosexual sex. A study in Boston, also conducted during the late 1980s, found that 77 percent of more than 400 homosexual men had more than 10 partners during the five years before the study (Seage, 1992). An earlier study had found that male homosexual relationships were characteristically nonmonogamous (Blumstein & Schwartz, 1983).

Berger (1990) reported that in a sample of 92 homosexual couples, 96.4 percent described their relationship as monogamous. However, 50 percent of the couples continued to have *protected* sex with their regular partner. This implies that they were not confident of physical monogamy, and apparently assumed that there was a health risk from their partner's having sexual encounters outside of their relationship.

In their study of a nationally representative sample, Sandfort et al. (2003) concluded, "Both homosexual men and women less frequently reported having a steady partner than did heterosexual men and women" (p. 17).

More recent research suggests that even contracting a publicly professed, legally binding partnership does not prevent homosexual couples from experiencing relationship breakup more frequently than do married heterosexual couples. Andersson, Noack, Seierstad, and Weedon-Fekjaer (2006) studied 2,819 homosexuals in registered partnerships in Norway and Sweden and 222,000 opposite-sex marriages. The researchers reported that:

- *Male* homosexual registered partnerships have 1.35 times the risk of divorcing compared to heterosexual marriages.
- *Female* homosexual registered partnerships have 3.03 times the risk of divorcing compared to heterosexual marriages.
- "Divorce-risk levels are considerably higher in same-sex marriages" (p. 262).
- "The divorce risk in *female* partnerships is practically double that of the risk in partnerships of *men*" (p. 262; emphases added).

### **Summary of Interpersonal Relationships**

Long-term male homosexual relationships are characteristically unfaithful. Even when a homosexual couple live together for a long period, the relationship eventually becomes open—in other words, nonmonogamous. Relationships between homosexual women, while tending to be more monogamous than those of homosexual men, also tend to be substantially shorter in duration than heterosexual marriages.

In summarizing a large number of studies, Whitehead and Whitehead (2007) concluded that the mean length of a relationship for homosexual couples—both male and female—is only 2.5 years. Could this relational instability be due to the unavailability of state-recognized same-sex marriage? Such a hypothesis is not supported by a study in the Nordic countries (Andersson et al., 2006), where civil unions are available, yet breakup rates of officially sanctioned homosexual partnerships are still significantly higher than in marriages between heterosexuals.

Overall, researchers comparing the longevity and frequency of interpersonal relationships between homosexual and heterosexual partners found that relationships between homosexuals are substantially less stable and more short-lived on the average compared to heterosexual relationships, notably marriages between a man and a woman. It is not unlikely that relationship instability contributes significantly to the reported greater frequency of unhappiness in homosexuals compared to heterosexuals.

### **Promiscuity as a New Social Norm**

A stereotype of gay sexual behavior is that it is wildly promiscuous. Conversely the stereotype is that lesbians have relatively few partners, even compared to straights. A review of the literature updates suggests that neither stereotype is accurate, and that the median number of sexual partners of both homosexual men and women is approximately three to four times as many as heterosexuals men and women.

There is a convention within the male homosexual community that nonexclusive sexual relationships are normal and healthy. As Hoffman (1987) wrote, "Sexual promiscuity is one of the most striking, distinguishing features of the gay life in America" (p. 45). However, the medical and emotional risks of such behavior, including intense rage and sense of betrayal experienced by many male homosexuals who discover infidelities by their partner, suggest that while "normal" (i.e., common, typical, usual, expected), promiscuity among homosexuals is hardly healthy.

Studies throughout the 20th century note that promiscuity is a major characteristic of homosexuality. Reliable estimates of the prevalence of promiscuity among either homosexuals or heterosexuals are rarely available. For most of the literature, means or maxima are given. In mathematical terms, this is misleading—the correct statistic is the median, which is rarely calculable from the data given. However, the maxima, characteristically of thousands of lifetime partners, suggest a pathological preoccupation with the sex act, at least for a few individuals, regardless of sexual orientation.

According to Saghir and Robins (1971), homosexual men "are rarely faithful in their relationships" (p. 505). Promiscuity and multiple partnerships within the homosexual lifestyle are commonly reported (Kelly et al., 1995). Homosexual men are more inclined to have multiple sexual partners (Rotheram-Borus & Gwadz, 1993), and they have long been reported as having a higher number of sexual partners compared to heterosexual men (Bell & Weinberg, 1978). Likewise, homosexual women were found to have more female partners than a large group of heterosexual women had male partners (Goode & Haber, 1977).

John Rechy, a well-known homosexual author, reports that he has had sex with more than 7,000 men and that "thousands of sex encounters [with as many different male partners] are not rare in the gay world" (Goode & Troiden, 1980, p. 58). The results from Goode and Troiden's study reveal that "the number of partners with whom our respondents admitted having engaged in sex was, by heterosexual standards, prodigious" (p. 52). One respondent reported that he had engaged in sex with more than 10,000 men. Only 35 percent reported that they had engaged in sexual intercourse with fewer than 100 men; 42 percent reported that they had engaged in sexual intercourse with between 100 and 499 men; and 23 percent admitted to having had 500 or more partners. In contrast, the National Opinion Research Center (NORC) found that although most of the general heterosexual adult population had been having sexual intercourse since age 18, they reported only 1.2 partners during the year before the survey and only 7.2 partners since age 18 (Smith, 1991).

During the early years of the AIDS epidemic, the CDC reported that homosexual men who at that time had AIDS reported having more than 1,100 sexual partners in their lifetime (Pryor & Reeder, 1993). Critics claimed that those reports came from high-risk homosexual men and were not representative of all homosexual men. But when samples of heterosexuals with AIDS were compared with homosexuals with AIDS, the homosexuals had a median of 1,160 lifetime partners versus a median of 41 for heterosexuals (Guinan, 1984). Before AIDS came on the scene, it was reported that some homosexual men had a "scorecard" of 1,000 partners, and most had had at least 100 partners (Masters & Johnson, 1979). The Multicenter AIDS Cohort Study of nearly 5,000 homosexual men found that a significant majority of those men (69 to 83 percent) reported having 50 or more sexual partners during their lifetime (Kaslow et al., 1987).

In a study of 30 homosexual men in support groups for the sexually compulsive, researchers estimate that they had experienced an average of 2,000 different sexual encounters over their lifetime—while the heterosexuals in the support group had experienced 500 sexual encounters. Despite their awareness of AIDS, these homosexual men reported they would like to average 14 sexual experiences per month. Even after "successfully" completing the group—with the goal of reducing sexual compulsivity—these men still reported at least three different sexual partners per month. That number equaled the average



number of sexual partners of the heterosexual men when they first began the support group. Three different partners a month is still very risky given the common consequences of homosexual sex (Fluker, 1983).

According to findings of the *Journal of the International Association of Physicians and AIDS Care*, homosexual men do not always consider “monogamy” to mean a completely exclusive sexual relationship. Davies et al. (1993) reported that homosexual men averaged 70 male partners per year. By comparison, Masters and Johnson (1979) estimated that heterosexual men average 11 female partners per year.

In their study of a convenience sample that may not be representative of the U.S. population, Bell and Weinberg (1978) reported that more than 40 percent of homosexual men estimated having sex with 500 or more partners, and 28 percent had sex with 1,000 partners or more. More than 70 percent of these reported that half their partners were men with whom they had sex only once.

Probably the best U.S. population-based study on promiscuity is the National Health and Social Life Survey conducted by the NORC at the University of Chicago (Laumann et al. 1994). The study was “based on personal interviews in 1992 with 3,432 respondents who were randomly drawn from the non-institutionalized civilian population of the United States by an area probability design” (p. xxxi). Laumann et al. found a clear pattern: “In all cases, when we dichotomize our sample, the group of people with same-gender partners (or who define themselves as homosexual or bisexual) have higher average numbers of partners than the rest of the sexually active people in the sample” (p. 314).

Because of the extreme range of lifetime partners reported by some homosexuals, especially men, calculating the median (rather than the mean) average number of partners allows for a more realistic comparison between the typical number of partners of heterosexuals and homosexuals. For example, results from the National Health and Social Life Survey reveal that the average number of partners in the final year of the study was 8 for homosexuals compared to 1.2 for heterosexuals, a ratio of 7:1 (Michael et al., 1994). But the *median* numbers of lifetime partners for gays and lesbians in the United States were 2.75 and 4 times as many as for straights respectively (Laumann et al., 1994).

High promiscuity rates are common not only among American homosexuals, but are also found among homosexual men in various other countries. For example, a study of Asian and Pacific Islanders found that 95 percent of homosexual men in those cultures reported multiple same-sex sexual partners during the five years before the study (Choi, Coates, Catania, & Lew, 1995). Homosexual men in Thailand reported a higher number of total sex partners than heterosexual men in that country (Beyrer et al., 1995).

Mercer, Hart, Johnson, and Cassell (2009) conducted a national probability survey of 5,168 men in the United Kingdom from 1999–2001. The researchers found that for the preceding five years, the median numbers of partners reported by heterosexual, bisexual and exclusively homosexual men were 2, 7 and 10, respectively. Thus bisexual and exclusively homosexual men reported having 3.5 and 5 times, respectively, as many partners as the heterosexual men. This finding is reasonably consistent with best U.S. study (Laumann et al., 1994) and supports a rule-of-thumb estimate that homosexuals have approximately 3–4 times as many partners as heterosexuals.

## **Sexual Addiction and Coercion**

Homosexual men and women report experiencing sexual addiction and are reported as being the victims and/or perpetrators of sexual molestation, rape, and other predation at rates much higher than their heterosexual counterparts. Relevant studies and findings are discussed below.

### ***Sexual Addiction***

Quadland and Shattls (1987) found that their clients reported having more sex than they wanted to have. Patients also reported feeling victimized by their frequent sexual activity in a variety of ways besides that of the obvious AIDS risk. The Pride Institute, an addiction treatment center for homosexuals, reported that sexual addiction is a severe problem in the homosexual population (Downton, 1995). Dr. Jennifer P. Schneider, an expert in the field of sexual addiction, concluded that homosexuals represent a high proportion of the sexual addiction cases (Schneider, 1991, personal communication).

Homosexual men report much greater prevalence of sexual addiction than the general population (Dodge, Reece, Cole, & Sandfort, 2004). Dodge et al. (2008) compared sexual compulsivity scores of homosexual men with those of heterosexual mean. They found higher scores for homosexual men at all venues where the homosexual men were surveyed. Dodge et al. (2008) concluded that the rate of sexual compulsivity is higher among homosexual men than their heterosexual counterparts.

### ***Rape/Sexual Coercion***

An alarming rate of sexual coercion is found in homosexual relationships. When 36 women and 34 men in homosexual relationships were asked about sexual coercion in their relationships, 12 percent of the men and 31 percent of the women reported being a victim of forced sex by their current or most recent partner (Waterman, Dawson, & Bologna, 1989).

McConaghy and Zamir (1995) found that among a group of medical students, sexual coercion against a homosexual person was significantly correlated with the coercer's homosexual orientation ( $r = 0.24$ ,  $p = 0.05$ ). One fourth of the men reported sexually coercing a male partner. Similarly, one fourth of the women reported sexually coercing a female partner.

A study of homosexual relationships found that 29 percent of the subjects reported being coerced into unwanted sexual contact; 92 percent of the time the coercion involved unprotected anal intercourse, increasing the already-high risk of HIV infection (Kalichman & Rompa, 1995). Similar findings were characteristic of homosexually active men in England and Wales, where 28 percent reported that they had been sexually assaulted or coerced against their will by intimate partners. Of those, 27.6 percent had been forced into same-gender anal intercourse or other sexual activity by someone with whom they had consensual sex in the past (Hickson et al., 1994).

In a study of 310 homosexual men, 15 percent reported being victims of sexual coercion (Krahé, Schütze, Fritsche, & Waizenhöfer, 2000), and a similar percentage admitted to being perpetrators. Ratner et al. (2003) reported that 14 percent of homosexual men disclosed that they had been sexually coerced before the age of 14, and 14 percent disclosed that they had been sexually coerced after the age of 14. Finally, in a recent study, 18.5 percent of homosexual men reported experiencing unwanted sexual activity (Houston & McKirnan, 2007). Comparisons with the incidence of sexual coercion among heterosexuals were not reported in any of the three studies.

### ***Molestation***

The surveyed literature concludes absolutely that the overwhelming majority of molestations of young people are committed by adults who are apparently heterosexual. Still, in relation to their numbers in the population, homosexuals may be disproportionately liable to commit such offenses, as suggested by the following paragraph, since homosexual prevalence in the population is typically only 2 to 3 percent (a percentage that includes bisexuals).

A disproportionate percentage of pedophiles are classed as homosexual in some studies: 36 percent (Freund, Heasman, Racansky, & Glancy, 1984), 35 percent (Freund & Watson, 1992), and 28 percent

(Erickson, Walbek, & Sely, 1988), depending on the study. “This suggests that the resulting proportion of true pedophiles among persons with a homosexual erotic development is greater than in persons who develop heterosexually” (Freund & Watson, 1992, p. 34). Similarly, “The frequency of homosexual contacts exceeded that of . . . other groups . . . attracted to children” (findings of Gebhard, Gagnon, Pomeroy, & Christenson, 1975, as cited in Lester, 1975, p. 82).

In a careful study comparing civilian and military rates of sexual abuse, McCarroll, Ursano, Fan, and Newby (2004) presented such detailed statistics on such large samples that pre- and post-puberty breakdowns were possible. From ages 12 to 15—post-pubertal but below the age of consent in most states—the rates per thousand (for men and women respectively) were 0.4 and 2.4. The numbers were almost identical in civilian and military populations. Assuming molestation is by homosexual and heterosexual men respectively, and if the ratio of homosexual to heterosexual in the population is taken as 3:97, a disproportionately large number of homosexual men are involved in post-pubertal molestation—about 5.3 times as many as their heterosexual counterparts.

Complicating many other studies on molestation, however, is the fact that the sexual orientation of the same-sex molester cannot always be known (as just one example, some of the men who molest same-sex children are married to women and might not be immediately identified as homosexual).

## Violence

Estimates of the extent of partner violence in homosexual relationships between women vary, depending on which definition of violence is used. The various estimates include 52 percent (Lie & Gentlewainer, 1991), 25 percent (Brand & Kidd, 1986), 25 to 33 percent (Koss, 1990), two thirds (Renzetti, 1992), one in three relationships (Berry, 1994), and 31 percent (Lockhart, White, & Causby, 1994).

Studies show that homosexual women are generally more violent and criminal than heterosexual women (Ellis, Hoffman, & Burke, 1990; Owen & Burke, 2004). This held true even within prisons (Climent et al., 1977). Since violence among homosexual women is so rampant, the National Coalition Against Domestic Violence (Lobel, 1986) published the anthology *Naming the Violence: Speaking Out About Lesbian Battering*, in which several homosexual women revealed their experiences about violence among homosexual women. Describing lesbian bars, one homosexual woman was quoted as saying, “On almost every occasion that I went and stayed until closing, there was an episode of violence” (p. 11).

Brand and Kidd (1986) compared 75 self-identified heterosexual women with 55 self-identified homosexual women who were otherwise demographically similar. The study showed no significant difference between the frequencies of physical aggression in the primary relationships of the two groups. Twenty-seven percent of heterosexual women reported being abused by male partners, while 25 percent of homosexual women reported being abused by female partners. In other words, homosexual women were equally as likely to abuse their female partners as were heterosexual men.

For combined samples of men and women in a selected sample of 48 homosexual women and 50 homosexual men, 47 percent had used physically assertive tactics in their intimate relationships. Between the two groups, women tended to report fewer physically aggressive partners than did the men (Kelly & Warshafsky, 1987).

Cochran and Cauce (2006) reported that 4.4 percent of homosexual men and women entering substance abuse treatment in Washington State had suffered domestic violence in the last month, compared with 2.9 percent of heterosexuals. Lifetime figures were 55 percent for homosexuals compared with 36 percent for heterosexuals. This is one of the few studies with clear homosexual/heterosexual comparisons in the same sample.

Researchers found that the domestic violence rate of homosexual men is greater than that of heterosexual men (Seligson & Peterson, 1992). In a representative population probability sample, Greenwood et al. (2002) found that the level of violence in relationships between homosexual men was considerably higher than the level of violence by men against women in the heterosexual community. Greenwood et al. reported:

The 5-year prevalence of physical battering among urban MSM [men having sex with men] (22.0%) was significantly higher than either the annual prevalence of severe violence (3.4%) or the annual prevalence of total violence (11.6%) among a representative sample of women who were married or cohabiting with men. (p. 1968)

## **Adjustment Problems for Homosexual Youth**

Savin-Williams (1994) found that homosexuality in youth is associated with school problems, runaway behaviors, substance abuse, prostitution, and suicide. A number of studies substantiate these findings (Erwin, 1993; Kourany, 1987; Prenzlauer et al., 1992; Remafedi, 1987; Rich et al., 1986; Roesler & Deisher, 1972; Rotheram-Borus, Hunter, & Rosario, 1994; Saunders & Valente, 1987; Schneider et al., 1989). Homosexual and bisexual youth are at greater risk for homelessness (Kruks, 1991).

A more recent report indicates that high school students with romantic homosexual relationships have a substantially higher suicide rate than do those with heterosexual relationships. Russell and Joyner (2001) studied a nationally representative study of the general U.S. population. Their sample consisted of 5,685 adolescent boys and 6,254 adolescent girls. Same-sex romantic relationships “were reported by 1.1% of boys (n = 62) and 2.0% of girls (n = 125)” (p. 1277). The researchers found that the odds of suicidal attempts were 2.45 times higher among adolescent boys with homosexual orientation than among heterosexual boys. Similarly, the odds of suicidal attempts among adolescent girls with homosexual orientation were 2.45 times higher than among heterosexual girls.

Although some social scientists may claim that parental and peer pressures are the stressors that lead to maladaptation among homosexual adolescents, Savin-Williams (1994) concluded that such a correlation could only be called “suggestive,” and acknowledged that “a causal link between these stressors and outcomes has not been scientifically established” (p. 261).

## **Sexuality**

### ***Scat and Water Sports***

“Scat” is a name for the use of feces and defecation in sex play (i.e., *coprophilia*). “Water sports” is a colloquial expression for sexual practices tied to urination and defecation. In *The Gay Report*, 4 percent of homosexual men admitted to using defecation in sexual encounters (Jay & Young, 1979).

### ***Fisting***

“Fisting” or “handballing”—in which one man places an entire fist and even a forearm into the rectum of another—“is usually a [male] homosexual activity” (Shook, Whittle, & Rose, 1985, p. 319). Despite the severe health risks of fisting (hepatitis C transmission, emergency colostomies, bowel rupture, and even death), several homosexual or S&M organizations exist to promote it.

The annual prevalence of fisting among homosexual men is variously reported as 15 percent (Spada, 1979), 13 percent (Jay & Young, 1979), 16 percent (Crosby & Mettey, 2004), and 5 percent per year (McKusick et al., 1985). Comparatively, in the entire population it is reported as 0.5 percent per year

(Richters, Grulich, de Visser, Smith, & Rissel, 2003). Among homosexual women, the incidence of anal fisting is reported as 7 percent (Roberts, Sorensen, Patsdaughter, & Grindel, 2000) and 9 percent (Young, 1994), and vaginal fisting as 35 percent and 26 percent, respectively.

### **Other Unconventional Sex Practices**

In *The Gay Report*, Jay and Young (1979) found that bestiality (sex with animals) was reported by 13 percent of homosexual men. Williams and Weinberg (2003) found that most participants in bestiality are bisexual or homosexual.

## **Conclusion**

Researchers report that many differences in psychological adjustment exist between homosexual and heterosexual men and women. Recent studies confirm the results of prior decades of research demonstrating that homosexuality is associated with a significantly increased risk for mental, emotional, and behavioral disorders. Although some researchers hypothesize that social stigma against homosexuals is a possible cause of these difficulties, other researchers find that such stigma exerts only a minor contribution to their development. We believe that this conclusion will be strengthened with further research. The claim that “studies have found no differences in the psychological adjustment of lesbians and gay men from heterosexual women and men” (Rothblum, 1994, p. 214) was not accurate for its day and is also incorrect today.

Assertions of nonpathology are a distortion of the scientific literature on the subject. Such claims lie instead in the political realm and are destructive because they ultimately delay or deny treatment to those who are affected. The unavailability of timely treatment puts the medical and psychological health—not to mention the very lives—of those affected at risk.

## **Summary Bullets**

This synthesis of the literature derived from hundreds of sources reveals that:

- Despite knowing the AIDS risk, homosexuals repeatedly and pathologically continue to indulge in unsafe sex practices.
- Homosexuals represent the highest number of STD cases.
- Many homosexual sex practices are medically dangerous, with or without protection.
- More than one third of homosexual men and women are substance abusers.
- Forty percent of homosexual adolescents report suicidal histories.
- Homosexuals are more likely than heterosexuals to have mental health concerns, such as eating disorders, personality disorders, paranoia, depression, and anxiety.
- Homosexual relationships are more violent than heterosexual relationships.
- Societal bias and discrimination do not, in and of themselves, contribute to the majority of homosexual maladaptivity.



## IV. Responses from the APA to NARTH

In the September 1994 issue of *Monitor on Psychology*, Clinton Anderson of the APA's Office of Gay and Lesbian Concerns reported that homosexuals "do not differ on any kind of measure" from heterosexuals except in sexual orientation—and that coming out of the closet "is positively correlated with mental health" (p. 39). On September 27, 1994, NARTH addressed a correspondence to Mr. Anderson, asking him to provide documentation to support his claims.

On January 19, 1995, Mr. Anderson responded to NARTH on APA letterhead and provided two source references. The first was a chapter by Garnets and Kimmel (1993) in the book they edited, *Psychological Perspectives on Lesbian and Gay Male Experiences*. The second was *Homosexuality: Research Implications for Public Policy*, a text edited by Gonsiorek and Weinrich (1991). Following is a review of these two references.

### ***Psychological Perspectives on Lesbian and Gay Male Experiences (Garnets & Kimmel, 1993)***

*Psychological Perspectives on Lesbian and Gay Male Experiences* offers no original data other than the authors' own interpretations of prior studies, now superseded by more recent literature. Its authors conclude, "Psychological research has shifted from removing the stigma of pathology from lesbians and gay men to examining issues of implicit concern to them" (p. 35). This may be true, since a large proportion of the recent writers on gay and lesbian issues are themselves homosexual and have made their social activism on these issues known. But, in contrast to Garnets and Kimmel's claim, recent researchers conclude that homosexually-oriented persons do indeed suffer from a higher level of psychopathology.

### ***Homosexuality: Research Implications for Public Policy (Gonsiorek & Weinrich, 1991)***

As with the Garnets and Kimmel (1993) volume, *Homosexuality: Research Implications for Public Policy* also offers no summary data to support Mr. Anderson's claim on behalf of the APA that "homosexuals do not differ from heterosexuals on any kind of measure."

Editor John C. Gonsiorek wrote the chapter, "The Empirical Basis for the Dismissal of the Illness Model of Homosexuality," which says that homosexuality as a diagnosis is "simply another example of

social control by mental health professionals” (p. 115). The chapter was based on Gonsiorek’s attempt to refute homosexuality as a sign of psychological distress. In that attempt, he reviews the studies that were conducted through the use of psychological tests. Gonsiorek criticizes those studies that found “significant differences suggestive of greater psychological disturbances in their homosexual samples” and says that “they [were] byproducts of the faulty sample and poor design” (p. 129). Gonsiorek further states:

This research was so consistent in its lack of findings suggesting inherent psychopathology in homosexuality that researchers began moving on to other projects by the 1980s. Recent research has dropped off because the inherent pathology of homosexuality has been answered from a scientific point of view and has not been seen as requiring more research. (p. 132)

This is not only an erroneous statement, unsupported by research conducted since the statement was made, but also one that does a disservice to homosexual people. Today, however, his claims about poor design have been overtaken by many well-designed studies and a prominent meta-analysis of the research as a whole.

### **Addendum: Sexual Orientation and Mental Health: What the Behavioral Sciences Know About Sexual Orientation and Why It Matters (Gonsiorek, 2006)**

Gonsiorek is one of the authorities that APA cites in support of its concerns about the harmfulness of reorientation therapy (APA, 2008; DeLeon, 1998), but his views about the relationship between religion and reorientation therapy contrast sharply with the APA.

The APA formally supports of diversity of religion. Principle E of the APA code of ethics states, “Psychologists are aware of and respect cultural, individual, and role differences, including those based on . . . religion . . . and consider these factors when working with members of such groups” (APA, 2002). However, Gonsiorek (2006) has questioned whether the work of “religiously conservative” researchers and sexual reorientation therapists ought to be taken seriously. Gonsiorek has asserted that while he made “no argument [that] conservative faith-based . . . thought is necessarily flawed as theology,” he did argue that such thought “is merely incompatible with scientific inquiry” (p. 266). Gonsiorek further suggested:

The espousal of the idea of diversity by conservative faith-based proponents is not truly an operating princip[le] or held value, but a temporary strategy, a ruse essentially, geared toward the acceptance of a nonscientific theologically based viewpoint as legitimate science. (p. 267)

Like Gonsiorek, others have expressed the need to isolate or marginalize religious belief within psychology, deeming that religiously motivated psychotherapeutic attempts to modify homosexuality are essentially religious pursuits that have no place in a science-based clinical practice (Silverstein, 2003). While religious motivations should not be immune from scrutiny in the contexts of research and psychotherapy, researchers and therapists need to be extremely cautious about pathologizing the religious values that may prompt a client to attempt any psychotherapeutic change, including sexual reorientation. A professional stance that endorses dialogue between religion and psychology is to be preferred over one that places them in opposition to one another in order to place certain religiously motivated therapeutic goals outside the domain of mental health practice.



Gonsiorek's concerns contrast greatly with the current *Zeitgeist* in which behavioral scientists and psychological caregivers are showing a renewed interest in and utilization of appropriate religious and spiritual activities and resources in therapy. In general, the use of spiritual/religious-inspired aides—such as prayer, forgiveness, meditation, and groups based on spiritual principles like the Twelve Steps of Alcoholics Anonymous—have been shown to be therapeutically effective as part of or as an adjunct to treatment for a variety of presenting problems (Benson & Stark, 1996; Enright & Fitzgibbons, 2000; Richards & Bergin, 1999, 2003, 2005). And, as discussed in Sections I and II, research already shows that some people have benefited from spiritual/religious/pastoral counseling approaches, either alone or along with therapy, to achieve intended sexual reorientation (Byrd et al., 2008; Jones & Yarhouse, 2007; Karten, 2006; Nicolosi et al., 2000b; Shidlo & Schroeder, 2002; Spitzer, 2003).

In contrast to Gonsiorek, NARTH, as a scientific and professional organization, recognizes the importance of respecting religious diversity—not only of clients, but also of fellow scholars and professional and paraprofessional colleagues—in our efforts to offer psychological care to people with unwanted homosexual attractions. While we disagree with the above-quoted material and many other assertions and generalizations in Gonsiorek's (2006) paper, we applaud his concluding suggestion, "that only those who operate via scientific principles have a legitimate place in the behavioral sciences, and those who aspire to manipulate and mimic science do not" (p. 268).



## Summary Narrative

This treatise is a historical review of more than a century of clinical and research reports. Both earlier, less methodologically sophisticated studies were included, as well as more recent, methodologically sounder studies to show how the older and newer findings parallel one another. The older, methodologically weaker studies and the newer, more methodologically rigorous studies all support the same conclusions.

Researchers have shown that homosexuals—notably homosexual men, but in some areas homosexual women—have greater prevalence of pathology than the general population. This is supported by studies that demonstrate the suicidal risk-taking of unprotected sex (van Kesteren et al., 2007), violence (Owen & Burke, 2004), antisocial behavior (Fergusson et al., 1999), higher levels of substance abuse (Sandfort et al., 2001), general suicidality (de Graaf et al., 2006), higher levels of promiscuity and of nonmonogamous primary relationships (Laumann et al., 1994), higher levels of paraphilias (such as fisting) (Crosby & Mettey, 2004), sexual addiction (Dodge et al., 2004), personality disorders (Zubenko, George, Soloff, & Schulz, 1987), and overall pathology (Cochran & Mays, 2007; Sandfort et al., 2001).

As a rule of thumb, many of these problematic behaviors and psychological dysfunctions are experienced among homosexuals at about three times the prevalence found in the general population—and sometimes much more. The preceding material shows that many different pathological traits are more prevalent in homosexual than in heterosexual groups. We believe that no other group of comparable size in society experiences such intense and widespread pathology.

The usual hypothesis is that societal discrimination toward homosexuals is solely or primarily responsible for the development of this pathology. However, the alternative possibility—that these conditions may somehow be inherent in the psychic structure of a homosexual orientation—has not been disconfirmed. Indeed, several cross-cultural studies suggest that this higher rate of psychological disturbance is in fact independent of a culture's tolerance of—or hostility toward—homosexual behavior. We believe that further research that is uncompromised by politics should be carried out to evaluate this issue.

While some anecdotal accounts claim that interventions aimed at changing sexual orientation can be harmful, the body of empirical literature to support these claims is lacking. No study using a random survey concludes that reorientation therapy is likely to be harmful.

A strong argument exists to hold a place at the clinical table for those who seek change in their sexual orientation. We cannot deny the call for such help, as long as that help is autonomous to the client rather than externally driven, and as long as the client remains free to change direction in therapy and to instead claim a homosexual identity.

Those who have received help from reorientation therapists have collectively stood up to be counted—as once did their openly gay counterparts in the 1970s. On May 22, 1994, in Philadelphia, the American Psychiatric Association was protested against for the first time in history—not by pro-gay activists, but by a group of people reporting that they had substantially changed their sexual orientation and that change is possible for others (Davis, 1994). The same thing happened at the 2000 Psychiatric Association convention in Chicago (Gorner, 2000), and again at the 2006 APA convention in New Orleans (Foust, 2006).

The APA cannot ethically deny treatment for unwanted homosexuality as long as there are patients who seek it and therapists who are competent and willing to provide this service after offering proper informed consent procedures. It would contradict the APA's own code of ethics to deny such treatment. The APA states, "Mental health organizations call on their members to respect a person's [client's] right to self-determination" (2008, p. 3).

By the same token, a client who is not distressed about his sexual orientation should not be directed to change, and therapy affirming homosexuality should be available for any client who seeks it.

Client self-determination is one of the cornerstones of any form of psychological care. We uphold the right to psychological care for those who have a persistent and marked distress with their homosexual attractions and behaviors and who wish to be helped in diminishing them and in discovering and developing their heterosexual potential.

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