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Culturally Competent Mental Health Care for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Clients

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The following are a combination of what will be covered during the 8:30 am Keynote on Tuesday, October 7th, 2014 and Workshop Session 5 from 1:45 – 3:00, Tuesday, October 7th, 2014.

Part 1: Introduction to the Gay World

- Introduction:
- Sexual minorities are one of only two minority groups not born into their minority:
    - Sexual minorities
    - Handicapped- physical and emotional
    - Sexual Minorities – use of the word "Queer"
- Washington State Psychological Association
- Reparative/Conversion Therapy
- Definitions: Common terms
- Homophobia
- Internalized Homophobia
- Gay History
- Assumptions

Part 2: Life

- Coming out Stages
- Psychological Issues Related to Coming Out
- Aspects of Coming Out
- Questions to Consider When Coming Out
- Coping Mechanisms for Gay Youth
- Strategies for Engagement
- Working With Families
- Religion
- Same-sex Relationships
- Domestic Violence
- Discussing Safe Sex: AIDS; STD's

Part 3: Therapeutic Focus and Resources

- Strategies for Effective Treatment
- Inclusive Language
- Differential Diagnosis
    - PTSD
    - Others
- Preventing/Reducing Harassment
- Increasing Cultural Competence – Heterosexual Lifestyle Questionnaire

- Your Organization; Your Forms/Paperwork
- Resources

Extra Items in the Packet

- Personal Assessment of Homophobia
- In-depth Description of Homophobia
- Printout from the APA Website regarding Sexual Orientation
- Bill HB2451 Process in Olympia
- “’Pray the Gay Away” Therapy Ban stuck in State Senate” Article
- “Majority of States Are Blocking Bill that Seeks to Ban Conversion Therapy for Gays” Article
- “Conversion Therapy Also Known as Reparative Therapy” Article from Wikipedia

Definitions:

LGBPTTQQIIAA+: any combination of letters attempting to represent all the identities in the queer community, this near-exhaustive one (but not exhaustive) represents Lesbian, Gay, Bisexual, Pansexual, Transgender, Transsexual, Queer, Questioning, Intersex, Intergender, Asexual, Ally

Advocate: a person who actively works to end intolerance, educate others, and support social equity for a group

Ally: a straight person who supports queer people

Androgyny: (1) a gender expression that has elements of both masculinity and femininity; (2) occasionally used in place of "intersex" to describe a person with both female and male anatomy

Asexual: a person who generally does not experience sexual attraction (or very little) to any group of people

"Being in the Closet": Hiding one's sexuality.

Bigender: a person who fluctuates between traditionally "woman" and "man" gender-based behavior and identities, identifying with both genders (and sometimes a third gender)

Binary Gender: a traditional and outdated view of gender, limiting possibilities to "man" and "woman"

Binary Sex: a traditional and outdated view of sex, limiting possibilities to "female" or "male"

Biological sex: the physical anatomy and gendered hormones one is born with, generally described as male, female, or intersex, and often confused with gender

Bisexual: a person who experiences sexual, romantic, physical, and/or spiritual attraction to people of their own gender as well as another gender; *often confused for and used in place of "pansexual"*

Cisgender: a description for a person whose gender identity, gender expression, and biological sex all align (e.g., man, masculine, and male)

Cis-man: a person who identifies as a man, presents himself masculinely, and has male biological sex, *often referred to as simply "man"*

Cis-woman: a person who identifies as a woman, presents herself femininely, and has female biological

Closeted: a person who is keeping their sexuality or gender identity a secret from many (or any) people, and has yet to "come out of the closet"

Coming Out or Coming Out of the Closet: the process of revealing your sexuality or gender identity to individuals in your life; often incorrectly thought to be a one-time event, this is a lifelong and sometimes daily process; *not to be confused with "outing"*

Cross-dressing: wearing clothing that conflicts with the traditional gender expression of your sex and gender identity (e.g., a man wearing a dress) for any one of many reasons, including relaxation, fun, and sexual gratification; *often conflated with transsexuality*

Down Low (DL): Generally refers to Black men who have sex with men, but who don't identify as gay, homosexual or bisexual.

Drag King: a person who consciously performs "masculinity," usually in a show or theatre setting, presenting an exaggerated form of masculine expression, often times done by a woman; *often confused with "transsexual" or "transvestite"*

Drag Queen: a person who consciously performs "femininity," usually in a show or theatre setting, presenting an exaggerated form of feminine expression, often times done by a man; *often confused with "transsexual" or "transvestite"*

Family: A group of significant others, sometimes replacing the family of origin in importance within the individual's life.
Freedom flag: Symbolizes support of all minorities within society.

Fluid(ity): generally with another term attached, like gender-fluid or fluid-sexuality, fluid(ity) describes an identity that is a fluctuating mix of the options available (e.g., man and woman, gay and straight); *not to be confused with "transitioning"*

FTM/MTF: a person who has undergone medical treatments to change their biological sex (**F**emale **T**o **M**ale, or **M**ale **T**o **F**emale), often times to align it with their gender identity; *often confused with "trans-man"/"trans-woman"*

Gay: a term used to describe a man who is attracted to men, but often used and embraced by women to describe their same-sex relationships as well

Gender Expression: the external display of gender, through a combination of dress, demeanor, social behavior, and other factors, generally measured on a scale of masculinity and femininity

Gender Identity: the internal perception of an individual's gender, and how they label themselves

Genderless: a person who does not identify with any gender

Genderqueer: (1) a blanket term used to describe people whose gender falls outside of the gender binary; (2) a person who identifies as both a man and a woman, or as neither a man nor a woman; *often used in exchange with "transgender"*

Gynesexual/Gynephilic: attracted to females, women, and/or femininity

GRS: Gender reassignment surgery

Heterosexism: behavior that grants preferential treatment to heterosexual people, reinforces the idea that heterosexuality is somehow better or more "right" than queerness, or ignores/doesn't address queerness as existing

Heterosexual: a medical definition for a person who is attracted to someone with the other gender (or, literally, biological sex) than they have; *often referred to as "straight"*

Homophobia: fear, anger, intolerance, resentment, or discomfort with queer people, often focused inwardly as one begins to question their own sexuality

Homosexual: a medical definition for a person who is attracted to someone with the same gender (or, literally, biological sex) they have, this is considered an offensive/stigmatizing term by many members of the queer community; *often used incorrectly in place of "lesbian" or "gay"*

Homosexuality: (1860) Sexual orientation toward the same sex.
Internalized Homophobia: Before individuals become aware of their sexual orientation, sexual minorities mistakenly learn that homosexuality is unlawful, evil, unhealthy and inferior to heterosexuality.

Intersex: a person with a set of sexual anatomy that doesn't fit within the labels of female or male (e.g., 47,XXY phenotype, uterus, and penis)

Lesbian: A homosexual female.
"M to F" or "F to M": Male to female, or female to male transgender person.

Male: a person with a specific set of sexual anatomy (e.g., 46,XY phenotype, penis, testis, higher levels of testosterone, coarse body hair, facial hair) pursuant to this label

Pansexual: a person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions

Pink Triangle: A symbol of the gay and lesbian community.

Queer: (1) historically, this was a derogatory slang term used to identify LGBTQ+ people; (2) a term that has been embraced and reclaimed by the LGBTQ+ community as a symbol of pride, representing all individuals who fall out of the gender and sexuality "norms"

Questioning: the process of exploring one's own sexual orientation, investigating influences that may come from their family, religious upbringing, and internal motivations

Same Gender Loving (SGL): a phrase coined by the African American/Black queer communities used as an alternative for "gay" and "lesbian" by people who may see those as terms of the White queer community

Sexual Orientation: the type of sexual, romantic, physical, and/or spiritual attraction one feels for others, often labeled based on the gender relationship between the person and the people they are attracted to; *often mistakenly referred to as "sexual preference"*

Sexual Preference: (1) generally when this term is used, it is being mistakenly interchanged with "sexual orientation," creating an illusion that one has a choice (or "preference") in who they are attracted to; (2) the types of sexual intercourse, stimulation, and gratification one likes to receive and participate in

Skoliosexual: attracted to genderqueer and transsexual people and expressions (people who aren't identified as cisgender)

Stonewall: 1969 riots at a gay bar. This event is considered to be the beginning of the gay rights movement.

Straight: a man or woman who is attracted to people of the other binary gender than themselves; *often referred to as "heterosexual"*

Third Gender: (1) a person who does not identify with the traditional genders of "man" or "woman," but identifies with another gender; (2) the gender category available in societies that recognize three or more genders

Transgender: a blanket term used to describe all people who are not cisgender; *occasionally used as "transgendered" but the "ed" is misleading, as it implies something happened to the person to make them transgender, which is not the case*

Transitioning: a term used to describe the process of moving from one sex/gender to another, sometimes this is done by hormone or surgical treatments

Transsexual: a person whose gender identity is the binary opposite of their biological sex, who may undergo medical treatments to change their biological sex, often times to align it with their gender identity, or they may live their lives as the opposite sex; *often confused with "trans-man"/"trans-woman"*

Transvestite: a person who dresses as the binary opposite gender expression ("cross-dresses") for any one of many reasons, including relaxation, fun, and sexual gratification; *often called a "cross-dresser," and often confused with "transsexual"*

Trans-man: a person who was assigned a female sex at birth, but identifies as a man; *often confused with "transsexual man" or "FTM"*

Trans-woman: a person who was assigned a male sex at birth, but identifies as a woman; *often confused with "transsexual woman" or "MTF"*

Two-Spirit: a term traditionally used by Native American people to recognize individuals who possess qualities or fulfill roles of both genders

Homophobia

In the clinical sense, homophobia is defined as an intense, irrational fear of same sex relationships that become overwhelming to the person. In common usage, homophobia is the fear of intimate relationships with persons of the same sex.

Below are listed 4 negative homophobic, and 4 positive levels of attitudes toward Gay and Lesbian relationships/people. They were developed by Dr. Dorothy Riddle, a psychologist from Tucson, Arizona.

Homophobic Levels of Attitude:

- Repulsion - Homosexuality is seen as a "crime against nature". Gays are sick, crazy, immoral, sinful, wicked, etc., and anything is justified to change them (e.g., prison, hospitalization, negative behavior therapy including electric shock).

- Pity - Heterosexual chauvinism. Heterosexuality is more mature and certainly to be preferred. Any possibility of becoming straight should be reinforced and those who seem to be born "that way" should be pitied, "the poor dears".

- Tolerance- Homosexuality is just a phase of adolescent development that many people go through and most people "grow out of". Thus, Gays are less mature than straights and should be treated with the protectiveness and indulgence one uses with a child. Gays and Lesbians should not be given positions of authority (because they are still working through adolescent behaviors).

- Acceptance - Still implies there is something to accept, characterized by such statements as "You're not a gay to me, you're a person". "What you do in bed is your bed is your own business", "That's fine as long as you don't flaunt it."- Denies social and legal realities. Ignores the pain of invisibility and stress of closet behavior. "Flaunt" usually means say or do anything that makes people aware.

Positive Levels of Attitude:

- Support - Basic ACLU approach. Work to safeguard the rights of Gays and Lesbians. Such people may be uncomfortable themselves, but they are aware of the climate and the irrational unfairness.

- Admiration - Acknowledges that being Gay/Lesbian in our society takes strength. Such people are willing to truly look at themselves and work on their own homophobic attitudes.

- Appreciation - Value the diversity of people and see Gays as a valid part of that diversity. These people are willing to combat homophobia in themselves and in others.

- Nurturance - Assume that Gay and Lesbian people are indispensable in our society. They view gays with genuine affection and delight and are willing to be Gay advocates.

Personal Assessment of Homophobia

(By A. Elfin Moses and Robert O. Hawkins, Jr.)

Homophobia may be defined as an unrealistic fear of or generalized negative attitude toward homosexual people and may be expressed by LGBT people as well as by non-LGBT people.

1. Do you stop yourself from doing or saying certain things because someone might think you're gay or lesbian? If yes, what things?

2. Do you ever intentionally do or say things so that people will think you're non-gay?

3. Do you believe that gays or lesbians can influence others to become homosexual? Do you think someone could influence you to change your sexual and affectional preference?

4. If you are a parent, how would you (or do you) feel about having a lesbian daughter or a gay son?

5. How do you think you would feel if you discovered that one of your parents or parent figures or a brother or sister were gay or lesbian?

6. Are there any jobs, positions, or professions that you think lesbians and gays should be barred from holding or entering? If yes, why?

7. Would you go to a physician whom you knew or believed to be gay or lesbian if that person were of a different gender form you? If that person were of the same gender as you? If not, why not?

8. If someone you care about wren to say to you "I think I'm gay" would you suggest that the person see a therapist?

9. Have you ever been to a gay or lesbian bar, social club or march? If not, why not?

10. Wood you wear a button that says "How dare you presume I'm heterosexual?" If not, why not?

11. Can you think of three positive aspects of a gay or lesbian lifestyle? Can you think of three negative aspects of a non-gay lifestyle?

12. Have you ever laughed at a "queer" joke?

Assumptions

List the ten most common assumptions that you have heard about Lesbian, Gay, Bisexual and/or Transgender Individuals. These do not have to represent your beliefs but what you have heard about LGBT individuals.

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

9. ______________________________

10. ______________________________

Assumptions about Homosexuality

1. Homosexuality is a “choice” and so “they” should choose to be straight.
2. Homosexuals try to recruit.
3. Homosexuals are pedophiles.
4. All homosexuals think only about sex.
5. Homosexuality is not family oriented.
6. Homosexual parents cannot provide like heterosexuals.
7. A child being raised by homosexuals will become a homosexual.
8. HIV/AIDS is a “gay” disease and all homosexuals are or will become infected.
9. All gays look “feminine” and all lesbians look “butch”.

Religion:

1. All religions are against homosexuality.
2. Homosexuality is a sin due to religious reasons.

Coming-out Stages

Stage 1: Identity Confusion

Wonders "Am I lesbian/gay?"
Expresses confused and alienated feelings with difficulty
Inhibits self-awareness
Seeks more lesbian/gay information

Stage 2: Identity Comparison

Thinks "I may be lesbian/gay."
Admits same gender feelings of attraction
Begins sharing feelings with others
Confronts conflict between self-image and heterosexual conditioning
Struggles with managing social alienation
Fears or devalues negative reactions

Stage 3: Identity Tolerance

Tolerates that: "I probably am lesbian/gay."
Explores social and sexual relationships
Experiences gay/lesbian adolescence
Seeks to find supportive community or ideology
Decided to whom to "come out" as well as when, where and how
Grows distant from heterosexual majority

Stage 4: Identity Acceptance

Accepts that "I am gay/lesbian."
Learns about relating to same-gender partners
Relaxes with new self-image
Develops intentional or surrogate family
Develops strategies for "asking" and selective disclosure
Participates in sexual minority community

Stage 5: Identity Pride

Abandons "assign" strategies
Overvalues gay/lesbian identity and ideology
Undervalues heterosexual minority
Adopts "us and them" philosophy
Fuses with sexual minority community

Stage 6: Integration

Integrate gay/lesbian identity into overall sense of self
Abandons "tem and us" philosophy
Proceeds with developmental tasks of adulthood

Aspects of Coming Out

Adapted from a piece developed by Vernon Wall and Jamie Washington, l989.

The term "coming out" (of the closet) refers to the potentially life-long process of recognizing one's GLBTQI identity. This may occur in many ways: one may come out to one's self, to another person in conversation, or to an entire set of people. It can be a very long and difficult struggle for many GLBTQI individuals because they often have to confront homophobic, biphobic, and/or transphobic attitudes, ignorance, and discriminatory practices along the way. Many GLBTQI individuals struggle with their won negative stereotypes, phobia, sand ignorance that they learned when they were growing up. Before these GLBTQI individuals can feel good about who they are, they often have to challenge their won attitudes. Because of our society, it can take years of painful work to develop a positive GLBTQI identity.

There are many aspects of coming out that are very different depending on which GLBTQI identities an individual holds However, these aspects to end to be similar for most people who are coming out.

What might GLBTQI people be afraid of when coming out?

- Rejection and loss of relationships
- Gossip
- Harassment or abuse
- Being thrown out of the family
- Being thrown out of the house
- Having their lover arrested
- Loss of financial support
- Losing their job
- Physical violence
- Being "outed" without their consent

Why might GLBTQI people want to come out to friends and relatives?

- End the "hiding game"
- Feel closer to those people
- Be able to be "whole" around them
- statement "GLBTQI is okay"
- Stop wasting energy by hiding all the time
- Feel like they have integrity
- Make a

How might GLBTQI people feel about coming out to someone?

- Scared shocked
- Disbelieving
- Uncomfortable
- Not sure what to say or do next
- Unsurprised
- Wondering why the person "came out"
- Supportive
- Flattered
- Honored
- Angry Disgusted

What do you think GLBTQI people want from the people they come out to?

- Acceptance and Support and Understanding
- Comfort
- Closer friendship
- No negative effects on your friendship
- A hug and a smile
- An acknowledgment of their feelings

Questions to Consider
When Coming Out to Family and Friends

1. What is the emotional climate? If you have the choice of when to come out, consider the timing. Ideally, you will be able to choose a time when your family and friends are not dealing with such matters as the death of a close friend, pending surgery, or the loss of a job. However, it is often true that there is no “good time' to come out, and if you need to do so at a somewhat “awkward” or “inconvenient” time, that is ok too.

2. What is your relationship with your family and friends? If you've gotten along well and have always known their love- and shared your love for them in return – chances are they'll be able to deal with the issue in a positive way.

3. Can you be patient? Your family and friends might need time to deal with this information if they haven't considered it prior to your sharing.

4. Do you have support and access to resources? In the event that your family's reaction devastates you, there should be someone or a group that you can confidently turn to for emotional support and strength. Maintain your sense of self-worth is critical. If you are financially dependent on your family or live in the same house, and you are worried about them withdrawing this support, you might consider waiting until you are most financially independent.

5. What's your motive for coming out now? Hopefully, it is because you care for your friends and family and are uncomfortable with the distance you feel. It is best not to come out in anger or during an argument.

6. Are you knowledgeable about GLBTQI issues? Your friends and family will probably respond based on a lifetime of misinformation from society. If you've done some reading on the subject, you'll be able to assist them by sharing reliable information and research. However, it is not your responsibility to be a repository of information; they are capable of doing their own research and exploration.

7. Do you have available resources? GLTBQI issues are a subject that some non-GLBTQI people know very little about. If you think it will help the process, you might bring one of the following resources to share: a book addressed t family and/or friends; a contract for the local or national Parents, Families, and Friends of Lesbians and Gays (PFLAG) or the name of a counselor or therapist who can help them.

8. Is this your decision? Not everyone should come out to their friends and family. Don't be pressured to come out if you question whether you'll be happier, regardless of their response.

9. What is their worldview? If family or friends see social issues in clear terms of good/bad, or if you know they have negative views on GLBTQI issues, you may anticipate that they will have serious problems dealing with your identity. If however, they've evidenced a degree of flexibility when dealing with other changing societal matters, you may be able to anticipate a willingness to understand you.

Psychological Issues Related to Coming Out

Sexual Minorities are one of only two minority groups not born into their minority:

1. Sexual Minorities
2. Handicapped – physical and emotional

Issues:

1. Isolation:
    a. Social
    b. Emotional
    c. Cognitive (lack of information or role models)

2. Family
    a. Distant/Detached
    b. Fear of Rejection
    c. Disclosure often precipitates a crisis
    d. Secrets intensify

3. Emotional
    a. Depression
    b. Anxiety

4. Violence
    a. Sexual abuse is common
    b. Males at increased risk for expulsion from home
    c. Females at increased risk for physical and verbal abuse

5. Vocational Problems
    Fear of:
    a. Applying for jobs
    b. Being fired
    c. Humiliation

Sexual AND Ethnic Minorities:

1. Have to deal with racism within sexual minority community and discrimination within ethnic group.
2. Feelings of guilt because of clash with religious beliefs
3. Family/community: fear of losing the connection with the group that one has identified with for so long.

Making Positive out of Negative:

1. Gaining access to accurate information.
2. Getting support from trusted peers and adults.
3. Moving to a more supportive and tolerant environment.

Coping Mechanisms for Gay Youth

1. Hiding/Remaining Closeted
   Vigilant in their: behavior,dress, walking, talking, friends

2. Denial
   Refusing to acknowledge/accept their sexuality

3. Those who try to change
   They try to deny their feelings, attractions and emotions for people of the same gender. They try to be heterosexual and may get into heterosexual relationships just to show that they are "like everyone else."

   At risk for inward and outward hatred and anger.

4. Youth who are open about sexual orientation.
   They decide to be open to some or all people in their life.

   For males: increased risk of homelessness
   For females: increased risk of sexual abuse

Possible negative outcomes of any of the above:

1. Low self-esteem
2. Feeling different but not knowing why- (Denial)
3. Anxiety -both from fear of being discovered or from fear of how others will treat them.
4. Depression
5. Suicide
6. Substance Abuse
7. Pregnancy and STD's
8. Truancy
9. Dangerous Environments
10. Abusive Relationships
11. Discrimination at: school, youth groups, places of worship, etc.
12. Family rejection
13. Attacked (verbally, physically, emotionally, sexually) by peers, parents and other adults
14. Homelessness- (in addition to the above) resulting in:
    a. Teenage prostitution
    b. Other health issues and exploitation
    c. Increased exposure to others who are living the same way, which reinforces negative stereotypes and decreases self-esteem
    d. Increased sense of hopelessness- despair over future
    e. Lack of positive role models to show something different
    f. Subjected to external pressure and judgment

Myths about Lesbian and Gay Domestic Violence

As reported from the Gay and Lesbian Community Action Council, Minneapolis, MN

1. Only heterosexual women get battered. Men are never victims of domestic violence and women do not abuse.
2. DOMESTIC VIOLENCE is more common in heterosexual relationships than it is in lesbian or gay male relationships.
3. It isn't really violence when a same sex couple fights. It is just a lover's quarrel and a fair fight between equals.
4. It isn't' really violence at all when gay men fight – it's just boys being boys.
5. The batterer will always be butch, bigger and stronger. The victim will always be femme, smaller and weaker.
6. People who are abusive under the influence of drugs or alcohol are not responsible for their actions.
7. Gay men's domestic violence has increased as a result of alcoholism, drug abuse and the AIDS epidemic.
8. Lesbian and gay domestic violence is sexual behavior, a version of sado-masochism. The victims actually like it.
9. The law does not and will not protect victims of lesbian and gay men's domestic violence.
10. Lesbian and gay male victims exaggerate the violence that happens to them. If it were really that bad, they could and would just leave.
11. It is easier for lesbian or gay victims of domestic violence to leave the abuser than it is for heterosexual battered women.
12. Domestic violence primarily occurs among gay men and lesbians who hang out at bars or poor or are people of color.
13. Victims often provoke the violence done to them. They are getting what they deserve.
14. Lesbian or gay male victims of domestic violence are co-dependent.

PTSD – Post Traumatic Stress Disorder

Listed in the Anxiety Disorder Section of the DSM IV - TR– Diagnostic and Statistical Manual, Fourth Edition Text Revision.

A. The person has been exposed to a traumatic event in which both of the following were present:
    a. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others.
    b. The person's response involved intense fear, helplessness, or horror.
B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
    a. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
    b. Recurrent distressing dreams of the event.
    c. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated.
    d. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
    e. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three 9r more of the following:
    a. Efforts to avoid thoughts, feelings or conversations associated with the trauma
    b. Efforts to avoid activities, places or people that a4rouse recollections of the trauma
    c. Inability to recall an important aspect of the trauma
    d. Markedly diminished interest or participation in significant activities
    e. Feeling of detachment or estrangement from others
    f. Restricted range of affect (unable to have loving feelings)
    g. Sense of a foreshortened future (does not expect to have a career, marriage, children or a normal life span)
D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two or more of the following:
    a. Difficulty falling or staying asleep
    b. Irritability or outbursts of anger
    c. Difficulty concentrating
    d. Hypervigilance
    e. Exaggerated startle response
E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than 1 month
F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Acute – if duration of symptoms is less than 3 months
Chronic – if duration of symptoms is 3 months or more

Differential Diagnosis

- Mis-diagnosing a client because of lack of total knowledge.
- Differentiate between symptoms of mental illness and developmental or other life issues of sexual minorities.

Homosexuality per se is not a psychological disorder; however, that does not mean that there are no psychologically disturbed homosexual individuals or that some persons are not disturbed on account of their homosexuality.

The processes of coming out are often profound and may shake an individual to his/her core. This alone may account for the production of florid symptoms. In addition, the coming out process may occur at an age chronologically removed form adolescence stage, which it resembles in some ways.

Coming-out process vs.

Borderline Personality Disorder

- Stable instability
- Poor ego differentiation
- Relatively primitive object relations
- Splitting operations occur in response to a stressful situation

Narcissistic Personality Disorder

- Individual suddenly and dramatically "outs" self
- Informs others indiscriminately
- Drastically changes: Career
Clothing
Non-verbal behavior
Speech
Attitudes
- Presents as shallowness and complete immersion of the personality in the changing whirlwinds of high fashion, the latest chick, or the "right" social circles.

Schizophrenia with paranoia Vs.
Paranoia connected with sexual identity Vs.
Lack of schizophrenia diagnosis:

*Any major threat to one's core sexual identity may elicit paranoid defenses.
*Freud suggested that paranoia was a defense against homosexual impulses.

- Interpersonal awkwardness
- Chronic lack of desire
- Pleasure deficit
- Disordered thought processes
- Pervasive ambivalence
- Delusions
- Reduction of functioning in: Work

Interpersonal relations
Self-care

- Doubts loyalty of friends
- Reluctant to confide in others
- Reads hidden demeaning or threatening meanings into benign remarks or event

Diagnosis of homosexuality as an illness is wrong: therefore diagnosis is wrong; therefore my schizophrenic client is not schizophrenic but merely oppressed (misunderstood) because of the homosexuality.

Post-traumatic Stress Disorder related to "Coming-out:"

- **Verbal abuse**
- **Physical violence**
- **Physical assault (multiple people)**
- **Rape**

Resulting in:

- **Increased internal homophobia**
- **Decreased self-esteem**
- **Decrease the "coming-out" process**

When a sexual minority individual experiences the "coming-out" process, she/he might experience flashbacks of previous abuse that has not been dealt with prior.

Heterosexual Lifestyle Questionnaire

1. What do you think caused your heterosexuality?

2. When and how did you first decide you were a heterosexual?

3. Is it possible your heterosexuality is just a phase you may grow out of?

4. Could it be that your heterosexuality stems from a neurotic fear of others of the same sex?

5. If you've never slept with a person of the same sex, how can you be sure you wouldn't prefer that?

6. To whom have you disclosed your heterosexual tendencies? How did they react?

7. Why do heterosexuals feel compelled to seduce others into their lifestyle?

8. Why do you insist on flaunting your heterosexuality? Can't you just be what you are and keep it quiet?

9. Would you want your children to be heterosexual, knowing the problems they'd face?

10. A disproportionate majority of child molesters are heterosexual men. Do you consider it safe to expose children to heterosexual male teachers, pediatricians, priests, or scoutmasters?

11. With all the societal support for marriage, the divorce rate is spiraling. Why are there so few stable relationships among heterosexuals?

12. Why do heterosexuals place so much emphasis on sex?

13. Considering the menace of overpopulation, how could the human race survive if everyone were heterosexual?

14. Could you trust a heterosexual therapist to be objective? Don't you fear s/he might be inclined to influence you in the direction of her/his own leanings?

15. Heterosexuals are notorious for assigning themselves and one another rigid, stereotyped sex roles. Why must you cling to such unhealthy role-playing?

16. With the sexually segregated living conditions of military life, isn't heterosexuality incompatible with military service?

17. How can you enjoy an emotionally fulfilling experience with a person of the other sex when there are such vast differences between you? How can a man know what pleases a woman sexually or vice-versa?

18. Shouldn't you ask your far-out straight cohorts, like skinheads and born-agains, to keep quiet? Wouldn't that improve your image?

19. Why are heterosexuals so promiscuous?

20. Why do you attribute heterosexuality to so many famous lesbian and gay people? Is it to justify your own heterosexuality?

21. How can you hope to actualize your God-given homosexual potential if you limit yourself to exclusive, compulsive heterosexuality?

22. There seem to be very few happy heterosexuals. Techniques have been developed that might enable you to change if you really want to. After all, you never deliberately chose to be a heterosexual, did you? Have you considered aversion therapy or Heterosexuals Anonymous?

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You and Your Organization

1. Does your agency have staff people who are knowledgeable about sexual minority issues and who are supportive of those issues.
2. Does you agency have sexual minorities on staff? Are they "out" (open about their sexual orientation)?
3. Do you have waiting room, or public area literature, artwork, or agency illustrations that reflect support of sexual minorities?
4. Do you give consumers or staff members the opportunity to identify as sexual minorities?
5. Do you use inclusive language?
6. Do you know various definitions (such as coming out, partner, etc…)?
7. Are you able to identify your own biases and your own limitations?
8. Do you believe that you can "guess" or assume someone's sexual orientation?

Resources

Seattle Counseling Service: www.seattlecounseling.org
Seattle Counseling Service is a community resource that advocates, educates and serves to advance the social well being and mental health of the Gay, Lesbian, Bisexual and Transgender communities.

Project NEON: www.crystalneon.org
This website contains information for gay and bisexual men who use methamphetamine. We in no way promote or encourage the use of this controlled substance. Instead, we seek to help individuals minimize the harms associated with use of methamphetamine. Because of our harm reduction goals, some language and imagery may not be suitable for individuals under 18 years of age. Also, if you quit using methamphetamine or are trying to quit, you may wish only to view the section of this website that pertains to managing, cutting down, and quitting.

Gay City: www.gaycity.org
Gay City Health Project is a grassroots health organization for gay, bisexual and transgender (GBT) men based in Seattle, Washington. Our mission is to promote gay and bisexual men's health and prevent HIV transmission by building community., fostering communication and nurturing self-esteem.

Lambert House: www.lamberthouse.org
Lambert House is a center for Gay, Lesbian, Bisexual, Transgender and Questioning youth and their allies that encourages empowerment through the development of leadership, social and life skills.

Safe Schools Coalition: http://www.safeschoolscoalition.org/safe.html

Safe Zones: http://www.slu.edu/organizations/rainbow/resources.html

PFLAG – Parents, Friends of Lesbians and Gays: www.pflag.org
Located in and representing communities nationwide, PFLAG promotes the health and well-being of gay, lesbian, bisexual and transgendered persons, their families and friends through support, education, and advocacy. PFLAG provides opportunity for dialogue about sexual orientation and gender identity, and acts to create a society that is healthy and respectful of human diversity.

HRC - Human Rights Campaign: www.hrc.org
The Human Rights Campaign (HRC), the largest national lesbigay political organization, works to end discrimination, secure equal rights, and protect the health and safety of all Americans. With a national staff, and volunteers and members throughout the country, HRC lobbies the federal government on gay, lesbian and HIV/AIDS issues, educates the public, participates in election campaigns, organizes volunteers, and provides expertise and training at the state and local level

Lambda Legal: www.lambdalegal.org
Lambda Legal is a national organization committed to achieving full recognition of the civil rights of lesbians, gay men, bisexuals, the transgendered, and people with HIV or AIDS through impact litigation, education, and public policy work

National Gay & Lesbian Task Force www.thetasforce.org
The National Gay and Lesbian Task Force works to eliminate prejudice, violence and injustice against gay, lesbian, bisexual and transgender people at the local, state and national levels.

Coming Out Stories www.comingoutstories.com
Provides a safe and encouraging place for gays and lesbians to post their stories to help somebody who is struggling with coming out! The coming out stories include the bad with the good so as to give the reader a realistic idea of what it is like to come out

APA Council of Representatives Passes Resolution on So-Called Reparative Therapy

Resolution Raises Ethical Concerns About Attempts to Change Sexual Orientation, Reaffirms Psychology's Opposition to Homophobia and Client's Rights to Unbiased Treatment

(Chicago, August 14, 1997). The Council of Representatives of the American Psychological Association (APA) has passed a resolution affirming four basic principles with regard to treatments to alter sexual orientation, so-called conversion or reparative therapies
These Principles are:

- Homosexuality is not a mental disorder and the APA opposes all portrayals of lesbian, gay and bisexual people as mentally ill and in need of treatment due to their sexual orientation;
- Psychologists do not knowingly participate in or condone discriminatory practices with lesbian, gay and bisexual clients;
- Psychologists respect the rights of individuals, including lesbian, gay and bisexual clients to privacy, confidentiality, self-determination and autonomy;
- Psychologists obtain appropriate informed consent to therapy in their work with lesbian, gay and bisexual clients.

The resolution further states that the APA "urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientation."

Supporters of the resolution, which passed the APA Council overwhelmingly by a voice vote, believed that it was critical for the Association to make such a statement due to the questions of the ethics, efficacy and benefits of conversion therapy which are now being debated within the profession and within society as a whole.

"Our concern," stated Douglas Haldeman, Ph.D., President of APA's Society for the Psychological Study Of Lesbian, Gay and Bisexual Issues, "is that a person, especially a young person, who enters into therapy to deal with issues of sexual orientation should be able to have the expectation that such therapy would take place in a professionally neutral environment absent of any societal bias. Additionally, therapists should be providing clients with accurate information about same-sex sexual orientation. This resolution reasserts the profession's commitment to those two principles."

The APA Council of Representatives is the major legislative and policy-setting body of the organization. The American Psychological Association (APA), in Washington, DC, is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. APA's membership includes more than 151,000 researchers, educators, clinicians, consultants and students. Through its divisions in 50 subfields of psychology and affiliations with 58 state, territorial and Canadian provincial associations, APA works to advance psychology as a science, as a profession and as a means of promoting human welfare.

The following items are included as additional information recognizing that such information is accurate as of this writing, 10/7/14.

Bill HB2451 2013-2014
Banning of Reparative "Conversion" Therapy in WA State

2014 Regular Session:

Jan 17	First reading, referred to Health Care & Wellness (Not Officially read and referred until adoption of Introduction report). (View Original Bill)
Jan 22	Public hearing in the House Committee on Health Care & Wellness at 8:00 AM. (Committee Materials)
Feb 3	Executive session scheduled, but no action was taken in the House Committee on Health Care & Wellness at 6:00 PM. (Committee Materials)
Feb 5	Executive action taken in the House Committee on Health Care & Wellness at 8:00 AM. (Committee Materials)
	HCW - Executive action taken by committee.
	HCW - Majority; 1st substitute bill be substituted, do pass. (View 1st Substitute) (Majority Report)
	Passed to Rules Committee for second reading.
Feb 7	Placed on second reading by Rules Committee.
Feb 13	**1st substitute bill substituted (HCW 14).** (View 1st Substitute)
	Floor amendment(s) adopted.
	Rules suspended. Placed on Third Reading.
	Third reading, passed; yeas, 94; nays, 4; absent, 0; excused, 0. (View Roll Calls) (View 1st Engrossed)

IN THE SENATE

Feb 17	First reading, referred to Health Care.
Feb 20	Public hearing in the Senate Committee on Health Care at 10:00 AM. (Committee Materials)
Mar 13	By resolution, returned to House Rules Committee for third reading.

‘Pray the gay away’ therapy ban stuck in state Senate **Posted by Jonathan Martin**

Until 1973, homosexuality was medically classified as a mental disorder. The vestige of that fundamentally wrong notion — that same-sex attraction is an illness to be cured — lives on in the fringes of psychology through the practice of “gay conversion therapy.”

In the coming weeks, Washington should become the third state to ban such “treatments” for minors. A bill in the Legislature, HB 2451, is hung up in the Senate Health Care Committee. Chairwoman Randi Becker, R-Eatonville, told The Seattle Times last week she didn’t plan to put the measure up for a vote, and there wasn’t sufficient support in the Senate. Without a vote, the bill dies this week.

That’s a mistake.

Gay conversion therapy, also called reparative therapy, is premised on the idea that sexual orientation is mutable, and that young gays and lesbians can be made into heterosexuals, often via religious counseling (hence the derisive title of “pray the gay away” therapy). The practice has a grim history; methods for forcing conversion include electroshock and ice water baths, administered while the patient watched gay porn. In legislative testimony, Daniel Cords of Seattle said he tried suicide “more times than I could count” after being forced into reparative therapy by fundamentalist parents.

Failing to put HB 2451 up for a vote is also a mistake because the politics here are clear. The House passed it 94-4. Rep. Larry Haler, R-Richland, told The Tri-City Herald the therapy was “cruel and unusual,” and “reminiscent of a country different than America.” Rep. Richard DeBolt, R-Centralia, on the House floor described his change from being skeptical to being convinced that some conversion therapy practices “border on child abuse.” Watch his testimony below.

If the bill gets a vote in the Senate Health Care Committee, it will pass the whole Senate easily, according to Sens. Jamie Pedersen, D-Seattle, and Marco Liias, D-Everett, who’ve championed the bill. Hearing concerns about religious freedom, amendments were passed on the House floor that emphasized the ability for pastors to counsel their flock. The bill only applies to therapy given to minors.

Nor is there any apparent legal barrier to HB 2451. The federal 9th Circuit Court (of which Washington is a member) upheld the California ban on reparative therapy, making a lawsuit here untenable.

Here are the major medical groups that have warned that gay conversion therapy is based on bunk science and is potentially harmful: the U.S. Surgeon General (in 2001), the American Academy of Pediatrics (1983), the American Psychiatric Association (2000), the American Psychological Association (1997), the National Association of Social Work (1997) and the American Counseling Association (1998).

Bottling up HB 2451 would put the Majority Coalition Caucus on the wrong side of history.

Majority of States Are Blocking Bills That Seek to Ban Conversion Therapy for Gay

By Michael Gryboski , Christian Post Reporter
July 29, 2014|1:34 pm

While two states have successfully banned conversion therapy for gay youth, a majority of state lagislatures have voted down bills that would implement such bans after hearing the testimonies of ex-gays who say they've benefitted from sexual orientation change therapy.

Proposed bans similar to California's and New Jersey's laws prohibiting sexual orientation change therapy, or SOCE, for minors have been voted down or withdrawn in Virginia, Illinois, Maryland, Minnesota, New York, Washington, Ohio, Florida, Wisconsin, Hawaii and Rhode Island.

In states like Massachusetts and Vermont, measures to ban conversion therapy for LGBT youth have been referred to committees only to have months go by without further action.

Christopher Doyle, head of the ex-gay group Voice of the Voiceless, wrote about the 13 states that have defeated or have stalled approval of gay conversion therapy bans.

Doyle attributed the bills' defeats to ex-gays showing up and testifying in favor of SOCE.

"Simply put, when ex-gays show up and tell the truth about SOCE therapy, how it helped them, and in some cases, saved their lives, legislators have listened," wrote Doyle.

"Stated another way, gays cannot speak for ex-gays. This is what we have been trying to get across in our work."

In late 2012, California became the first state in the nation to ban conversion therapy for gay minors when Democrat Gov. Jerry Brown signed Senate Bill 1172 into law.

The following year, New Jersey Republican Gov. Chris Christie signed into law a similar measure known as Assembly bill 3371.

Both states were sued by the Liberty Counsel on behalf of conversion therapy practitioners. Thus far, the laws have survived constitutional muster.

Liberty Counsel appealed to the United States Supreme Court regarding the California law, but the Court declined to hear the appeal.

LGBT organizations hailed the Supreme Court's refusal to hear the appeal as a victory against SOCE.

Shannon Minter, legal director for the National Center for Lesbian Rights, said in a statement that the decision will help lead to other states adopting similar legislation.

"This life-saving law has cleared the final hurdle and will now protect California youth from harmful practices that have been rejected by all leading medical and mental health organizations," Minter claimed.

Several other legislators across the country have mulled measures to similarly regulate gay conversion therapy in their states.

None of them have seen the success that anti-therapy groups have had in California and New Jersey. However, the debates continue, with Washington D.C.'s city government having held a hearing on an SOCE therapy ban bill late last month.

"Close to 30 supporters and opponents of a bill that would ban licensed mental health providers from performing gay conversion therapy for minors gave strongly worded and sometimes emotional testimony," reported the Washington Blade.

"Eleven members of the 13-member council have signed on as co-sponsors of the bill, including council member Yvette Alexander, D-Ward 7, who chairs the Committee on Health that has jurisdiction over the measure."

Also called reparative therapy, SOCE therapy has been rejected by the American Psychiatric Association.

The following is included only as an "interesting read" depecting was has been written about conversion therapy and other gay history on Wikipedia as of 10/7/14. This presenter does not verify the accuracy of the following only that it was directly retrieved from Wikipedia.

Conversion Therapy also known as Reparative Therapy From: Wikipedia

Conversion therapy (also known as **reparative therapy**) is a range of treatments that aim to change sexual orientation from homosexual to heterosexual. Such treatments have been criticized for being pseudo-scientific.[1][2][3][4][5] Conversion therapy has been a source of controversy in the United States and other countries.[6] The American Psychiatric Association has condemned "psychiatric treatment, such as reparative or conversion therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual homosexual orientation."[7] It states that, "Ethical practitioners refrain from attempts to change individuals' sexual orientation."[8] It also states that political and moral debates over the integration of gays and lesbians into the mainstream of American society have obscured scientific data about changing sexual orientation "by calling into question the motives and even the character of individuals on both sides of the issue."[7]

The highest-profile contemporary advocates of conversion therapy tend to be fundamentalist Christian groups and other right-wing religious organizations [9] and the therapy is derided by critics as "pray the gay away". The main organization advocating secular forms of conversion therapy is the National Association for Research & Therapy of Homosexuality (NARTH), which often partners with religious groups.[9] Psychologist Douglas Haldeman writes that conversion therapy comprises efforts by mental health professionals and pastoral care providers to convert lesbians and gay men to heterosexuality by techniques including aversive treatments, such as "the application of electric shock to the hands and/or genitals," and "nausea-inducing drugs...administered simultaneously with the presentation of homoerotic stimuli," masturbatory reconditioning, visualization, social skills training, psychoanalytic therapy, and spiritual interventions, such as "prayer and group support and pressure."[10]

American medical and scientific organizations have expressed concern over conversion therapy and consider it potentially harmful.[7][11][12] The advancement of conversion therapy may cause social harm by disseminating inaccurate views about sexual orientation.[11]

The ethics guidelines of major mental health organizations in the United States vary from cautionary statements to recommendations that ethical practitioners refrain from practicing conversion therapy (American Psychiatric Association) or from referring patients to those who do (American Counseling Association).[7][13] In a letter dated February 23, 2011 to the Speaker of the U.S. House of Representatives, the Attorney General of the United States stated "while sexual orientation carries no visible badge, a growing scientific consensus accepts that sexual orientation is a characteristic that is immutable".[14]

In 2012, the Pan American Health Organization (the North and South American branch of the World Health Organization) released a statement cautioning against services that purport to "cure" people with non-heterosexual sexual orientations as they lack medical justification and represent a serious threat to the health and well-being of affected people, and noted that the global scientific and professional consensus is that homosexuality is a normal and natural variation of human sexuality and cannot be regarded as a pathological condition. The Pan American Health Organization further called on governments, academic institutions,

professional associations and the media to expose these practices and to promote respect for diversity. The World Health Organization affiliate further noted that gay minors have sometimes been forced to attend these "therapies" involuntarily, being deprived of their liberty and sometimes kept in isolation for several months, and that these findings were reported by several United Nations bodies. Additionally, the Pan American Health Organization recommended that such practices be denounced and subject to sanctions and penalties under national legislation, as they constitute a violation of the ethical principles of health care and violate human rights that are protected by international and regional agreements.[15]

History

The history of conversion therapy can be divided broadly into three periods: the early Freudian period; the period of mainstream approval of conversion therapy, when the mental health establishment became the "primary superintendent" of sexuality; and the post-Stonewall period where the mainstream medical profession disavowed conversion therapy.[9]

During the earliest parts of psychoanalytic history, analysts granted that homosexuality was non-pathological in certain cases, and the ethical question of whether it ought to be changed was discussed. By the 1920s psychoanalysts assumed that homosexuality was pathological and that attempts to treat it were appropriate, although psychoanalytic opinion about changing homosexuality was largely pessimistic. Those forms of homosexuality that were considered perversions were usually held to be uncurable. Psychoanalysts' tolerant statements about homosexuality arose from recognition of the difficulty of achieving change. Beginning in the 1930s and continuing for roughly twenty years, major changes occurred in how psychoanalysts viewed homosexuality, which involved a shift in the rhetoric of psychoanalysts, some of whom felt free to ridicule and abuse their gay patients.[16]

Europe

Sigmund Freud

Main article: Sigmund Freud's views on homosexuality
Freud (1856–1939) was skeptical of the possibility of therapeutic conversion.

Sigmund Freud was a physician and the founder of psychoanalysis. Freud stated that homosexuality could sometimes be removed through hypnotic suggestion,[17] and was influenced by Eugen Steinach, a Viennese endocrinologist who transplanted testicles from straight men into gay men in attempts to change their sexual orientation,[18] stating that his research had “thrown a strong light on the organic determinants of homo-eroticism”.[19] Freud cautioned that Steinach's operations would not necessarily make possible a therapy that could be generally applied, arguing that such transplant procedures would be effective in changing homosexuality in men only in cases in which it was strongly associated with physical characteristics typical of women, and that probably no similar therapy could be applied to lesbianism.[20][21] In fact Steinach’s method was doomed to failure because the immune system rejects transplanted glands, and was eventually exposed as ineffective and often harmful.[22]

Freud‘s main discussion of female homosexuality was the 1920 paper “The Psychogenesis of a Case of Homosexuality in a Woman“, which described his analysis of a young woman who had entered therapy because her parents were concerned that she was a lesbian. Her father wanted

this condition changed. In Freud‘s view, the prognosis was unfavourable because of the circumstances under which she entered therapy, and because homosexuality was not an illness or neurotic conflict. Freud wrote that changing homosexuality was difficult and possible only under unusually favourable conditions, observing that “in general to undertake to convert a fully developed homosexual into a heterosexual does not offer much more prospect of success than the reverse.”[23] Success meant making heterosexual feeling possible, not eliminating homosexual feelings.[24]

Gay people could seldom be convinced that heterosexual sex would provide them with the same pleasure they derived from homosexual sex. Patients often wanted to become heterosexual for reasons Freud considered superficial, including fear of social disapproval, an insufficient motive for change. Some might have no real desire to become heterosexual, seeking treatment only to convince themselves that they had done everything possible to change, leaving them free to return to homosexuality after the failure they expected. Freud therefore told the parents only that he was prepared to study their daughter to determine what effects therapy might have. He eventually broke off the treatment entirely because of what he saw as her hostility to men.[25][26][27]

In 1935, a mother asked Freud to treat her son. Freud replied in a letter that later became famous:[28]

"I gather from your letter that your son is a homosexual...it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by a certain arrest of sexual development. By asking me if I can help [your son], you mean, I suppose, if I can abolish homosexuality and make normal heterosexuality take its place. The answer is, in a general way we cannot promise to achieve it. In a certain number of cases we succeed in developing the blighted germs of heterosexual tendencies, which are present in every homosexual; in the majority of cases it is no more possible. It is a question of the quality and the age of the individual. The result of treatment cannot be predicted."[29]

Sándor Ferenczi

Sándor Ferenczi was an influential psychoanalyst. Native to Hungary, he wrote many of his works in German.

Ferenczi denied the importance of inherited factors on homosexuality, claiming that it was caused by “excessively powerful heterosexuality (intolerable to the ego)“. Ferenczi tried to distinguish between several different types of homosexuality, basing his distinctions on an unspecified number of patients whose analyses had sometimes lasted for a short period and sometimes “a whole year and even longer.” Ferenczi hoped to cure some kinds of homosexuality completely, but was content in practice with reducing what he considered gay men's hostility to women, along with the urgency of their homosexual desires, and with helping them to become attracted to and potent with women. In his view, a gay man who was confused about his sexual identity and felt himself to be “a woman with the wish to be loved by a man” was not a promising candidate for cure. Ferenczi believed that complete cures of homosexuality might become possible in the future when psychoanalytic technique had been improved. Sándor Radó and Melanie Klein were pupils of Ferenczi.[16][30][31]

Anna Freud

Daughter of Sigmund Freud, Anna Freud became an influential psychoanalytic theorist in the UK after she left Austria in 1938 to escape the Nazis.[32]

Anna Freud reported the successful treatment of homosexuals as neurotics in a series of unpublished lectures. In 1949 she published “Some Clinical Remarks Concerning the Treatment of Cases of Male Homosexuality” in the *International Journal of Psychoanalysis*. In her view, it was important to pay attention to the interaction of passive and active homosexual fantasies and strivings, the original interplay of which prevented adequate identification with the father. The patient should be told that his choice of a passive partner allows him to enjoy a passive or receptive mode, while his choice of an active partner allows him to recapture his lost masculinity. She claimed that these interpretations would reactivate repressed castration anxieties, and childhood narcissistic grandiosity and its complementary fear of dissolving into nothing during heterosexual intercourse would come with the renewal of heterosexual potency.[16]

Anna Freud in 1951 published “Clinical Observations on the Treatment of Male Homosexuality” in *The Psychoanalytic Quarterly* and “Homosexuality” in the *American Psychoanalytic Association Bulletin.* These articles insisted on the attainment of full object-love of the opposite sex as a requirement for cure of homosexuality. In 1951 she gave a lecture about treatment of homosexuality which was criticised by Edmund Bergler, who emphasised the oral fears of patients and minimized the importance of the phallic castration fears she had discussed.[16]

Anna Freud recommended in 1956 to a journalist who was preparing an article about psychoanalysis for the London *Observer* that she not quote Freud‘s letter to the American mother, on the grounds that “...nowadays we can cure many more homosexuals than was thought possible in the beginning. The other reason is that readers may take this as a confirmation that all analysis can do is to convince patients that their defects or ‘immoralities‘ do not matter and that they should be happy with them. That would be unfortunate.”[32]

Melanie Klein

The Austrian-born psychoanalyst Melanie Klein moved to London in 1926. Her seminal book *The Psycho-Analysis of Children*, based on lectures given to the British Psychoanalytic Society in the 1920s, was published in 1932. Klein claimed that entry into the Oedipus Complex is based on mastery of primitive anxiety from the oral and anal stages. If these tasks are not performed properly, developments in the Oedipal stage will be unstable. Complete analysis of patients with such unstable developments would require uncovering these early concerns. The analysis of homosexuality required dealing with paranoid trends based on the oral stage. *The Psycho-Analysis of Children* ends with the analysis of Mr. B., a gay man. Klein claimed that he illustrated pathologies that enter into all forms of homosexuality: a gay man idealizes “the good penis” of his partner to allay the fear of attack he feels due to having projected his paranoid hatred onto the imagined “bad penis“ of his mother as an infant. She stated that Mr. B.’s homosexual behaviour diminished after he overcame his need to adore the “good penis” of an idealized man. This was made possible by his recovering his belief in the good mother and his ability to sexually gratify her with his good penis and plentiful semen.[16]

Edmund Bergler

Edmund Bergler's first contribution to the psychoanalytic theory of homosexuality was "Der Mammakomplex des Mannes", an article co-authored with L. Eidelberg and published in the *Internationale Zeitschrift fuer Psychoanalyse* in 1933. It described a "breast complex" found in both normal and pathological conditions, among which Eidelberg and Bergler included "a type of homosexuality." The male child reacts violently to weaning, making unsuccessful attempts to inhibit his frustrated aggression that only heighten it. This causes ambivalent identifications, object choices, and narcissistic compensations. Cathexes are displaced from the breast onto the penis, and the infant substitutes urine for milk, attempting to make active what was once passive. He unsuccessfully tries to transfer hatred of the mother onto the father, but the Oedipus complex does not reach normal intensity because of the unresolved ambivalence of the oral period. The unstable organization achieved at the Oedipal period regresses to an earlier stage involving fixation on the oral mother, whose vagina is conflated with the infant's own cannibalistic mouth, transmuting it into the *vagina dentata*. This oral fixation leads to character traits such as spite and libido charged with aggression.[16]

United States

20th century

Psychoanalysis started to receive recognition in the United States in 1909, when Sigmund Freud delivered a series of lectures at Clark University in Massachusetts at the invitation of G. Stanley Hall.[33]

Abraham Brill in 1913 wrote "The Conception of Homosexuality", which he published in the *Journal of the American Medical Association* and read before the American Medical Association's annual meeting, where it was criticised by several doctors. Brill declared that after long study he had slowly overcome his disgust for homosexuality. He denied that homosexuality was influenced by inherited factors or necessarily related to emotional disturbance. Brill observed that it was impossible to use the term *homosexuality* diagnostically, since it could refer to several different entities. Brill asserted that the development of sexual attraction to the same sex was always related to narcissism, which he incorrectly defined as love for one's self. Brill criticised physical treatments for homosexuality such as bladder washing, rectal massage, and castration, along with hypnosis, but referred approvingly to Freud and Sadger's use of psychoanalysis, calling its results "very gratifying."[34] Since Brill understood curing homosexuality as restoring heterosexual potency, he claimed that he had cured his patients in several cases, even though many remained homosexual.[16][35]

Wilhelm Stekel, an Austrian, published his views on treatment of homosexuality, which he considered a disease, in the American *Psychoanalytic Review* in 1930. Stekel believed that "success was fairly certain" in changing homosexuality through psychoanalysis provided that it was performed correctly and the patient wanted to be treated. In 1932, the *Psychoanalytic Quarterly* published a translation of Helene Deutsch's paper "On Female Homosexuality". Deutsch reported her analysis of a lesbian, who did not become heterosexual as a result of treatment, but who managed to achieve a "positive libidinal relationship" with another woman. Deutsch indicated that she would have considered heterosexuality a better outcome.[35]

Edmund Bergler moved to the USA after vacating his post as psychoanalyst in Vienna in 1937.[36] He published "Preliminary Phases of the Masculine Beating Fantasy", a response to Freud's "A Child Is Being Beaten", in *Psychoanalytic Quarterly* in 1938. Bergler claimed to have detected the early phase of a beating fantasy in boys. This phase began with the weaning

shock, which mobilizes enormous sadistic rage against the breasts of the depriving phallic mother, which is an attempt at narcissistic restitution for the lost breasts of the mother. Due to guilt, this rage is transmuted into a masochistic fantasy of being beaten by the father, substituting the boy's own buttocks for the mother's breasts and idealizing the father out of hatred of the mother, thereby substituting a homosexual for a heterosexual bond. The paper shifted the important stage in the development of homosexual perversion back from the Oedipus complex to the oral stage, minimized the importance of object libido and emphasised more primitive narcissistic oral rage, and established that homosexual perversion could not be based on a primary homosexual attachment to the father, since there was always an earlier heterosexual attachment to the mother. The implication was that all outcomes of the Oedipus complex involving a passive homosexual stance toward the father are perverse.[16][30]

Bergler was the most important psychoanalytic theorist of homosexuality in the 1950s.[16] He was vociferous in his opposition to Alfred Kinsey, who argued that homosexuality was normal human variation. Bergler argued that Kinsey's statistical research overestimated the incidence of homosexuality because it was conducted in cities where perversion thrived. Bergler based his theories partly on analysis of the novels of literary figures known to be gay. Kinsey's work, and its reception, led Bergler to develop his own theories for treatment, which were essentially to 'blame the victim'.[36]

Bergler claimed that if gay people wanted to change, and the right therapeutic approach was taken, then they could be cured in 90% of cases.[37] Bergler used confrontational therapy in which gay people were punished in order to make them aware of their masochism. Bergler openly violated professional ethics to achieve this, breaking patient confidentiality in discussing the cases of patients with other patients, bullying them, calling them liars and telling them they were worthless.[36] He insisted that gay people could be cured, and that if they believed they should be accepted, they were asking for punishment, which confirmed their pathological immaturity. Bergler initially blamed those who mistreated gay people, because it provided a rationale for the masochistic view of the world; but, from the 1950s, and following the emergence of gay rights organisations, he began to blame homosexuals for their own oppression. Bergler confronted Kinsey because Kinsey thwarted the possibility of cure by presenting homosexuality as an acceptable way of life, which was the basis of the homosexual rights activism of the time.[36] Bergler popularised his views on homosexuality and its cure in the USA in the 1950s using magazine articles and books aimed at non-specialists.[36][38]

In 1951, the mother who wrote to Freud asking him to treat her son sent Freud's response to the *American Journal of Psychiatry*, in which it was published.[16] The 1952 first edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-I) classified homosexuality as a mental disorder.[39]

During the three decades between Freud's death in 1939 and the Stonewall riots in 1969, conversion therapy received approval from most of the psychiatric establishment in the United States.[40] Sandor Rado in 1940 criticized Freud's theory of innate bisexuality in his article "A Critical Examination of the Concept of Bisexuality". Rado concluded that pursuing the genital organs of the opposite sex is the standard form of achieving genital stimulation and that the main cause of homosexuality is anxiety, although he granted that "constitutional factors may have an influence on morbid sex developments."[41] Rado's article appears to have been partly motivated by the desire to combat homosexuality.[16][33]

The homosexuality as sickness theory started to come under criticism in the 1950s. Evelyn Hooker in 1957 published “The Adjustment of the Male Overt Homosexual”, which found that "homosexuals were not inherently abnormal and that there was no difference between homosexual and heterosexual men in terms of pathology."[42] This paper subsequently became influential.[43] Irving Bieber and his colleagues in 1962 published *Homosexuality: A Psychoanalytic Study of Male Homosexuals*, which concluded that "although this change may be more easily accomplished by some than by others, in our judgment a heterosexual shift is a possibility for all homosexuals who are strongly motivated to change."[44] The same year, Albert Ellis published *Reason and Emotion in Psychotherapy*, which claimed that "fixed homosexuals in our society are almost invariably neurotic or psychotic:... therefore, no so-called *normal* group of homosexuals is to be found anywhere."[45] Ellis published his main work on homosexuality, *Homosexuality: Its Causes and Cure*, in 1965.[46]

Charles W. Socarides, M.D.

Charles Socarides’s first book, *The Overt Homosexual*, was published in 1968. Socarides regarded homosexuality as an illness arising from a conflict between the id and the ego usually arising from an early age in "a female-dominated environment wherein the father was absent, weak, detached or sadistic". He credited the earlier work of Irving Bieber with clarifying progress in therapeutic knowledge and effectivenes.[47]

There was a riot in 1969 at the Stonewall Bar in New York after a police raid. The Stonewall riot acquired symbolic significance for the gay rights movement and came to be seen as the opening of a new phase in the struggle for gay liberation. Following these events, conversion therapy came under increasing attack. Activism against conversion therapy increasingly focused on the DSM's designation of homosexuality as a psychopathology.[39]

Lawrence Hatterer in 1970 published *Changing Homosexuality in the Male*, which advocated a therapy based on simplified psychoanalytic ideas and behavior modification techniques.[16]

In 1973, after years of criticism from gay activists and bitter dispute among psychiatrists, the American Psychiatric Association removed homosexuality as a mental disorder from the *Diagnostic and Statistical Manual of Mental Disorders*. Supporters of the change used evidence from researchers such as Alfred Kinsey and Evelyn Hooker. Psychiatrist Robert Spitzer, a member of the APA's Committee on Nomenclature, played an important role in the events that lead to this decision. Critics argued that it was a result of pressure from gay activists, and demanded a referendum among voting members of the Association. The referendum was held in 1974 and the APA’s decision was upheld by a 58% majority.[39]

Books promoting new forms of conversion therapy were published in the 1980s. Robert Kronemeyer in 1980 published *Overcoming Homosexuality*,[48] while research psychologist Elizabeth Moberly in 1983 published *Homosexuality: A New Christian Ethic*.[49]

The APA removed ego-dystonic homosexuality from the DSM-III-R in 1987 and opposes the diagnosis of either homosexuality or ego-dystonic homosexuality as any type of disorder.[50]

Joseph Nicolosi began playing an important role in the development of conversion therapy in the early 1990s, publishing his first book *Reparative Therapy of Male Homosexuality* in 1991.[51] In 1992, Joseph Nicolosi, Charles Socarides, and Benjamin Kaufman founded the National

Association for Research & Therapy of Homosexuality (NARTH), a mental health organization that opposes the mainstream medical view of homosexuality and aims to "make effective psychological therapy available to all homosexual men and women who seek change."[52] Former American Psychological Association President Dr. Nicholas Cummings was the Keynote Speaker at the 2011 NARTH Conference and said that he had a "high regard" for NARTH and considered it an honor to be invited to speak at NARTH's scientific gathering.[53]

21st century

United States Surgeon General David Satcher in 2001 issued a report stating that "there is no valid scientific evidence that sexual orientation can be changed".[54] The same year, a study by Robert Spitzer concluded that some highly motivated individuals whose orientation is predominantly homosexual can become predominantly heterosexual with some form of reparative therapy.[55] Spitzer based his findings on structured interviews with 200 self-selected individuals (143 males, 57 females). He told *The Washington Post* that the study "shows some people can change from gay to straight, and we ought to acknowledge that."[56] Spitzer's study caused controversy and attracted media attention.[6] Spitzer recanted his study in 2012,[57] and apologized to the gay community for making unproven claims of the efficacy of reparative therapy,[58] calling it his only professional regret.[59]

The American Psychoanalytic Association (APsaA) spoke against NARTH in 2004, stating "that organization does not adhere to our policy of nondiscrimination and ... their activities are demeaning to our members who are gay and lesbian."[60] NARTH believes that it is discriminatory and unethical to ignore the needs and goals of people who do not wish to be gay.[61] In 2006, Focus on the Family and several other organizations announced that they would protest the American Psychological Association's convention in New Orleans. Mike Haley, the director of gender issues for Focus on the Family, commented that, "The APA's views on issues such as the immutability of homosexuality have caused real harm to real people and patients."[62] The same year, a survey of members of the American Psychological Association rated reparative therapy as "certainly discredited", though the authors warn that the results should be interpreted carefully as an initial step, not a final word.[63]

The American Psychological Association in 2007 convened a task force to evaluate its policies regarding reparative therapy. Ex-gay organizations expressed concerns about the lack of representation of pro-reparative-therapy perspectives on the task force, while alleging that anti-reparative-therapy perspectives were amply represented.[64]

In 2008, the organizers of an APA panel on the relationship between religion and homosexuality canceled the event after gay activists objected that "conversion therapists and their supporters on the religious right use these appearances as a public relations event to try and legitimize what they do."[65][66]

In 2009, American Psychological Association stated that it "encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation and concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation".[67]

Theories and techniques

Behavioral modification

Main article: Behavior modification

Douglas Haldeman writes in "Sexual Orientation Conversion Therapy for Gay Men and Lesbians: A Scientific Examination" that early behavioral forms of conversion therapy mainly employed aversive conditioning techniques, involving electric shock and nausea-inducing drugs during presentation of same-sex erotic images. Cessation of the aversive stimuli was typically accompanied by the presentation of opposite-sex erotic images, with the objective of strengthening heterosexual feelings. Haldeman discusses the work of M. P. Feldman, who in "Aversion therapy for sexual deviation: a critical review", published in 1966, claimed a 58% cure rate. Haldeman is skeptical that such stressful methods permit feelings of sexual responsiveness, and notes that Feldman defined success as suppression of homosexuality and increased capacity for heterosexual behavior.[68]

Haldeman also discusses the covert sensitization method, which involves instructing patients to imagine vomiting or receiving electric shocks, writing that only single case studies have been conducted, and that their results cannot be generalized. He writes that behavioral conditioning studies tend to decrease homosexual feelings, but do not increase heterosexual feelings, citing Rangaswami's "Difficulties in arousing and increasing heterosexual responsiveness in a homosexual: A case report", published in 1982, as typical in this respect.[69]

Haldeman concludes that such methods applied to anyone except gay people would be called torture, writing, "Individuals undergoing such treatments do not emerge heterosexually inclined; rather they become shamed, conflicted, and fearful about their homosexual feelings."[70]

Haldeman writes in "Gay Rights, Patient Rights: The Implications of Sexual Orientation Conversion Therapy" that aversive treatments sometimes involved the application of electric shock to the hands and/or genitals, or nausea-inducing drugs, administered simultaneously with the presentation of homoerotic stimuli, while less cruel methods included masturbatory reconditioning, visualization, and social skills training. All of these methods were based on the idea that homosexuality is a learned behavior that can be reconditioned.[10]

Ex-gay ministry

Main article: Ex-gay

Some sources describe ex-gay ministries as a form of conversion therapy, while others state that ex-gay organizations and conversion therapy are distinct methods of attempting to convert gay people to heterosexuality.[6][11][71][72] Ex-gay ministries have also been called transformational ministries.[11] Some state that they do not conduct clinical treatment of any kind.[73] Exodus International once believed reparative therapy could be a beneficial tool,[73] but ceased activities in June 2013, issuing a statement which repudiated its aims and apologized for the harm their pursuit has caused to LGBT people.[74] Evergreen International has stated that it is unlikely therapy can erase all homosexual feelings,[75] and does not advocate any particular form of therapy. In January 2014 Evergreen International announced it would be subsumed into North Star which does not emphasize changing sexual orientation.[76]

Psychoanalysis

Main article: Psychoanalysis

Douglas Haldeman writes that psychoanalytic treatment of homosexuality is exemplified by the work of Irving Bieber and his colleagues in *Homosexuality: A Psychoanalytic Study of Male Homosexuals*. They advocated long-term therapy aimed at resolving the unconscious childhood conflicts that they considered responsible for homosexuality. Haldeman notes that Bieber's methodology has been criticized because it relied upon a clinical sample, the description of the outcomes was based upon subjective therapist impression, and follow-up date were poorly presented. Bieber reported a 27% success rate from long-term therapy, but only 18% of the patients in whom Bieber considered the treatment successful had been exclusively homosexual to begin with, while 50% had been bisexual. In Haldeman's view, this makes even Bieber's unimpressive claims of success misleading.[77]

Haldeman discusses other psychoanalytic studies of attempts to change homosexuality. Curran and Parr's "Homosexuality: An analysis of 100 male cases", published in 1957, reported no significant increase in heterosexual behavior. Mayerson and Lief's "Psychotherapy of homosexuals: A follow-up study of nineteen cases", published in 1965, reported that half of its 19 subjects were exclusively heterosexual in behavior four and a half years after treatment, but its outcomes were based on patient self-report and had no external validation. In Haldeman's view, those participants in the study who reported change were bisexual at the outset, and its authors wrongly interpreted capacity for heterosexual sex as change of sexual orientation.[78]

Reparative therapy

Reparative therapy has been used as a synonym for conversion therapy generally, but Jack Drescher has argued that strictly speaking it refers to a specific kind of therapy associated with Elizabeth Moberly and Joseph Nicolosi.[79] Joseph Nicolosi's *Reparative Therapy of Male Homosexuality*, published in 1991, introduced *reparative therapy* as a term for psychotherapeutic attempts to convert gay people to heterosexuality.[51]

Douglas C. Haldeman writes that Nicolosi promotes psychoanalytic theories suggesting that homosexuality is a form of arrested psychosexual development, resulting from "an incomplete bond and resultant identification with the same-sex parent, which is then symbolically repaired in psychotherapy".[10] Nicolosi's intervention plans involve conditioning a man to a traditional masculine gender role. He should "(1) participate in sports activities, (2) avoid activities considered of interest to homosexuals, such [as] art museums, opera, symphonies, (3) avoid women unless it is for romantic contact, (4) increase time spent with heterosexual men in order to learn to mimic heterosexual male ways of walking, talking, and interacting with other heterosexual men, (5) Attend church and join a men's church group, (6) attend reparative therapy group to discuss progress, or slips back into homosexuality, (7) become more assertive with women through flirting and dating, (8) begin heterosexual dating, (9) engage in heterosexual intercourse, (10) enter into heterosexual marriage, and (11) father children".[80]

Most mental health professionals consider reparative therapy discredited, but it is still practiced by some.[9]

Psychoanalysts critical of Nicolosi's theories have offered gay-affirmative approaches as an alternative to reparative therapy.[79][81] Exodus International regarded reparative therapy as a useful tool to eliminate "unwanted same-sex attraction"[82] but ceased activities in June 2013 and issued a statement repudiating its aims and apologizing for the harm the organization had caused to LGBT people.[74]

Sex therapy

Main article: Masters and Johnson

Douglas Haldeman has described William Masters' and Virginia Johnson's work on sexual orientation change as a form of conversion therapy.[83]

In *Homosexuality in Perspective*, published in 1979, Masters and Johnson viewed homosexuality as the result of blocks that prevented the learning that facilitated heterosexual responsiveness, and described a study of 54 gay men who were dissatisfied with their sexual orientation. The original study did not describe the treatment methodology used, but this was published five years later. John C. Gonsiorek criticized their study on several grounds in 1981, pointing out that while Masters and Johnson stated that their patients were screened for major psychopathology or severe neurosis, they did not explain how this screening was performed, or how the motivation of the patients to change was assessed. Nineteen of their subjects were described as uncooperative during therapy and refused to participate in a follow-up assessment, but all of them were assumed without justification to have successfully changed.[84]

Douglas Haldeman writes that Masters and Johnson's study was founded upon heterosexist bias, and that it would be tremendously difficult to replicate. In his view, the distinction Masters and Johnson made between "conversion" (helping gay men with no previous heterosexual experience to learn heterosexual sex) and "reversion" (directing men with some previous heterosexual experience back to heterosexuality) was not well founded. Many of the subjects Masters and Johnson labelled homosexual may not have been homosexual, since, of their participants, only 17% identified themselves as exclusively homosexual, while 83% were in the predominantly heterosexual to bisexual range. Haldeman observed that since 30% of the sample was lost to the follow-up, it is possible that the outcome sample did not include any people attracted mainly or exclusively to the same sex. Haldeman concludes that it is likely that, rather than converting or reverting gay people to heterosexuality, Masters and Johnson only strengthened heterosexual responsiveness in people who were already bisexual.[*citation needed*]

Studies of conversion therapy

Can Some Gay Men and Lesbians Change Their Sexual Orientation?

In May 2001, Robert Spitzer presented *Can Some Gay Men and Lesbians Change Their Sexual Orientation?* 200 Participants Reporting a Change from Homosexual to Heterosexual Orientation", a study of attempts to change homosexual orientation through ex-gay ministries and conversion therapy, at the American Psychiatric Association's convention in New Orleans. The study was partly a response to the APA's 2000 statement cautioning against clinical attempts at changing homosexuality, and was aimed at determining whether such attempts were ever successful rather than how likely it was that change would occur for any given individual. Spitzer wrote that some earlier studies provided evidence for the effectiveness of

therapy in changing sexual orientation, but that all of them suffered from methodological problems.[6]

He reported that after intervention, 66% of the men and 44% of the women had achieved "Good Heterosexual Functioning", which he defined as requiring five criteria (being in a loving heterosexual relationship during the last year, overall satisfaction in emotional relationship with a partner, having heterosexual sex with the partner at least a few times a month, achieving physical satisfaction through heterosexual sex, and not thinking about having homosexual sex more than 15% of the time while having heterosexual sex). He found that the most common reasons for seeking change were lack of emotional satisfaction from gay life, conflict between same-sex feelings and behavior and religious beliefs, and desire to marry or remain married.[6][85] This paper was widely reported in the international media and taken up by politicians in the United States, Germany, and Finland, and by conversion therapists.[6]

In 2003, Spitzer published the paper in the Archives of Sexual Behavior. Spitzer's study has been criticized on numerous ethical and methodological grounds, and "press releases from both NGLTF and HRC sought to undermine Spitzer's credibility by connecting him politically to right-wing groups that had backed the ex-gay movement."[86] Gay activists argued that the study would be used by conservatives to undermine gay rights.[6] Spitzer acknowledged that the study sample consisted of people who sought treatment primarily because of their religious beliefs (93% of the sample), served in various church-related functions, and who publicly spoke in favor of changing homosexual orientation (78%), and thus were strongly motivated to overreport success. Critics felt he dismissed this source of bias, without even attempting to measure deception or self-deception (a standard practice in self-reporting psychological tests like MMPI-2).[87] That participants had to rely upon their memories of what their feelings were before treatment may have distorted the findings. It was impossible to determine whether any change that occurred was due to the treatment because it was not clear what it involved and there was no control group.[6] Spitzer's own data showed that claims of change were reflected mostly in changes in self-labelling and behavior, less in attractions, and least in the homoerotic content during the masturbatory fantasies; this particular finding was consistent with other studies in this area.[88] Participants may have been bisexual before treatment. Follow-up studies were not conducted.[6] Spitzer stressed the limitations of his study. Spitzer said that the number of gay people who could successfully become heterosexual was likely to be "pretty low",[89] and conceded that his subjects were "unusually religious."[90]

Spitzer renounced[91][92] and retracted his own study in 2012, stating "I was quite wrong in the conclusions that I made from this study. The study does not provide evidence, really, that gays can change. And that's quite an admission on my part."[57][93][94][95] He also apologized to the gay community for making unproven claims of the efficacy of reparative therapy,[58] calling it his only professional regret.[59] Spitzer has requested that all "ex-gay" therapy organizations such as NARTH, PFOX, American College of Pediatricians, and Focus on the Family stop citing his study as evidence for conversion therapy.[95]

Changing Sexual Orientation: A Consumer's Report

Ariel Shidlo and Michael Schroeder found in "Changing Sexual Orientation: A Consumer's Report", a peer-reviewed study of 202 respondents[96] published in 2002, that 88% of participants failed to achieve a sustained change in their sexual behavior and 3% reported changing their orientation to heterosexual. The remainder reported either losing all sexual drive or attempting to remain celibate, with no change in attraction. Some of the participants who

failed felt a sense of shame and had gone through conversion therapy programs for many years. Others who failed believed that therapy was worthwhile and valuable. Shidlo and Schroeder also reported that many respondents were harmed by the attempt to change, causing; depression, suicidal ideation and attempts, hypervigilance of gender-deviant mannerisms,social isolation, fear of being a child abuser and poor self-esteem. Of the 8 respondents (out of a sample of 202) who reported a change in sexual orientation, 7 worked as ex-gay counselors or group leaders.[97] NARTH states that the Shidlo study has often been used by gay activists as "proof" that conversion therapy is on average harmful, but they advertised for study participants with an ad that said, "Help Us Document the Harm".[61] The Shidlo-Schroeder recruitment poster is available at NARTH online,[98] stating that the study's authors did not seek to measure the average outcome of conversion therapy, although their study has often been used by activists as if it had, in fact, sought a representative sample; the lack of a representative sample therefore means that the 80% failure rate, cited above in this same paragraph, should be taken with caution. The study does show however that qualitatively conversion therapy can cause significant harm.

Ethical Issues in Attempts to Ban Reorientation Therapies

Mark Yarhouse and Warren Throckmorton, of the private Christian school Grove City College, in 2002 published "Ethical Issues in Attempts to Ban Reorientation Therapies", which argues that conversion therapy should be available out of respect for a patient’s values system and because there is evidence that it can be effective. They state that studies from the 1950s–1980s generally reported rates of positive outcomes at about 30%, with more recent survey research generally consistent with the extant data. Their paper was partly a response to Jack Drescher's 2001 paper, "Ethical issues surrounding attempts to change sexual orientation", which used the principle of "Do no harm" to argue against conversion therapy.[99]

Medical, scientific and legal views

Further information: Biology and sexual orientation, Environment and sexual orientation, sexual orientation and medicine and homosexuality and psychology

United States

National health organizations in the United States have announced that there has been no scientific demonstration of conversion therapy's efficacy in the last forty years.[4][11][100][101] They find that conversion therapy is ineffective, risky and can be harmful. Anecdotal claims of cures are counterbalanced by assertions of harm, and the American Psychiatric Association, for example, cautions ethical practitioners under the Hippocratic oath to do no harm to refrain from attempts at conversion therapy.[100] Mainstream medical bodies state that conversion therapy can be harmful because it may exploit guilt and anxiety, thereby damaging self-esteem and leading to depression and even suicide.[102] There is also concern in the mental health community that the advancement of conversion therapy can cause social harm by disseminating inaccurate views about sexual orientation and the ability of gay and bisexual people to lead happy, healthy lives.[11]

Mainstream health organizations critical of conversion therapy include the American Medical Association,[103] American Psychiatric Association, the American Psychological Association, the American Association for Marriage and Family Therapy, the American Counseling Association,

the National Association of Social Workers, the American Academy of Pediatrics, the National Association of School Psychologists, and the American Academy of Physician Assistants.[11][104][105]

The American Psychological Association undertook a study of the peer-reviewed literature in the area of sexual orientation change efforts (SOCE) and found a myriad of issues with the procedures used in conducting the research. The taskforce did find that that some participants experienced a lessening of same sex attraction and arousal, but that these instances were "rare" and "uncommon." The taskforce concluded that, "given the limited amount of methodically sound research, claims that recent SOCE is effective are not supported.[106] Two issues with SOCE claims are that conversion therapists falsely assume that homosexuality is a mental disorder and that their research focuses almost exclusively on gay men and rarely includes lesbians.[11][80][90][107][108]

Self-determination

The American Psychological Association's code of conduct states: "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination," but also: "Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making."[109] The American Counseling Association says that "it is of primary importance to respect a client's autonomy to request a referral for a service not offered by a counselor."[13] No one should be forced to attempt to change their sexual orientation against their will, including children being forced by their parents.[110]

Supporters of SOCE focus on patient self-determination when discussing whether therapy should be available. Mark Yarhouse, of Pat Robertson's Regent University, wrote that "psychologists have an ethical responsibility to allow individuals to pursue treatment aimed at curbing experiences of same-sex attraction or modifying same-sex behaviors, not only because it affirms the client's rights to dignity, autonomy, and agency, as persons presumed capable of freely choosing among treatment modalities and behavior, but also because it demonstrates regard for diversity."[111] Yarhouse and Throckmorton, of the private Christian school Grove City College, argue that the procedure should be available out of respect for a patient’s values system and because they find evidence that it can be effective.[99] Douglas Haldeman similarly argues for a client's right to access to therapy if requested from a fully informed position: "For some, religious identity is so important that it is more realistic to consider changing sexual orientation than abandoning one's religion of origin... and if there are those who seek to resolve the conflict between sexual orientation and spirituality with conversion therapy, they must not be discouraged."[10]

In response to Yarhouse's paper, Jack Drescher argued that "any putative ethical obligation to refer a patient for reparative therapy is outweighed by a stronger ethical obligation to keep patients away from mental health practitioners who engage in questionable clinical practices."[112] Chuck Bright wrote that refusing to endorse a procedure that "has been deemed unethical and potentially harmful by most medical and nearly every professional psychotherapy regulating body cannot be justifiably identified as prohibiting client self-determination."[80] Some commentators, recommending a hard stand against the practice, have found therapy inconsistent with a psychologist's ethical duties because "it is more ethical to let a client continue to struggle honestly with her or his identity than to collude, even peripherally, with a practice that is discriminatory, oppressive, and ultimately ineffective in its own stated ends."[113]

They argue that clients who request it do so out of social pressure and internalized homophobia, pointing to evidence that rates of depression, anxiety, alcohol and drug abuse and suicidal feelings are roughly doubled in those who undergo therapy.[97]

Douglas Haldeman wrote:

However this distinction between religious identity and sexual orientation may be viewed, psychology does not have the right to interfere with individuals' rights to seek the treatments they choose. This is why the mental health organizations have adopted advisory policies about conversion therapy that affirm the right of LGB clients to unbiased treatment in psychotherapy and that reject treatments based upon the premise that homosexuality is a treatable mental disorder. They do not, however, ban the practice of conversion therapy outright out of concern for the individual whose personal spiritual or religious concerns may assume priority over his sexual orientation.[10]

Ethics guidelines

In 1998, the American Psychiatric Association issued a statement opposing any treatment which is based upon the assumption that homosexuality is a mental disorder or that a person should change their orientation, but did not have a formal position on other treatments that attempt to change a person's sexual orientation. In 2000, they augmented that statement by saying that as a general principle, a therapist should not determine the goal of treatment, but recommends that ethical practitioners refrain from attempts to change clients' sexual orientation until more research is available.[7]

The American Counseling Association has stated that they do not condone any training to educate and prepare a counselor to practice conversion therapy. Counselors who do offer training in conversion therapy must inform students that the techniques are unproven. They suggest counselors do not refer clients to a conversion therapist or to proceed cautiously once they know the counselor fully informs clients of the unproven nature of the treatment and the potential risks. However, "it is of primary importance to respect a client's autonomy to request a referral for a service not offered by a counselor." A counselor performing conversion therapy must provide complete information about the treatment, offer referrals to gay-affirmative counselors, discuss the right of clients, understand the client's request within a cultural context, and only practice within their level of expertise.[13]

NARTH states that refusing to offer therapy aimed at change to a client who requests it, and telling them that their only option is to claim a gay identity, could also be considered ethically unacceptable.[114]

International medical views

See also: LGBT rights in the United Kingdom

The World Health Organization's ICD-10, which along with the DSM-IV is widely used internationally, states that "sexual orientation by itself is not to be regarded as a disorder". It lists ego-dystonic sexual orientation as a disorder instead, which it defines as occurring where "the gender identity or sexual preference (heterosexual, homosexual, bisexual, or prepubertal) is not

in doubt, but the individual wishes it were different because of associated psychological and behavioural disorders, and may seek treatment in order to change it."[115]

The development of theoretical models of sexual orientation in countries outside the United States that have established mental health professions often follows the history within the U.S. (although often at a slower pace), shifting from pathological to non-pathological conceptions of homosexuality.[116][*need quotation to verify*]

Legal views

For the legal status of conversion therapy and other sexual orientation change efforts, see Sexual orientation change efforts#Legal status.

In a 1997 U.S. case, the Ninth Circuit addressed conversion therapy in the context of an asylum application. A Russian citizen "had been apprehended by the Russian militia, registered at a clinic as a 'suspected lesbian,' and forced to undergo treatment for lesbianism, such as 'sedative drugs' and hypnosis.... The Ninth Circuit held that the conversion treatments to which Pitcherskaia had been subjected constituted mental and physical torture. The court rejected the argument that the treatments to which Pitcherskaia had been subjected did not constitute persecution because they had been intended to help her, not harm her, and stated "human rights laws cannot be sidestepped by simply couching actions that torture mentally or physically in benevolent terms such as 'curing' or 'treating' the victims."[117]

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