

NARTH

National Association for Research and
Therapy of Homosexuality

A Comprehensive Response to the American Psychological Association's Objections to the Treatment of Homosexuality*

Introduction

In 1973, the American Psychological Association succumbed to years of pressure from gay and lesbian activists and removed homosexuality from its diagnostic list of mental disorders. Over the years, and despite substantial protest, the APA continues to bow to pressure from an active Committee on Gay, Lesbian, Bisexual, and Transgender (GLBT) concerns, in order to take policy positions supporting a political agenda rather than respond to legitimate scientific research.

For example, during the 2004 Annual Convention in Honolulu, APA's Council of Representatives adopted a resolution supporting gay marriage by stating it is "unfair and discriminatory to deny same-sex couples legal access to civil marriage and its attendant benefits, rights and privileges." The resolution was based upon the recommendation of the APA Working Group on Same-Sex Families and Relationships, chiefly composed of gay and lesbian activists and individuals appointed to the task force because of their known support of the GLBT political agenda.

In 1997, the APA adopted its current policy that opposes any counseling treating homosexuality as a mental illness, but did not explicitly denounce reparative type therapies. In April of this year, once again responding to the demands

of vocal homosexual members, the APA authorized the creation of a task force on Appropriate Responses to Sexual Orientation, revising and updating the 1997 policy. Not surprisingly, the APA ignored the nomination of many qualified candidates who had actual clinical background in the change therapy process and appointed a committee chiefly composed of known pro-gay therapists and academics who have made their opposition to gender-affirming therapies well known over the years.

The opposition to change therapies seems to revolve around three general objections that the Scientific Advisory Committee, working under the direction of James E. Phelan, Psy.D, will address in this NARTH fact sheet.

The American Psychological Association (APA) asserts the following as their objections to the treatment of homosexuality:

1. There is no conclusive or convincing evidence to show such therapeutic attempts offer actual change.
2. Efforts to change sexual orientation are shown to be harmful and can lead to greater self-hatred, depression, and other self-destructive results.
3. There is no greater pathology in the homosexual population than the general population.

¹The term homosexuality (and forms of it) is used throughout this report as per its historical and scientific tenses. The authors are aware the terms lesbian and gay are preferred when referring to specific groups.

*This is a shortened version of an extensive paper which is available from NARTH, 16633 Ventura Blvd, Encino, CA 91436-1801; (818) 789-4440.

The Scientific Advisory Committee and the Board of Directors of The National Association for the Research and Therapy of Homosexuality (NARTH) presents the following data in response to these objections:

1. "There is no conclusive or convincing evidence such therapeutic attempts offer actual change."

Outcomes of interventions aimed at changing sexual orientation have been widely documented within the literature since the late 18th-century. Various paradigms and approaches applied have shown various outcomes. This, in and of itself, has shown the potential for change even in the absence of randomized studies. Treatment outcomes usually were defined by a shift in sexual desire from homosexuality toward heterosexuality, either through self-reporting or through various other measurements (Kinsey, Pomeroy, & Martin, 1948; Klein, 1978; Sell, 1997). Even without intervention, studies have shown sexual orientation is not a unitary, one-dimensional construct (Weinrich & Klein, 2002).

Sexual orientation defined in terms of the sex, or sexes, 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 orientated toward one sex but possess some attraction or history of behavior with the other sex. Other individuals experience more or less balanced attractions to both women and men. Although, in reality, sexual attraction conceptualized as being on a continuum, individuals (at least in Western cultures) tend to describe themselves as falling into one of three orientations: gay or lesbian, bisexual, or heterosexual. One's declared sexual orientation may or may not be congruent with one's actual sexual activities, which include behaviors, cognitions, and fantasies related to sexuality (p. 266).

Several approaches to report change in sexual orientation from homosexual to heterosexual have been documented in the literature using various paradigms. Even before Freudian

psychoanalysis, Charcot, through the use of hypnotic modality in 1882, reported success in that "the homosexual patients became heterosexual" (Horstman, 1972, p. 5). Albert von Schrenck-Notzing (1892) also recounted a case using hypnosis therapies whereas a shift in sexual drives and attractions from homosexuality to heterosexuality occurred.

Although the Bieber et al. (1962) psychoanalytic study of homosexual men which reported 27% of those completing treatment became exclusively heterosexual was widely criticized for research flaws, over 30 years later a survey of 285 anonymous members of the American Psychoanalytic Association conducted by Macintosh (1994) revealed that out of 1,215 homosexual patients treated by psychoanalysts, 23% changed to heterosexuality from homosexuality, and 84% of the total group received significant therapeutic benefits.

The level of success in decreasing homosexuality claimed by behavioral therapists was essentially a third or more in reported cases (Bancroft, 1974; Birk, Huddleston, Miller, & Cohler 1971). Throckmorton (1998) reviewed treatment outcomes and noted many behavioral counselors who have advocated for the use of a variety of behavioral techniques to achieve sexual shifts toward heterosexuality.

Dr. Nicholas Cummings, a past president of the APA, served as Chief of Mental Health with the Kaiser-Permanente Health Maintenance Organization during a period of 20 years saw over 2,000 patients with same-sex attraction, and his staff saw another 16,000. They did not attempt to reorient same-sex attraction to heterosexuality unless patients strongly indicated that as the therapeutic goal. Of those with that goal, 67% had good outcomes with 20% of them reorienting (Cummings, 2007).

Sex therapists have also reported changes in sexual orientation. The Kinsey Institute reported treatment of more than 80 homosexual men who had made satisfactory heterosexual adaptation (Pomeroy, 1972). In Masters and Johnsons (1979) treatment of 90 homosexuals, a 28.4% failure rate was reported after a 6-year follow-up (Schwartz &

Masters, 1984). They chose to report failure rates to avoid vague concepts of success. Although the failure rate was not equated in terms of success rate, it was valid to compare the success of their work with those reported in other studies dealing with change of orientation (Diamant, 1987).

Meta-analyses of studies have also shown that patients made a heterosexual shift: Thirty-three percent found in the meta-analyses by Clippinger (1974); 35% by James (1978); and 33% by Jones and Yarhouse (2000). Byrd and Nicolosi (2002) used the meta-analytic technique for 146 studies evaluating treatment efficacy. The analysis revealed that the average patient receiving treatment was better off than 79% of those undergoing alternative treatments or when compared to pretreatment scores on several outcome measures.

Finally, asking consumers themselves how they experienced change has provided data that change does exist, at least for some. Nicolosi, Byrd, and Potts (2000), with large efforts from the National Association for Research and Therapy of Homosexuality NARTH, retrospectively surveyed 882 dissatisfied homosexuals with a 70-item, client-answered scale. After receiving therapy or engaging in self-help, 20-30% of participants said they shifted from a homosexual orientation to an exclusively or almost exclusively heterosexual orientation. Of the 318 who identified as exclusively homosexual before treatment, 56, or 17.6%, reported they viewed themselves as exclusively heterosexual at the time of the study.

Shidlo and Schroeder (2002) interviewed 182 men and 20 women who were consumers of sexual orientation conversion interventions to find out how they perceived its harmfulness and helpfulness. The researchers originally recruited participants by advertising, "Help us document the harm of homophobic therapies!" in homosexual publications. Of the 202 participants, 176 were considered as having failed conversion therapy and 26 as having been successful. Twelve were still struggling in that they reported "slips" or some incidences of homosexuality; 6 were not still struggling with same-sex attractions, in that they were managing them; and 8 were termed to

be in a "heterosexual shift period" (p. 253), whereas they rated 3 or less on the 7-point Kinsey scale, self-labeled as heterosexual, reported having heterosexual behaviors and in a heterosexual relationship, and denied homosexual behavior.

Spitzer (2003), from Columbia University, interviewed 200 subjects who had participated in sexual reorientation processes by using a telephonic sexual orientation interview consisting of 114 closed-ended questions. Prior to intervention, 46% of the males and 42% of the females reported exclusive same-sex attraction. After intervention, 17% of the males and 54% of the females reported exclusive opposite-sex attraction. By way of his findings, Spitzer stated, "Thus, there is evidence that change in sexual orientation following some form of reparative therapy does occur in some gay men and lesbians" (p. 403).

Karten's (2006) dissertation examined the sexual reorientation efforts of 117 same-sex attracted men who had undergone some type of intervention to change orientation. Using a 7-point sexual self-identity scale with 1 indicating exclusive homosexuality and 7 indicating exclusive heterosexuality, he found at the onset of intervention, on average, men reported a mean score of 2.57 (2 = almost entirely homosexual; 3 = more homosexual than heterosexual), and at the time of the study (after intervention), they reported a mean score of 4.81 (4 = equally homosexual and heterosexual; 5 = more heterosexual than homosexual). The shift was statistically significant.

Finally, a compilation and average of 3 recent consumer survey reports (Nicolosi, Byrd, & Potts, 2000; Shidlo & Schroeder, 2002; and Spitzer, 2003) yielded a 31% success rate. There was a huge disconnect in the success rates between the Nicolosi et al. (2000) and Spitzer (2003) studies compared to the Shidlo and Schroeder (2002) study. This was likely due to the researchers' methods of sampling. Nicolosi et al. (2000) and Spitzer (2003) used samples from sources that would likely give positive results (e.g. from organizations such as NARTH), while Shidlo and Schroeder (2002) used samples largely from

homosexual sources, more likely to yield negative responses to reparative therapies. Nevertheless, in the end, the average still yielded a 31% success rate, not a significant difference from previous meta-analysis reports.

In summary, several reports about change in sexual orientation from homosexual to heterosexual have been documented in the literature using a variety of therapies as detailed above. This evidence is counter to the claims which say there is no convincing evidence of change. Even in the absence of a randomized study, the outcomes of interventions aimed at changing sexual orientation are vast and varied.

2. "Efforts to change sexual orientation are shown to be harmful and can lead to greater self hatred, depression, and other self-destructive results."

In general, reparative therapy has not been shown to be invariably harmful to its consumers. As discussed above, therapeutic efforts to change sexual orientation have been shown to be helpful for a number of clients. Even when disappointed with not changing their same gender sexual thoughts, feelings, fantasies, or behaviors as much as they had hoped, clients commonly reported satisfaction with the changes they did achieve. And, while client dissatisfaction is a possible and unfortunate consequence of any therapy, such dissatisfaction is not itself "harmful" and may be minimized by the responsible practice of timely and accurate informed consent.

Authors who clearly oppose the practice of reparative therapy and caution it can or may be harmful, nonetheless recognize such therapy is not always so. For example, Haldeman (2001), who claims to have helped past consumers of such therapy, remarked: "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 believed reparative therapy clients were subjected, Haldeman qualified 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).

Another oft-cited body of research critical of the actual or potential harm to "consumers of conversion therapies" demonstrated such therapies are not always considered harmful by consumers (Shidlo & Schroeder, 2002). While the 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" (from text used in participation recruitment), unexpected reports of helpful change led to recruiting and including "both self-perceived successes and self-perceived treatment failures" (p. 259) in the study.

The authors stated in general, "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, italics in original). They found among the 31 "self-perceived successes" who participated in clinical treatment courses ("any therapy administered by a licensed psychologist, psychiatrist, social worker, family and marriage therapist, or counselor-). 22 viewed their treatment as "helpful only" and 9 as "both helpful and harmful." Of the remaining 168 self-perceived treatment -failures," 9 were viewed as "helpful only," 72 as "both helpful and harmful." 85 as "harmful only," and 2 as "neither harmful nor helpful." Clearly, a significant number of consumers of conversion therapy did not find their experience unequivocally "harmful" (p. 257).

Is reorientation therapy harmful? For the participants in his study, Spitzer (2003) notes, there was no evidence of harm. "To the contrary," he says, "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 said, the American Psychological Association should stop applying a double standard in its discouragement of reorientation therapy, while actively encouraging gay-affirmative therapy to confirm and solidify a gay identity, which has no

“rigorous scientific evidence of effectiveness” (p. 413).

Furthermore, Spitzer wrote in his conclusion, “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” (p. 413).

Is reorientation therapy chosen only by clients who are driven by guilt—that is, what’s 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).

It is suggested by critics one outcome of reparative therapy is the development of a negative attitude towards homosexuality (e.g., Haldeman, 1991). It is not clear whether this vague criticism refers to individual clients, the general public, professional bodies, or all of them. If the statement about increased homophobia is intended to mean those who have elected therapy gain more negative attitudes toward same-sex attraction, and/or themselves for being same-sex attracted, this would be a valid criticism only if such attitudes were shown to be inculcated by reparative therapy and to be an inevitable side-effect of such therapy.

The continuing availability of reparative therapy over the past several decades has had negligible effect on promoting or maintaining a negative evaluation by the gay community of itself or by the public as a whole. There is a clear trend in the last few decades toward a greater belief by homosexuals themselves, and in the general public, homosexuality is innate, those experiencing homosexuality are not to be blamed, and unjust discrimination against such persons should not be permitted (Bell, 1976; 2000 Harris Poll in Schneider, 2006; Herek, 2002; Kryzan & Walsh, 1998; Otis & Skinner, 2004; Robinson, 2006).

The assertion that “greater self hatred, depression,

and other self-destructive” experiences are a harmful consequence of “efforts to change sexual orientation” must also be considered in the context of any therapeutic process. For example, short-term, dynamic psychotherapy often lead clients to become aware of depression, anxiety, and other emotions leftover from the clients’ recent or distant past. In the short-term, as clients attempt to practice sexual or other (e.g., substance use) sobriety, they may experience an increase in their “feeling” of depression, etc.

An increase in unpleasant feelings may not be an indication of “harm,” but an opportunity to deal with feelings formerly numbed by mood altering behaviors (e.g., sexual gratification), substances (e.g., alcohol or drugs), or other paraphernalia (e.g., pornography). Clients, who terminate any therapy before underlying emotional issues or compulsive behavior patterns are effectively resolved, will undoubtedly feel worse than when they began therapy. Also, to the extent persons with homosexual desires are engaged in sexual compulsions, and/or suffer from other psychological or relational difficulties, a high recidivism rate such as is found when treating substance abuse and other habits, may not be unrealistic.

We agree with and broaden Haldeman’s (2001) assertion, “Clearly, all of the potential (and actual) outcomes of conversion therapy (both harmful and helpful) need to be further documented and assessed” (p. 119). Better understanding of when and how the process of reparative therapy is most helpful or not will result. Further studies must take into account not all “reparative therapists” practice the same way and use many, if not most, of the therapeutic approaches used to help any clients with common presenting problems, including: depression, anxiety, shame, unresolved family of origin distress, sexual and emotional abuse, relationship difficulties, lack of assertiveness, compulsive and addictive habits, etc.

Any credible critique of the harmfulness or helpfulness of reparative therapies needs to define precisely the methods, goals, and theoretical constructs of treatment which are alleged to be inherently and generally, or even

specifically and individually, harmful. To date, this has not been clearly demonstrated. In fact, negative consequences are unavoidable in any arena, and the negative consequences attributed to experiencing reparative therapy have not proven to outweigh the benefits claimed by those who have found the therapies helpful.

3. “There is no greater pathology in the homosexual population than the general population.”

Research has proven homosexuals (mainly male representatives) have greater prevalence of pathology than the general population. This has been proven true among the following areas: Suicidal risk-taking in unprotected sex (van Kesteren, Hospers, & Kok, 2007); violence (Owen & Burke, 2004); antisocial behavior (Fergusson, Horwood, & Beautrais, 1999); substance abuse (Sandfort, de Graaf, Bijl, & Schnabel, 2001); suicidality (de Graaf, Sandfort, & Ten Have, 2006); promiscuity (Laumann, Gagnon, Michael, & Michaels, 1994); paraphilias (fisting) (Crosby, & Mettey, 2004); being paid for sex (Schrimshaw, Rosario, Meyer-Bahlburg, ScharfMatlick, Langstrom, & Hanson, 2006); sexual addiction (Dodge, Reece, Cole, & Sandfort, 2004); personality disorders (Zubenko, George, Soloff, & Schulz, 1987); and psychopathology (Cochran & Mays, 2007; Sandfort, de Graaf, Bijl, & Schnabel, 2001).

Lesbians have much greater problems than their heterosexual counterparts, particularly in health issues (Cochran & Mays, 2007; Johnson, & Palermo, 1992; Moran, 1996). Findings from a national survey of approximately 1,925 lesbians, the largest to date, revealed over 50% had considered suicide and 18% had attempted suicide; 37% had been physically abused; 32% had been raped/sexually attacked; and 19% had been in incestuous relationships. Almost one-third used tobacco daily and about 30% drank alcohol more than once a week (Bradford, Ryan, & Rothblum 1994).

As a rule of thumb, many of these characteristics have prevalence about three times what is found in the general population, sometimes much more. There are many different pathological traits well

established as more prevalent. It is difficult to find a group of comparable size in society with such intense and widespread pathology.

A complete literature review shows the very large number of papers in which a quantitative link with homosexuality is established. Only the most prominent categories have been surveyed; there are many others. The usual explanation is societal discrimination alone is responsible. However, the alternative possibility that the conditions which are inherent in the psychic structure of homosexuals has not been eliminated; indeed several cross-cultural studies show that prevalence seems independent of the cultural tolerance or hostility towards homosexuality.

A quantitative link of pathology with homosexuality is well established — the alternative is mainly theoretical, and its quantitative extent largely undemonstrated.

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