

Conversion Therapy versus Gay-affirmative Therapy:  
Working with Ego-dissonant Gay Clients

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Working with Ego-dissonant Gay Clients

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**ATTESTATION OF AUTHORSHIP**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the reward of any other degree or diploma of a university or other institution of higher learning.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Andrew David Kirby 22<sup>nd</sup> February 2008

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## **ABSTRACT**

This dissertation explores the issue of doing psychotherapy with ego-dissonant gay male clients. The methodology used is a modified systematic literature review with clinical illustrations. A dichotomy exists in the literature in relation to treating ego-dissonant gay clients who experience conflict between their sexuality and opposing values and beliefs. Each position tends to respond with a limited, exclusionary choice to either reject or accept one's sexual orientation. This dissertation examines if there is a way to treat ego-dissonant clients without endorsing homophobic treatments or negating opposing values and beliefs. Freud's views on homosexuality and sexual reorientation are delineated to inform and contextualise later writings on the subject. A review of conversion therapy and gay-affirmative therapy investigates the evidence of each, following which emerging integrative solutions are examined. Finally, a Kleinian model is proposed for individuals where neither a choice of a side nor comfortable resolution of the conflict seems feasible. While it is proposed that gay-affirmative therapy benefits the majority of ego-dissonant gay clients, this study recognises that each psychotherapeutic paradigm discussed caters, to some degree, to the uniquely different needs of individuals.

## **CHAPTER ONE**

### **INTRODUCTION**

This study explores the issue of working with ego-dissonant gay male clients. In clinical practice I see many individuals who seek help in exploring aspects of their sexuality. The environment I work in adopts a gay-affirmative philosophy that disavows treatments based upon therapeutic modifications of sexual orientation, and views homosexuality as a normal variation of human sexuality.

While some gay individuals experience relatively little conflict over their sexuality, others experience a host of problems resulting from an inability to resolve perceived irreconcilable differences between personal values and sexual feelings. For these individuals, same-sex attraction is experienced as confusing or unwanted and can stem from holding traditional values regarding marriage and family, or religious beliefs that view homosexuality as unnatural and immoral. These conflicts are not restricted solely to individuals who are in the initial stages of the 'coming-out' process, but can also affect those who openly acknowledge their same-sex attraction and identify as gay.

Therapy, guided by a gay-affirmative approach that tackles biased socialisation and internalised homophobia, may assist conflicted gay clients to achieve a sense of self-acceptance and pride. Yet there are a few whose dissonance is so persistent and fundamental that it causes them to consider sexual reorientation as a plausible resolution to their distress. At such times, the very professionals they turn to for assistance can also be in conflict over how to best help (Throckmorton & Yarhouse, 2006). It is one such encounter that elicited my research topic.

### **Client introduction**

Matt (pseudonym) is a confident, attractive gay man in his mid-thirties who was raised in a conservative Christian home. He recalls having always been attracted to men rather than women and 'came out' to his parents in his early twenties. Despite some sadness that he had disappointed his parents by being gay, Matt has generally felt loved and supported by his family. After several short-term relationships, Matt settled into a happy, long-term relationship of 10 years with another man. Matt enjoys an accomplished career and has a close circle of friends both in and out of the gay community. On entering therapy Matt described a conflict between his homosexuality and a desire to have children of his own. This, combined with his Christian faith that does not support same-sex attraction, created an underlying gnawing angst that often made him question his gay identity and lifestyle.

*C1: I realise on the one hand that this is who I am, and I love Luke. If I just think of that, I'm fine. But, then the whole doubt thing creeps in.*

*T1: Doubt?*

*C2: Like maybe I've got it wrong. Maybe, I'm just convincing myself I'm happy, and I can change.*

*T2: You're being pulled in two opposite directions.*

*C3: More like torn apart – like these two parts of my life just can't go together.*

Despite sensitive inquiry and exploration into possible determinants stopping Matt from achieving a sense of self-cohesion and identity integration (i.e. biased socialisation and condemnatory religious convictions), his dissonance persisted. Even with insight into how formative influences contributed to his core belief system and values, he remained unresponsive to a gay-affirmative approach. It seemed that where Matt was experiencing a powerful conflict, simply adding weight to one side (i.e. gay-affirmative therapy) only served to activate the opposing side and increase his level of distress.

## **Research topic**

My experiences with Matt caused me to wonder whether certain conflicted gay clients might not benefit (initially or at all) from gay-affirmative therapy.<sup>1</sup> In examining the problems that beset people who struggle with their sexual orientation, I wondered if it was right to assume that the only way to alleviate their distress was to work towards individuals accepting their homosexuality. Should therapists<sup>2</sup> automatically view such clients as only suffering from internalised homophobia and heterosexism,<sup>3</sup> and thereby downplay or override personal values, attitudes, and/or religious beliefs? Is there a way to treat such a client without either endorsing homophobic treatments or negating opposing values and beliefs? If so, how does the therapist respect these two seemingly conflicting expressions of the client's identity as legitimate aspects of diversity? It is these questions this dissertation attempts to address.

Reading the literature regarding individuals who struggle to accept their same-sex attraction, I discovered a clear split between two therapeutic approaches for those who experience their homosexuality as ego-dissonant, both offering a 'cure.' Each position tends to respond with a limited, exclusionary choice to be either an 'out' gay or an 'ex' gay; to accept or reject one's sexual orientation. On the one hand, there are those who argue that some variety of treatment – whether formal conversion therapy conducted by a professional practitioner or a self-help 'ex-gay' group – should be available for those who experience their same-sex attractions as incompatible with competing values or beliefs (Throckmorton, 2002; Yarhouse & Burkett, 2002).

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<sup>1</sup> In this study 'gay-affirmative therapy' refers to a conventional left-wing approach - also known as 'pink therapy' (Davies & Neal, 1996b), which established itself in the 1970s in reaction to pathologically held views of homosexuality at the time.

<sup>2</sup> The words 'therapist' and 'analyst' are used interchangeably in this study, as are the words 'patient', 'analysand', and 'client'. This reflects the different terminology used by different authors.

<sup>3</sup> Heterosexism is an ideology that includes the cultural assumption that all people are or would want to be heterosexual (Chernin & Johnson, 2003).

On the other hand, proponents of gay-affirmative therapy consider antigay social stigma and internalised homophobia, not sexual orientation, as the primary motivator of those seeking to change their sexual orientation. These authors (e.g., Liddle, 1996; Schidlo & Schroeder, 2002) question the justification and ethicality of sexual reorientation when homosexuality is no longer considered a mental illness and highlight the potential harms to those who attempt conversion therapy.

These dichotomised treatment options may not serve all clients who seek help in dealing with conflicts regarding sexual orientation. According to Meyer (1995), many such individuals, like Matt, end up in therapy embroiled in attempts to resolve their internal dissonance that causes distress and prevents them from achieving emotional congruency and identity cohesion.

### **Aim of research**

This research examines two contrasting psychotherapies – conversion therapy and gay-affirmative therapy – in relation to working with ego-dissonant gay male clients. I have chosen these modalities for two reasons. First, they both exist as current treatment options, and second, each has positive aspects that recognise something essential to the client: the endorsement of personal beliefs/values and sexuality respectively. Although a strong psychoanalytic thread runs through this dissertation, I also consider behavioural, cognitive, group, and religious treatment approaches. Finally, considerations are given as to whether or not it is possible, or even appropriate, to depolarise the present debate and how current research outcomes might best inform clinical practice in working with ego-dissonant gay clients.

### ***Definition of the term 'ego-dissonant'***

Throughout this dissertation I refer to the term *ego-dissonant* to describe individuals who struggle to integrate their same-sex attraction with competing aspects of their identity. Dissonance stems from the words 'dis' meaning 'lack of' or 'apart', and the Latin '*sonans*' meaning 'sound' or 'accord'. Together they describe a 'discord' or 'lack of agreement or consistency' with the ego or conscious 'I' (Harper, 2001).

Ego-dissonant homosexuality primarily refers to conflicts experienced by individuals who identify as homosexual, but the term is used interchangeably and may also apply to those who identify as bisexual or as predominantly heterosexual but who engage in sex with other men.

### **Organisation of the dissertation**

This chapter has served to introduce the research topic, following which Chapter Two describes the methodology used in this study. Chapter Three explores Freud's original thinking on homosexuality and sexual reorientation to inform and contextualise later writings on the subject. Chapter Four outlines the origins and concepts of conversion therapy from early psychoanalytic thinking to contemporary practice. Different theoretical approaches and supporting research are discussed. Chapter Five delineates the theory and practice of gay-affirmative therapy, examining the developing relationship between the mental health profession and homosexuality. Different theoretical underpinnings to this relatively new approach are discussed and evaluated in relation to relevant research. In Chapter Six, comparisons and common themes from both sides are elucidated, gaps identified, and emerging integrative solutions are examined. A Kleinian perspective is proposed for individuals for whom none of the aforementioned approaches are appropriate. Chapter Seven concludes with a synthesis of consecutive findings from previous chapters and implications for practice are commented upon.

## CHAPTER TWO

### METHOD

This dissertation uses a modified systematic literature review to investigate views on conversion therapy versus gay-affirmative therapy and working with ego-dissonant gay clients. In this chapter I briefly describe the nature of a systematic review and its location within evidence-based practice and psychotherapy. In addition, methods for defining the topic, search strategies, and selection, appraisal and synthesis of the literature are delineated.

#### **The systematic review in evidence-based practice**

A chasm often exists between academic research and psychotherapy due to evidence-based practices originating from a positivist tradition, while many psychotherapeutic modalities align themselves with the interpretive paradigm or hermeneutics (Milton, 2002). Goodheart (2004) claims research is a necessary part of psychotherapy, one that enlightens practice about epidemiology and degree of response to treatment; however, it is not *all* of psychotherapy and therefore “may never be able to technologize existence and develop complete certainty” (p. 162). Downing (2000) believes that regardless of our philosophical affiliation we all function to some degree as naïve realists. Therefore, psychotherapists should be concerned with the importance of incorporating research into practice as paramount to the survival of psychotherapy as a viable and credible treatment option.

Research represents an attempt to bridge the gap between scientific certainty and practice reality, to move treatment forward and improve client outcomes. By having a research and a practice eye, both endeavours may be enriched through practice-based evidence (Sanderson & Woods, 1991). The purpose of a systematic review is to select the literature relevant to the topic, and to review it critically in order to inform clinical practice. In this study, the data is the literature and therefore lends itself well to this method of research. Survey research (Bartley, 2003), unstructured

interviewing (Opie, 2003), and discourse analysis (Wetherell, 2003) might also have been appropriate methodological approaches for this research. However, before such methods are warranted I believe it is useful to first explore existing literature on the topic.

### **Systematic literature review**

Systematic literature reviews have been used in the social sciences for many years to inform theory and practice (Petticrew & Roberts, 2006). Dickson (1999) defines a systematic review as a method to “locate, appraise, and synthesise evidence from scientific studies in order to provide informative, empirical answers to scientific questions” (p. 42). It supersedes the traditional literature review, demanding a high standard of methodical and rigorous locating, assessing, and integrating of data. A strength of the systematic review lies in the thorough analysis of empirical studies. Thus, systematic reviews are regarded as “the ‘gold standard’ for assessing the effectiveness of a treatment or intervention” (Dickson, 1999, p. 42).

The modified systematic review used in this dissertation incorporates clinical vignettes to provide illustration, a departure from the standard systematic review. This material was acquired from a consenting client invited to participate in the research and is used to illustrate and augment clinical concepts rather than provide evidence for the ideas contained in this dissertation. Client confidentiality has been protected by using a pseudonym and disguising some of the material.

### **Defining the topic for review**

The research topic in a systematic review defines the participants, assesses a clinical intervention, and measures the outcomes (Sackett, Richardson, Rosenberg, & Haynes, 2000). In this study the participants are individuals who experience their homosexuality as ego-dissonant. The main body of this review consists of the data collected from selected literature. The clinical intervention being assessed is the application of conversion therapy, gay-affirmative therapy, and emerging integrative solutions with ego-dissonant gay clients. The outcome aims to elucidate clinical

applications for working with such clients, define what is known about such treatment approaches, highlight gaps in knowledge, and stimulate further research on the topic.

### **Search strategies**

A comprehensive review of the literature consisted of database searching, manual searching, and scanning reference lists of relevant articles. Below is a summary of database reference sources and publications located. See Appendix A for a list of combination search words used.

<b>Database reference sources</b>	<b>Number of useful publications located</b>
PsycINFO	81
Psychoanalytic Electronic Publishing (PEP)	32
Proquest Dissertations and Theses	9
Medline (Ebsco, Ivid, and PubMed)	5
Wiley Interscience (Medical Sciences and Psychology)	1
Forum (New Zealand Association of Psychotherapists)	1
AUT Library Catalogue (Books)	10
St Johns Theological College Library	4
AUT Interloans	37
Borrow Direct (From other Universities)	11

### **Selection of studies**

Defining inclusion and exclusion criteria at the outset of the review helps to prevent bias and provides clarity regarding how the studies were selected (Dickson, 1999). Inclusion criteria in this review comprised literature on the treatment of ego-dissonant gay adult males. Although most homosexuals experience some conflict over their sexual orientation during the coming-out process, this study addresses

persistent and fundamental dissonance in individuals who already identify as gay. While links between the two have been made, vast bodies of gay development literature have been excluded, with the exception of well-known authors such as Cass (1979) and Isay (1986). Due to the narrow scope of this study, related clinical material with infants, adolescents, lesbians, bisexuals, transgender persons, and families were excluded, as were publications not in English, not reflecting Western and European culture, on faiths other than Christianity, on medical/surgical interventions, and on those whose character structure is not at the neurotic level.

### **Quality appraisal, extraction, and synthesis of studies**

The first phase of data collection involved gathering information on the theory and aetiology of homosexuality to provide context for the study. Secondly, data on how understandings and treatment of homosexuality has evolved was examined; its antecedents, manifestations, and sequelae were extracted from the literature in relation to conversion therapy, gay-affirmative therapy, and emerging integrative solutions. Thirdly, findings from each paradigm were synthesised and data on best practice for working with ego-dissonant gay clients was delineated. A critique of the literature occurs throughout the main body of the dissertation.

### **Summary**

This chapter outlines the methodological approach – a modified systematic review – used in this study to ensure a comprehensive, objective, and reliable overview of the literature pertaining to the issues of working with ego-dissonant gay clients.

Although a rigorous literature search has been conducted, it is important to note that, ultimately, this review and the arguments throughout present my interpretation of the data and might differ to those of other reviewers.

## **CHAPTER THREE**

### **FREUD ON HOMOSEXUALITY**

#### **Introduction**

As founder of the psychoanalytic school of psychology, Freud made numerous references to homosexuality (1905, 1908, 1909, 1910, 1911, 1914, 1920, 1922). Taken out of context, Freud can be portrayed as either virulently anti-homosexual (Nicolosi, 1991) or as a closeted friend of gays (McWilliams, 1996); this contradiction has been used to promote both sides of a polarised debate on the theory and treatment of homosexuality. This chapter examines Freud's views on homosexuality in relation to psychosexual developmental theory, whether he believed same-sex attraction was constitutional or acquired, and his thoughts on sexual reorientation.

#### **Constitutional bisexuality**

Freud's view on homosexuality was tolerant for its time. In 1930, Freud signed statements calling for decriminalisation of homosexual acts in Germany and Austria (Abelove, 1986). When asked whether one ought to undertake to cure homosexuals or make their lot easier by increasing society's tolerance, he replied, "Naturally, the emphasis ought to be put on social measures" (Wortis, 1954, p. 56). Freud understood the burden to be lifted from homoeroticism primarily as a burden society had itself placed there.

Freud disputed degeneracy theories' pejorative views (e.g., Krafft-Ebing, as cited in Drescher, 2001), asserting that humans were by nature bisexual. He believed homosexuality to be a variation of the sexual function produced by arrest of sexual development, and attributed homoeroticism to insufficient repression of the original bisexual disposition. Freud argued that a sublimated homosexuality was necessary for normal heterosexual function. Similarly, all homosexuals had some heterosexual feelings.

Yet, despite his view of constitutional bisexuality as the origins of homoeroticism, and efforts to protect homosexuals from social malevolence, Freud never asserted complete parity between homoeroticism and hetero-eroticism (Weeks, 1985). Freud understood homoeroticism as undesirable (if blameless) sexuality when it was the primary erotic orientation in an adult (Drescher, 2001; Murphy, 1992) and believed heterosexuality and reproduction to be the goal of sexual maturation (Freud, 1905, 1925).

Freud recognised homosexuality in people whose efficiency is unimpaired, and who are, indeed, distinguished by specially high intellectual development and ethical culture such as Plato, Michelangelo, and Leonardo da Vinci (Freud, 1905, 1935). He believed homoeroticism was not *eo ipso* a pathological condition, stating, “I am of the firm conviction that homosexuals must not be treated as sick people... wouldn’t that oblige us to characterize as sick many great thinkers and scholars whom we admire precisely because of their mental health?” (quoted in Lewes, 1988, p. 32). His resistance of pathological interpretation of homoeroticism is evident in the Dutch psychoanalytic association’s inquiry about whether a homosexual man should be admitted to psychoanalytic training. Freud declared, “We cannot exclude such persons without other sufficient reasons, as we cannot agree with their legal persecution... a decision should depend upon other qualities of the candidate” (quoted in Abelow, 1986, p. 60).

### **Psychosexual developmental model**

Freud theorised that early childhood development was organised into psychosexual stages of libido, moving from oral to anal to genital stages. Adult sexuality was defined as penile-vaginal intercourse, and oral and anal sexuality were labelled immature vestiges of childhood sexual expression. Homosexuality could be due to a *libidinal arrest* (in the phallic stage) or failure to reach the final psychosexual stage of genitality due to a blockage of the energetic force. Alternatively, an individual had reached the more mature genital stage but due to trauma reverted to an earlier stage. This was termed *libidinal regression*. For Freud, changing an individual’s same-sex

orientation to a heterosexual one meant helping them 'grow up' through achieving a higher level of psychosexual development, rather than a 'cure' (Drescher, 2001).

### **Aetiological theories of homosexuality**

During his lifetime, Freud posed four different theories of the aetiology of homosexuality (Lewes, 1988). In each, he addresses a different metapsychological issue in relation to homosexuality, i.e. libido and bisexuality (1905), narcissism (1910, 1914), projective mechanisms (1911, 1922), or unsatisfactory Oedipal resolutions (1920, 1922). Each theory refers to a narrowly constructed 'hypothetical homosexual', which Freud used to hypothesise different psychodevelopmental events possibly involved in the emergence of adult homosexuality (Drescher, 2001):

1. Homosexuality arises as a result of the Oedipus conflict and the boy's discovery that his mother is 'castrated'. This produces intense castration anxiety causing the boy to turn from his castrated mother to a 'woman with a penis'.
2. In the *Three Essays*, Freud (1905) theorised that the future homosexual child is so over-attracted to his mother that he identifies with her and narcissistically seeks love objects like himself so he can love them like his mother loved him.
3. If a 'negative' or 'inverted' Oedipus complex occurs, a boy seeks his father's love and masculine identification by taking on a feminine identification and reverting to anal eroticism.
4. Finally, homosexuality could result from reaction formation:<sup>4</sup> sadistic jealousy of brothers and father is safely converted into love of other men.

While Freud believed the expression of homoeroticism has psychological origins, he did not believe psychoanalysis alone could solve the problem of homosexuality. He argued that explanation beyond this belonged to biology (Freud, 1920). As a result,

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<sup>4</sup> Reaction formation is a psychological defence mechanism in which one form of behaviour substitutes for or conceals a diametrically opposed repressed impulse in order to protect against it (McWilliams, 1994).

Freud cautioned against seeing homosexuality as either unequivocally acquired or congenital (Murphy, 1992).

### **Sexual reorientation**

In his *Letter to an American Mother*, Freud (1935) reassured a woman that her homosexual son was not ill: “Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation. It cannot be classified as an illness” (quoted by Anderson, 2001, p. 23). Drescher (2001) believes Freud used the term *illness* as a synonym for symptom formation, by which he meant the product of intra-psychic conflict. Freud went on to suggest analysis might help in a different way, “If he is unhappy, neurotic, torn by conflicts, inhibited in his social life, analysis may bring him harmony, peace of mind, full efficiency, whether he remains a homosexual or gets changed” (quoted by Grotjahn, 1951, p. 331). In this case, Freud does not view homosexuality as an illness – rather an un-conflicted expression of an infantile sexual wish. Neither does he believe it implies health (Freud, 1905, 1920). In suggesting the benefits of psychoanalysis, regardless of whether change occurs, Freud does not reject the idea of sexual reorientation outright, although neither does he seem optimistic.

There is nothing in Freud’s notion of bisexuality that rules out the possibility of sexual reorientation. Some authors (Bieber et al., 1962; Nicolosi, 1991; Ovesey, 1969; Socarides, 1978) have assimilated Freud’s understanding that sexual gratification found in people of one anatomy at one point in life does not rule out later change in the intensity of direction of sexual desire. This hypothesis has come to form the basis of contemporary conversion therapies.

Opponents of conversion therapy (Drescher, 2001; Isay, 1989; Murphy, 1992) highlight Freud’s (1905) views on bisexuality in *Three Essays on Sexuality*, where he rejects the idea that individuals could be born with object choices already determined prior to psychosexual development. This seems to be aimed at those claiming homoeroticism to be an innate condition. Freud also rejects the ‘third sex’

view.<sup>5</sup> Yet, in stipulating constitutional bisexuality in people, it seems hard to understand Freud saying something other than homoeroticism will come to the fore in certain persons independent of their psychic environment.

According to Wortis (1954), Freud claimed some people had a special susceptibility to homoeroticism. In *Psychogenesis of a Case of Homosexuality in a Woman*, Freud (1920) believed constitutional factors determined the intensity of the homoeroticism in an eighteen-year-old girl. While accepting this patient for the purposes of sexual reorientation, Freud noted that such a case was not attractive to psychoanalysis because it did not begin with the personal suffering of a divided personality. To the contrary, his patient did not suffer at all from her attraction to other women. Freud (1920) cautioned that removal of homosexuality was never easy and success found only in especially favourable circumstances, “and even then the success essentially consisted in making access to the opposite sex... thus restoring him to full bisexual functions” (p. 151). He concluded that, “to convert a fully developed homosexual into a heterosexual does not offer much more prospect of success than the reverse, except for the good practical reasons the latter is never attempted” (p. 151).

### **Summary**

Freud did not think homosexuality was pathological in the sense that it was the consequence of degenerative physiology or psychology. He found homoeroticism compatible with normal psychological functioning and even associated it with elevated capacities and superior psychic and moral qualities. However, Freud did believe homosexuality represented stunted individual psychosexual development and from this perspective saw it as inferior sexuality in a mature adult. There is nothing in Freud’s writings to suggest that conversion therapy is desirable or successful, nor is there anything to suggest that conversion therapy should not be pursued if a person is suffering from his or her sexual orientation. In most discussions regarding ego-dissonant homosexuality, Freud left the prospect open.

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<sup>5</sup> The ‘third sex’ view was that male homoeroticism resulted from a female mind in a male body. Female homoeroticism was the opposite.

## **CHAPTER FOUR**

### **CONVERSION THERAPY**

#### **Introduction**

Pathological interpretation of homosexuality (based on faulty object relations) and interest in sexual reorientation therapy gained popularity in psychoanalysis after Freud's death in 1935. Theories proliferated that differed significantly from Freud's, but which, nevertheless, remained within the mainstream psychoanalytic movement. Some authors (Drescher, 2001; Isay, 1989; Murphy, 1992) believe this change was due to historical and cultural influences rather than the logic of psychoanalysis itself. The emergence of new paradigms offering 'therapeutic possibilities' for treating homosexuality influenced what has become known as conversion therapy. This chapter describes the philosophical underpinnings of conversion therapy and provides an historical overview of emerging aetiological theories of homosexuality. Different theoretical approaches to treating homosexuality with conversion therapy are discussed before concluding with an evaluation of this model including ethical considerations and critique.

#### **Philosophical underpinnings**

Social constructionism and essentialism (see Chapter Five) have developed as a means of understanding and describing sexual orientation. Some of the basic tenets of social constructionism underpin conversion theory and suggest that sexual orientation is chosen or constructed, challenging therapists to view conceptual categories through which people interpret eroticism not as biologically or psychologically determined but as socially constituted. This implies the social meaning of homosexuality has shaped the domain of emotions, identity, and behaviour associated with gay sex. Hence, constructionism views nurture, not nature, as creating homosexuality and the phrase *sexual preference* indicates individuals taking an active part in constructing their sexuality (DeLamater & Hyde, 1998; Houston, 2006; Karten, 2006; Throckmorton & Yarhouse, 2006).

## **Historical overview: Aetiological theories**

### ***Beginnings***

In 1949, Rado's (1969)<sup>6</sup> adaptation model of homosexuality grew out of the refutation of Freud's belief in psychological bisexuality<sup>7</sup> and aligned itself instead with the theory of evolution, namely adaptational dynamics.<sup>8</sup> Rado defined human beings as self-regulating biological systems that perpetuate themselves by means of their surrounding system – the more adaptive, the more able to survive and reproduce. Heterosexuality was viewed as the non-pathological outcome of human sexual development, and Rado refuted any possibility of innate homoeroticism. Homosexuality was caused by parental discouragement prohibiting the sexual activity of the child. As a result, the male would view in the 'mutilated' female organ a reminder of punishment, and escape into homoeroticism whenever fear and resentment of the opposite organ became insurmountable; a deficient adaptation or evolutionary response to its own emergency overreaction and dyscontrol (Drescher, 2001).

Bieber et al. (1962) expanded Rado's theory suggesting that if personality was formed within the triangular system (the patient-mother-father unit), then personality maladaptation must also originate there. Homosexuality was considered a pathological adaptation resulting from fears surrounding expression of heterosexual impulses caused by a faulty triadic constellation. The authors concluded: "In our view, every homosexual...is a 'latent' heterosexual" (Bieber et al., 1962, p. 220).

Building on this, Socarides (1978) claimed that homosexuality resulted from a pre-Oedipal fixation involving intense symbiotic union with the mother. Socarides's conflict model suggested therapeutic interventions to bring unconscious struggles

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<sup>6</sup> Although this volume was published toward the end of Rado's life, it is based on ideas and lectures that he developed and taught in the 1930s and 40s.

<sup>7</sup> Rado believed Freud's view on libidinal bisexuality was based on a faulty analogy of anatomical bisexuality, a later-disproved 19<sup>th</sup> century belief in hermaphroditism: the hypothesis that the potential to become an anatomical man or woman was present in every embryo (Drescher, 2001).

<sup>8</sup> Adaptational dynamics analyses behaviour in the context of its environment.

into awareness in order to reduce 'homosexual symptoms'. Restructuring Freud's (as cited in Gill, 1988) meta-psychological construct,<sup>9</sup> he claimed homosexuality was a neurotic condition where the libidinal instinct had undergone excessive transformation and disguise in order to be gratified in the perverse act. This resulted from the conflict between the ego and the id and represented a compromise formation that simultaneously must be acceptable to the demands of the superego. The instinctual gratification takes place in disguised form while its real content remains unconscious (Drescher, 2001).

Ovesey (1969) believed homosexuality arose from faulty-learning. His behavioural model emphasised the role of gender-identity and how understandings of masculinity and femininity were socially constructed in terms of dependency and power. Refuting the authenticity of homoeroticism, Ovesey termed these feelings 'pseudo-homosexuality'<sup>10</sup> and suggested that they were symbolic of competition and status issues commonly found in heterosexual men. Homosexuality was a defence against fear of the opposite sex and the only way to overcome this phobia was in bed with a woman. Kolb and Johnson (1956) and Ovesey (1969) urged using ultimatums threatening the end of treatment for non-conforming patients and suggested pressure be directed at "insufficient efforts to performing heterosexually" (Ovesey, 1969, p. 121). This approach highlights similar expectations by many conversion therapists to abandon psychoanalytic neutrality and function as behavioural therapists.

### ***Current status***

Nicolosi (1991) developed a reparative model for 'non-gay homosexuals'<sup>11</sup> who are unhappy with their sexual orientation. This perspective suggests homosexuality is an attempt to repair emotional deficits, in particular a gender deficit caused by a

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<sup>9</sup> Freud's metapsychology described a speculative superstructure of psychoanalysis in which the concepts of drive (instinct/drive), psychical apparatus and libido correspond to dynamic, topographical and economic viewpoints. These three points of view refer respectively to the forces, structures, and energies involved in a psychical process.

<sup>10</sup> Ovesey (1969) refers to 'pseudohomosexuality' as homosexual fantasies or behaviour where the sexuality serves as a vehicle for power and dependency motivations.

<sup>11</sup> 'Non-gay homosexual' defines an individual with homoerotic thoughts, fantasies and/or behaviour who experiences a split between his value system and sexual orientation (Nicolosi, 1991).

disruption in the father-son relationship. Nicolosi asserts that the child's emotional hurt, from feeling rejected by an absent or distant father, causes the child to defensively detach, and feelings of distrust and isolation transfer into same-sex relationships. Through eroticisation of what he feels disenfranchised from, the non-gay homosexual man seeks initiation into manhood through other males. Homosexuals are doubly burdened with defensive attachment and the motivation to compensate for personal deficit, hence: "I do not believe that the gay life-style can ever be healthy, nor that the homosexual identity can ever be completely ego-syntonic" (Nicolosi, 1991, p. 13).

In 1992, Nicolosi and Socarides co-founded the National Association for Research and Therapy of Homosexuality (NARTH), the current primary mental health organisation promoting sexual reorientation (Byrd, 2004). NARTH maintains it is a secular organisation, however Nicolosi's theory offers a deliberate fusion of spiritual and psychoanalytic thought that, in addition to Radoite adaptive theory, draws on pastoral counselling literature. NARTH members have been criticised for being homophobic, with reports of Socarides and others filing affidavits supporting antigay legislation (Socarides, 1993). Socarides declared: "social opprobrium must be reinforced if homosexuals are to be motivated to change their sexual orientations" (cited in Drescher, 2001, p. 20). Such political activism has moved reparative therapists from the psychoanalytic centre to being embraced by conservative religious forces opposed to homosexuality on moral grounds.

Judeo-Christian prohibitions against homosexuality are well documented (Haldeman, 1996). Across Christian denominations, an international coalition of self-styled ex-gay ministries<sup>12</sup> has emerged catering to homosexuals who feel conflicted over their religious beliefs and sexuality and seek help to resolve their feelings of guilt and shame through sexual reorientation. These conservative religious groups introduced the term 'ex-gay', which they define as an individual who has changed, or is in the

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<sup>12</sup> Examples of ex-gay ministries include Exodus International (the largest interdenominational group with 135 operations in 17 countries), Courage (Roman Catholic), Evergreen (Church of Jesus Christ of Latter Day Saints), OneByOne (Presbyterian USA), Fidelity (Anglican), and JONAH (Jewish).

process of changing their sexual orientation from exclusive homosexuality to exclusive heterosexuality due to religious motivation (Pattison & Pattison, 1980). Ex-gay ministries base their spiritual model on interpretations from scripture that condemn same-sex attraction as 'sinful' and promote 'freedom from homosexuality' through spiritual intervention. They claim that the spiritual dimension inherent in a person is the most salient identity and forms the basis of an individual's sense of self and purpose (Miranti, 1996).

### **Application: Key concepts, treatment approaches and research**

Goetze (2001) identified 84 articles or books related to conversion therapy and the treatment of homosexuality. Of the 84 studies, 31 reported some quantitative outcome, although 12 of these provided insufficient data to evaluate the effects of treatment. The remaining 19 suggested that in some participants homosexual orientation can be changed to varying degrees through a variety of interventions such as psychoanalytic, behavioural, cognitive, group, and religious approaches, each of which are discussed below.

#### ***Psychoanalytic and psychodynamic approaches***

Freud generally took a negative view of modifying sexual orientation; however, a number of subsequent psychoanalytic therapists, including his daughter Anna (Freud, 1951), advocated therapeutic efforts to explore change (e.g., Bieber et al., 1962; Fairbairn, 1952; Mayerson & Lief, 1965; Ovesey & Woods, 1980; Poe, 1952; Rado, 1969; Socarides, 1978; van den Aardweg, 1986; Wallace, 1969). Psychoanalytic treatment of homosexuality consists of intensive, long-term therapy aimed at resolving unconscious anxiety stemming from childhood conflicts in disturbed parental relationships that create the patient's neurotic fear of heterosexuality (Acosta, 1975). There is an encouragement of a positive transference and identification with the analyst, often based on parent denigration, the mother for her intrusiveness and the father for his ineffectuality. Identification with the therapist is pivotal in providing what was developmentally missing – a good father to assist him to break the emasculating, symbiotic tie to the mother (Mitchell, 2002).

Nicolosi (1991) emphasises the homosexual's disrupted gender-identity where "same-sex eroticism is used as symbolic reparation of a deficit of masculine strength" (p. 157). Reparative therapy focuses on assertion problems, sexualisation of dependency and aggression,<sup>13</sup> and 'gender lessons' where clients adopt traditional gender roles and develop non-sexual identifications with same-sex individuals (Morrow & Beckstead, 2004). With these psychological shifts, clients can "catch up, to conquer what the heterosexual ...achieved years before" (Nicolosi, 1993, p. 213).

In a study of 106 gay men, Bieber et al. (1962) claimed their findings confirmed developmental and adaptational theories of homosexuality caused by a "hidden but incapacitating fear of the opposite sex" (p. 303). They reported 27% of participants, who engaged in 150 to 350 hours of intensive therapy, experienced a shift to exclusive heterosexuality. Churchill (1967) and Taylor (1965) criticised their methodology for using an entirely clinical sample and outcomes based on subjective therapist impression that were not externally validated. Furthermore, only 18% of subjects were exclusively homosexual to begin with and 50% of the 'successfully' treated patients were more appropriately labelled bisexual.

Hatterer (as cited in Mitchell, 2002) recommended a 'dehomosexualization process',<sup>14</sup> in which he describes a supportive, somewhat active, psychodynamic approach to treating homosexuality, which similarly recognised a patient's fear of women and detachment from male identity. Hatterer presented case information of 143 clients, claiming 34% achieved some shift towards heterosexuality, with 13% patients 'partially recovered' and the remaining 53% unchanged.<sup>15</sup> Self-dissatisfaction and motivation to convert to heterosexuality were identified as key predictors to achieving some change. Blechner (1993) has criticised Hatterer's

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<sup>13</sup> In gay males, Nicolosi (1991) describes this as sexualising or 'loving' a feared or hated male as a way of evading competition.

<sup>14</sup> 'Dehomosexualisation process' refers to the reassurance of the therapist's respect and liking for the patient during treatment, encouragement in efforts to change, tales of other successful treatments, and portraying negative prospects for happy or permanent homosexual relationships.

<sup>15</sup> A Kinsey rating – which measures sexual orientation from 0 (exclusively heterosexual) to 6 (exclusively homosexual) – was conducted on the 143 clients and follow-up adjustment assessed.

ruthless approach as “exploiting the patient’s sense of shame to prod him into heterosexuality” (p. 627).

Nicolosi, Byrd, and Potts (2000) conducted the largest survey of its kind, reporting on 882 clients engaged in sexual reorientation therapy. Of the 318 who initially self-identified as exclusively homosexual, 18% rated themselves as exclusively heterosexual, 17% as almost entirely heterosexual, and 12% as more heterosexual than homosexual post-treatment. Throckmorton (2002) argues that the study failed to provide definitions of ‘sexual orientation’ and ‘exclusive homosexual’. Furthermore, respondents were not required to assess aspects of sexual orientation such as behaviour and fantasies before and after change, so the exact degree of change is not known. Therefore, outcomes are more accurately described as broad assessments of self-identity or self-perception change rather than changes in sexual orientation.

Throckmorton’s (2002) review of psychoanalytic studies indicates conversion therapy successes range from 18% to 44%. Individuals with prior heterosexual interest who are motivated to change seem most likely to report modifications of sexual orientation. However, Curran and Parr (1957), who studied 100 gay males in analysis, and Woodward (1958) report practically no increased heterosexuality among their exclusive homosexual patients.

### ***Behaviour therapy approaches***

Behaviour therapists attribute ‘learning’ to explain sexual orientation, believing homosexuality is established when such behaviour is followed by physical and/or social reinforcement and/or when heterosexual behaviour is followed by negative events such as punishment or humiliation. A chain of events that reinforces one sexual orientation and/or is aversive to another is likely to create consistency in the one encouraged (Greenspoon & Lamal, 1987). Behavioural approaches seek to counter-condition the learned homoerotic response with aversive stimuli, replacing it with desired hetero-erotic response through aversive therapies, covert sensitisation,

systematic desensitisation, and social skills training (Callahan & Leitenberg, 1973; Hayes, 1970; James, 1962; MacCulloch & Feldman, 1967).

Behavioural approaches have included aversive stimuli<sup>16</sup> paired with slides of attractive nude males, followed by rewarding the patient in the presence of slides of the opposite sex (Feldman & MacCulloch, 1965; Freeman & Meyer, 1975; Max, 1935). Covert sensitisation<sup>17</sup> employs techniques of imagery in which visualisation of negative consequences or physical sensation is used in the presence of same-gender sexual arousal (Kendrick & McCullough, 1972; Mandel, 1970; Segal & Sims, 1972). Research outcomes have been mixed. Feldman, MacCulloch, and Orford (1971) reported on 63 gay clients in sexual reorientation therapy in which a total of 65% of subjects reported some shift in sexual orientation, with 29% of participants without prior heterosexual experience and 78% with previous heterosexual experience describing change.

Bancroft (1969) criticises the study for failing to explain how the patient's acquisition of an avoidant response to specific homosexual stimuli affected his sexual behaviour outside of treatment. Other studies (McConaghy, 1971; McConaghy, Armstrong, & Blaszczyński, 1981) conclude that sexual orientation is unalterable and that such a stressful situation is likely to inhibit feelings of sexual responsiveness in any direction. While aversive treatments may suppress or extinguish homoerotic response, they do little to promote alternative orientation. Haldeman (1994) and Shidlo and Schroeder (2002) highlight the harmful effects of such approaches including intrusive flashback-like negative imagery associated with long-term sexual dysfunction.

Some researchers (Barlow & Agras, 1973; McCrady, 1973) have attributed non-aversive classical conditioning techniques to success in modifying sexual orientation where gay male clients are shown nude male pictures which fade into female nudes,

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<sup>16</sup> Aversive stimuli can include electric shock (also known as faradic therapy), nausea-inducing substances, or noxious smells.

<sup>17</sup> Covert sensitisation was previously known as verbally aversive therapy.

or vice versa. Systematic desensitisation has also been used to facilitate change (Bergin, 1969; Huff, 1970; James, 1978a; Phillips, Fischer, Groves, & Singh, 1976). From this perspective homosexuality is viewed as a symptom of a phobia – a fear of the opposite sex – and the patient is required to confront his/her fear in bed with someone of the opposite sex. Desensitisation helps the homosexual client who experiences anxiety about heterosexual physical contact by becoming familiar with being touched or initiating heterosexual behaviours, such as dating (Throckmorton, 1998). Stevenson and Wolpe (1960) describe the case of a 22-year-old gay man who had experienced homoeroticism since the age of fourteen. Through re-education, assertiveness and social skills training, the client terminated therapy after ten sessions with plans to marry, and reported heterosexual adjustment at a three-year follow-up assessment. Haldeman (1994) argues that methodologically the near-exclusive use of self-report outcome measures, as in Stevenson and Wolpe's (1960) study, is problematic, particularly where social opinions may strongly influence subjects' reports.

Behavioural approaches have progressed from reliance on aversive stimuli to the use of more sophisticated multimodal approaches. These approaches attempt to extinguish same-sex attraction while simultaneously increasing heterosexual responsiveness through provision of a variety of behavioural supportive counselling techniques (Throckmorton, 1998). Reviews of behavioural studies by Adams and Sturgis (1977) – who appraised 37 behavioural studies – and Conrad and Wincze (1976) report that externally validated studies show little or no change of sexual orientation after treatment and conclude further research is needed to improve the efficacy of such procedures.

### ***Cognitive therapy approaches***

Ellis (1959) did not view homosexuality as a product of emotional disturbance but as a neurotic condition if, in its 'fixed' form, it eliminated other modes of sexual fulfilment, notably heterosexuality. He believed there was no logical reason to

obliterate homoeroticism; instead, his goal was to “help the client overcome his irrational blocks against heterosexuality” (p. 339).

Through ‘rational psychotherapy’<sup>18</sup> Ellis hypothesised that human emotion, feelings and behaviour, i.e. a gay man’s fear of women, stem from basic assumptions, consciously or unconsciously, which are caused and maintained by irrational ideas or attitudes. Treatment consists of bringing these irrational beliefs to conscious attention, interpreting their origins (as in analytically orientated therapies) and replacing them with rational, non-defeating beliefs. This involves adopting a new interpretative schema or framework based on ‘understanding’ the nature of homosexuality. Ellis (1959) claimed that a client had “changed from a hundred percent fixed homosexual to virtually one hundred percent heterosexual” in 12 weeks; however, outcomes were based on subjective self-reporting methods and lacked empirical evidence (p. 342).

### ***Group therapy approaches***

Rogers, Roback, McKee, and Calhoun (1976) assert that group psychotherapy can be a successful method of intervention in sexual reorientation “whether the treatment orientation is one of a change in sexual pattern of adjustment, or a reduction in concomitant problems” (p. 24). Group interventions offer distinct advantages over individual therapy such as an opportunity for self-comparison, identification, inspiration, and role-modelling. Group work provides a forum for developing assertion skills and working through anger, which can be hurtful and stimulate old narcissistic wounds originally inflicted by the father. A decrease in isolation from same-gender peers and a feeling of belonging to a surrogate family is fostered as individuals are united in a common struggle (Nicolosi, 1993).

Birk (1980) claims that by using a combination of group and individual therapy “100% of exclusively gay men beginning therapy with strong motivation to change were able to attain a heterosexual adaptation” (p. 291). Criteria included subjects

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<sup>18</sup> Rational psychotherapy later became known as Relational-Emotive-Behavior Therapy (REBT).

remaining in the group for at least two-and-a-half years or having achieved their goals before this period. Birk reports that out of the 14 participants, 10 were still married at follow-up. Critics claimed subjects had pre-existing hetero-erotic tendencies and pointed out that individuals in group treatments are especially susceptible to the influence of social demand in their own reporting of treatment success (Haldeman, 1994).

### ***Religious programmes***

The theoretical base of ex-gay ministries and many mainstream conservative churches is founded on scriptural interpretations that condemn homosexual behaviour as immoral and sinful. 'Healing' by supernatural intervention is offered to those whose religious beliefs supersede concerns about their 'competing' sexual orientation. These institutions' often-unspecified treatment methods, combining individual and group work, rely on prayer, peer support, doctrinal prohibitions, threats of damnation, and accountability to motivate willpower and limit behaviour (Ritter & O'Neill, 1989). Ponticelli (1999) has identified 'role acceptance' as a major indicator of conversion within these organisations and ex-gays are encouraged to testify to their change to demonstrate acceptance of their role of being healed.

Ex-gay research is sparse with only 11 reports in professional literature that claim certain people shifted their sexual orientation due to following their religious beliefs (Anderson-Barnes, 1990; Davies & Rentzel, 1993; MacIntosh, 1994; Pattison & Pattison, 1980; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Spitzer, 2003; Struble, 1991; Throckmorton, 2002). Tozer (2001), Dreikorn (1998), and Schaeffer et al. (2000) have identified religious motivation as a significant predictor of individuals seeking conversion therapy due to religious beliefs opposing homosexuality.

In the most recent research on religiously mediated conversion therapy, 143 men were interviewed with the primary sample criteria of having successfully managed to sustain efforts to change their sexual orientation for at least five years (Spitzer,

2003). Post-treatment, 17% of the men self-identified as exclusively heterosexual. While concluding that a few participants made some changes, Spitzer (2003) notes that complete change was uncommon. Close examination of the sample revealed it was heavily weighted towards highly religious Christian, Caucasian, middle-class individuals, thus ignoring the diversity of individuals who might seek conversion therapy (Carlson, 2003).

Research into religiously mediated conversion therapies reveals scientific concerns, from theoretical weaknesses to methodological problems. Having no empirical basis, reports of change are limited to testimonials with more and more stories of 'ex-gays' who have become 'ex-ex-gay' (Yarhouse & Burkett, 2002). Michael Buss and Gary Cooper, co-founders of Exodus International, have denounced conversion therapy as ineffective stating, "not one person was healed" (Newsbriefs, cited in Haldeman, 1994, p. 225). This has been echoed by other prominent leaders in church organisations ("Doubt cast on ex-gay programmes," 2007).

Ex-gay ministries hold tremendous symbolic power over individuals raised with traditional Christian beliefs, targeting vulnerable homosexuals with already-heightened levels of internalised shame, guilt and lower self-concepts. The workings of these groups are well documented (Blair, 1982; Lawson, 1987), with many of their practices identified as fraught with unethical behaviour, sexual abuse, deception, and theological malpractice. Furthermore, while many of these practitioners publicly promise change, they privately acknowledge that celibacy is the more realistic goal.

### **Meta-analysis**

In a meta-analysis of 101 studies between 1930 and 1976 on outcomes of conversion therapy, James (1978b) found 37% of clients rated 'not improved', 27% 'improved', and 35% 'recovered'. He concluded that bisexuals rather than homosexuals showed consistently greater improvement in long-term therapy. He found little significant difference of efficacy between the various approaches discussed above.

### **Evaluation and critique**

Many authors (Drescher, 2001; Forstein, 2001; Isay, 1989; Murphy, 1992; Schidlo & Schroeder, 2002) object to conversion therapy, arguing it violates professional ethicality, as it represents a cure for a condition that has not been judged an illness by the scientific, medical, and mental health professions. Though some contemporary conversion therapists claim a value-free stance, why would one attempt to change sexual orientation unless it is negatively valued? Offering therapeutic options only reinforces antigay sentiment and devalues homosexuality (Davison, 1976, 1978). Furthermore, the directive-suggestive approach used by many conversion therapists, rather than psychoanalytic neutrality, limits exploration into factors influencing the desire of homosexuals to change their sexual orientation. This can prohibit important questions from emerging for analytic inquiry and study, resulting in misinformation based on unproven assumptions.

Although many conversion theorists claim to cater to 'dissatisfied' homosexuals, Silverstein (1977) believes what were historically viewed as 'ego-dystonic' responses to homosexuality are really internalised reactions to a hostile society. Not every homosexual seeking change does so from a moral evaluative framework, but from societal ignorance and prejudice about same-gender sexual orientation and family or social coercion and/or lack of information (American Psychological Association, 1998). These conversion theorists also fail to consider minority identity-development literature (e.g., Helms, 1995; Pederson, 1988; Sue, Arredondo, & McDavis, 1992), which implies that unhappiness with one's sexual orientation often stems from self-loathing that occurs when individuals come to terms emotionally and cognitively with their minority status in the context of not necessarily feeling valued.

Some authors (Nicolosi et al., 2000; Schaeffer, Nottebaum, Smith, Dech, & Krawczyk, 1999) claim that extinguishing unwanted homosexuality leads to significant improvements in areas of self-acceptance, personal power, emotional stability, depression, and spirituality. Yet, others emphasise the damaging effects of failed conversion treatments where individuals, who feel they have 'succumbed' to

what opponents of conversion therapy would describe as the most powerful natural urge within them, emerge more conflicted and depressed with increased guilt, shame, low self-esteem, and suicidal ideation (Liddle, 1996; Moor, 2001; Schidlo & Schroeder, 2002).

Gonsiorek, Sell, and Weinrich (1995), Isay (1985) and Schreier (1998) argue that sexual orientation goes beyond the realms of behaviour and includes cognitions, emotions, fantasies, and impulses that are often not reflected in measuring reorientation outcomes. Worthington (2004) distinguishes between 'sexual orientation' (an individual's sexuality-related disposition towards a particular gender), 'sexual orientation identity' (an individual's acceptance of their sexual orientation), and 'sexual identity' (the individual's broader self-definition as a sexual being, which includes sexual orientation identity). Conversion theorists often fail to make the distinction between living with a heterosexual identity and more fundamental sexual orientation change. Sexual attraction and arousal patterns are relatively immutable, whereas patterns of sexual behaviour, affiliation, and identification might change over time. Even Nicolosi et al. (2000), Bieber et al. (1962) and Feldman and MacCulloch (1965) acknowledge that conversion therapy is not suitable for all homosexuals. Closer investigation suggests conversion programmes enhance heterosexual responsiveness in people with already-established hetero-eroticism (i.e. bisexuals) rather than provide evidence that exclusive homosexuals can successfully convert to exclusive heterosexuality.

While appreciating the potentially harmful aspects of a detached father and its effect on the individual's self-concept or capacity for intimacy, Haldeman (1994) questions why this criterion is selected as key in causing homosexuality unless an a priori decision about homosexuality as pathological has been made and investigated as the cause. This belief does not explain those heterosexuals who have absent or distant fathers, or those homosexuals with strong father-son relationships.

Non-random sampling does not reflect the diverse homosexual population, resulting in generalisations from a highly motivated subgroup who sought treatment. It is

inappropriate to postulate that all homosexuals experience the same emotional problems that clinicians encounter in their homosexual clients. A belief in a unitary gay lifestyle is a reductionist view that does not account for the innumerable homosexuals who have no wish to change and describe themselves as happy and fulfilled (Churchill, 1967; Hooker, 1969; West, 1959). In addition to weaknesses in sampling, near-exclusive uses of self-report methods to assess sexual orientation and subsequent changes are limited and unreliable. Finally, conversion therapy research provides little conclusive systematic follow-up and essentially no research on the longitudinal stability of sexual change over the adult life span (Churchill, 1967; Gonsiorek et al., 1995; Taylor, 1965; Throckmorton, 1998).

### **Summary**

Conversion therapy claims to defend the rights of dissatisfied homosexuals to self-determine treatment options that respect their values and religious beliefs regarding the moral status of same-sex behaviour. This approach has been widely criticised as naïvely locating clients' difficulties in their homosexuality, rather than helping the client deal with society's homophobia. Despite large claims (mainly by outdated studies), evidence for the efficacy of conversion therapy in permanently changing an individual's core sexual orientation is less than compelling, and research has not been consistent in proving it to be successful in the treatment of homosexuality. Yet, there are a few who believe a modicum of change is possible for those individuals who are motivated enough to pursue it, even if this change more accurately represents controlled behaviour or celibacy.

## **CHAPTER FIVE**

### **GAY-AFFIRMATIVE THERAPY**

#### **Introduction**

Anthropologists (Greenberg, 1988; Weinrich & Williams, 1991) have documented that homosexuality is a universally occurring phenomenon. In some cultures it is approved of and encouraged with homosexuals awarded leadership roles and even spiritual status. Over the last three centuries, religion, medicine, law, and politics have had the greatest influence on sexuality, primarily in Western societies. These institutions came to view homosexuality as sinful, sick, and illegal, resulting in attempts by the mental health profession to treat the ‘condition’ by changing an individual’s homosexual orientation to heterosexual (Weeks, 1985). More recently, a shift in opinion has caused psychology to dramatically develop and expand its capacity to recognise human diversity. This chapter examines philosophical perspectives, events and research that have culminated in contemporary ‘gay-affirmative therapy’. Different theoretical approaches within a gay-affirmative framework are discussed, including an evaluation and critique of this relatively new model.

#### **Philosophical underpinnings**

Essentialism has advanced as the most popular philosophical perspective on causation of sexual orientation and in part informs the worldview of most gay-affirmative therapists. Its biomedical view suggests that sexual categories – homosexual, bisexual, heterosexual – describe an inner essence/core of a person that is both ahistorical and acultural (Throckmorton & Yarhouse, 2006). Thus, homosexuality is similar to one’s race, gender, or eye-colour: a biological characteristic that defines something different about those in one category from those in another. Sexual orientation is something one is born with and, therefore, attributable to nature (DeLamater & Hyde, 1998; Houston, 2006; Karten, 2006).

### **The mental health profession and homosexuality**

Over the last sixty years, homosexuality has been conceptualised by the American Psychiatric Association as a mental disorder, as a possible disorder in the case of the *DSM-III* ego-dystonic homosexuality, and as neutral as it relates to the mental status of an individual when it was removed from the *DSM*<sup>19</sup> in 1973. Davies and Neal (1996a) explain that this controversial decision resulted from social science research, influenced by black and feminist civil rights protests, which reflected the new social values of egalitarianism.

Bieschke, McClanahan, Tozer, Grzegorek, and Park (2000) identified three primary studies that signalled a shift from the assumption of homosexuality as a psychopathology to current views of gay mental health. In the first two studies, Kinsey and colleagues (1948, 1953) provided empirical data on the incidence of homosexuality, which they portrayed as a normal variation of human sexuality. Findings contradicted assumptions that sexuality was a dichotomous phenomenon: heterosexual and homosexual; rather, sexuality encompassed a continuum with more people experiencing same-sex attraction than had previously been believed. These studies reported 37% of males had as adults engaged in same-gendered sexual contact to orgasm. Rothblum (1991) criticised sampling methods as over-representing college students, prisoners, and urban gay communities; therefore, not accurately reflecting the general population. However, similar cross-cultural studies by Sell, Wells and Wypij (1995) report that 7-12% of large random samples throughout France, Europe and America 'admitted' to having homosexual sex more than once. The authors claim these figures were conservative as some people were likely to underreport same-sex behaviour due to social pressures.

In a third study, Hooker (1957) conducted a landmark survey that established, under blind analysis using psychological testing, no difference could be found in mental health status between homosexual and heterosexual men. Outcomes indicated

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<sup>19</sup> The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1973)

homosexual men were as well adjusted as heterosexuals; a remarkable finding given the extremely negative attitudes held by the public and mental health profession at the time. Similar evidence from the ranks of psychiatry also came from the work of Szasz and Halleck (cited in Silverstein, 1991).

It is difficult to pinpoint the first instance of a therapy not based on the belief that homosexuality is a pathology. However, the literature describes the formation of gay counselling centres in the early 1970s, which marked the most significant step in providing an alternative form of therapy for gay people who were experiencing emotional distress but did not want to change their sexual orientation (Silverstein, 1991). These centres chose to affirm the homosexuality and then proceeded to treat the person. Publications raised awareness about the therapeutic needs of gay individuals, and professionals started using the term ‘gay-affirmative psychotherapy’. This suggested that homosexuality was an acceptable lifestyle and therapists should attempt to “provide corrective experiences to ameliorate the consequences of biased socialization” (Malyon, 1982, p. 62).

Since then, all major mental health associations,<sup>20</sup> including the New Zealand Association of Psychotherapists (2002), issued statements reiterating their official position that homosexuality is not a mental disorder, and warned of the potential harm from attempting sexual reorientation. In 1985, Division 44<sup>21</sup> was formulated within the American Psychological Association and a British equivalent – the Lesbian and Gay Psychology Section – was officially founded in 1998 within the British Psychological Society (BPS).

In 1991, the American Psychoanalytic Association, once renowned for their discriminatory policies against homosexual members, issued a non-discriminatory statement regarding the acceptance of homosexual candidates and the promotion of

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<sup>20</sup> American Psychiatric Association (2000), American Psychological Association (1997), and American Counseling Association (1998).

<sup>21</sup> American Psychological Association’s Division 44 is psychology’s focal point for research, practice, and education on the lives and realities of lesbian, gay, bisexual, and transgender people.

training and supervising analysts in their affiliated institutes. Since then, there has been an increasing volume of writers openly advocating a gay-affirmative stance (Cornett, 1995; Harrison, 2000; Isay, 1989; Lewes, 1988). Currently, the American Psychological Association is embarking on the first review of its ten-year-old policy on counselling homosexuals; a step that gay-affirmative activists hope will end with a denunciation of any attempt by therapists to change sexual orientation. A final report from the task force is expected in March 2008 (Crary, 2007).

### **Application: Key concepts, treatment approaches and research**

#### ***Gay-affirmative therapy***

Gay-affirmative therapy views homosexuality as non-pathological, valuing heterosexuality and homosexuality as equally desirable, valid, and potentially healthy. Resting on the assumption that affirming responses from others causes individuals to see themselves as having positive self-worth (Harrison, 2000), gay-affirmative therapy represents a special range of psychological knowledge that considers homophobia and heterosexism, as opposed to homosexuality, as a major pathological variable in the development of gay men. Gay-affirmative therapy uses traditional psychotherapeutic methods but proceeds from a non-traditional perspective (Malyon, 1982).

While the skills and understandings of most theoretical schools can be assimilated with gay-affirmative concepts, adjustments are necessary to some of the more traditional schools of psychotherapy. As a result, Cass (1979) developed the Homosexual Identity Formation (HIF) model, integrating both psychological and sociological perspectives of gay-identity into six stages.<sup>22</sup> This model set the groundwork for future gay-identity development models (Marszalek & Cashwell, 1999; Troiden, 1984), which emphasise movement across the stages from less acceptance to more acceptance and involves a paradigm shift engendering changes

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<sup>22</sup> Cass's (1979) six stages of the Homosexual Identity Formation (HIF) are identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis.

in emotions, cognitions, and behaviours, similar to minority-identity development models (Perez & Amadio, 2004). Fassinger and Miller's (1996) findings supported the validity of Cass's theory, with 90% of participants correctly aligning themselves to the appropriate phases of development.

When working with gay clients, some authors contend that it is not enough for therapists simply to offer Rogers's (1951) 'core conditions,'<sup>23</sup> nor is it sufficient to have a sound grasp of psychodynamic or cognitive-behavioural principles (Chernin & Johnson, 2003; Davies, 1996; Malyon, 1982; Marszalek, Cashwell, Dunn, & Jones, 2004; Perez & Amadio, 2004; Rubinstein, 2003; Shannon & Woods, 1991). Clients in conflict regarding their sexual orientation face unique challenges and, as with any special population, the therapist helps facilitate and educate through raising awareness about the nature and origin of their distress. On the other hand, a defensively counter-homophobic therapist who assumes that there is nothing different or problematic about an individual's sexual orientation can inadvertently discourage a client talking about the painful feelings that go along with being in a minority that is ignored, ridiculed, despised, and persecuted. Such a dismissive acceptance of difference can be as counter-therapeutic as rejection of it (McWilliams, 1996).

Harrison (2000) synthesised the findings from 33 papers into an integrated model of gay-affirmative therapy that recognises that many gay men who have moved through the 'coming-out' process towards self-acknowledgment will have experienced being rejected or marginalised. With this expectation embedded in their belief structure, Harrison assumes that such men will face the same fears in seeking professional help. Thus, Harrison's model has at its core a non-pathological view of gay people and the therapist's role is to challenge oppression in the form of heterosexism and internal/external homophobia. This involves empowering clients and acting as their advocate. The therapist requires an understanding of the potential effects of social

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<sup>23</sup> Rogers believed if the therapist is successful in conveying genuineness, unconditional positive regard and empathy, then clients will respond with constructive changes in personality organisation.

stigma and inquires as to the client's experience. Additionally, the therapist needs to be familiar with the particular issues presented by gay clients, i.e. addictive disorders, isolation, anxiety, depression, and low self-esteem (Shannon & Woods, 1991), and develop competence in using a range of therapeutic interventions.

Fundamental to gay-affirmative therapy is the belief that clients may benefit from having gay therapists who self-disclose their sexuality and act as role models. However, studies (Moon, 1994; Pixton, 2003; Rochlin, 1981) show that gay affirmative experiences are not dependent on therapists' sexuality and suggest that heterosexual clinicians can develop their knowledge about gay lifestyles and resources and, in some cases, offer increased objectivity and the advantage of a different perspective from the client's. Traditionally, it was thought that to disclose sexual orientation would interfere with the development of the transference. However, as long as the gay therapist is aware of the possibility of a countertransference need to establish a sense of social alliance through one's client and that such information by the analyst is in the service of the client, "all transference paradigms will eventually be established" (Meyers, as cited in Isay, 1991, p. 208).

Finally, Harrison (2000) emphasises the need for therapists to fully explore their own homophobia and be comfortable with their and their clients' sexuality, endeavouring to develop self-awareness of personal limitations in working with a gay client group. Therapists' unrecognised prejudice or misinformation regarding sexual orientation can risk exacerbating clients' distress. Friedman (1991) has criticised Harrison's analysis, claiming he only focuses on the healthier side of the health spectrum and does not include those with severe and enduring mental illness.

Gay-affirmative theorists believe any explicit or implicit attempts at changing an individual's sexuality will inevitably injure the homosexual's self-esteem (Cornett, 1995; Davison, 1991; Drescher, 2002; Isay, 1986; McWilliams, 1996; Phillips, 2004; Tozer & McClanahan, 1999). Silverstein (as cited in Davison, 1991) argues that, "to

suggest that a person comes voluntarily to change his sexual orientation is to ignore the powerful environmental stress, oppression if you will, that has been telling him for years that he should change” (p. 144). Where is the ‘free choice’ for those homosexuals who are racked with internalised guilt, self-hate, and discrimination? These authors believe it is more ethical to let a client continue to struggle honestly with their identity than to collude, even peripherally, with a practice that is discriminatory, oppressive, and ultimately ineffective.

### ***Psychoanalytic and psychodynamic approaches***

In *Three Essays on the Theory of Sexuality*, Freud (1905) separated sexual behaviour from gender, thus founding a radical and invaluable way of thinking about diversity of sexual experience and expression. However, Freud recognised that Oedipal theory, central to his project concepts, depended on maintaining what Sinfield (as cited in Davies & Neal, 1996a) called ‘the cross-sex grid’.<sup>24</sup> The cross-sex grid had its origins in 19<sup>th</sup> century Victorian dominance and oppression of the heterosexual family mode over all possible other modes. Although Freud acknowledged his own inability to completely enter this new discourse, it is this early concept of the separation of human sexuality from gender that forms the basis of many gay-affirmative psychoanalytic writers (Davies & Neal, 1996a; Isay, 1986; Izzard, 2000; Roughton, 2002; Rubinstein, 2003).

Schwartz (1995) divides psychoanalytic writing into two groups. The first proposes a genetic model of homosexuality based in psychobiology and endocrinology that sees sexual orientation as biologically determined. In twins studies, Kallman (1952) and Ekert, Bonchard, Bohlen and Heston (1986) found a significantly greater preponderance of homosexual behaviour in monozygotic than dizygotic twins. Pillard and Weinrich (1986) also reported that gay men have significantly more homosexual or bisexual brothers (22%) than do heterosexual men (4%). Scientific research by gay geneticist Le Vay (2003) has attempted to find a ‘gay gene’ and,

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<sup>24</sup> In Oedipal theory, the ‘cross-sex grid’ refers to bipolar explanations of genders and sexualities as ‘opposite’ to one another.

despite inconclusive results to date, continued research has fuelled the writings of genetic theorists such as Friedman and Downey (1993). While not ruling out the importance of the early environment in the development of sexual object choice, these authors suggest a genetic predisposition in the origin of sexuality. However, this theoretical perspective leaves out mobility of object choice (Schwartz, 1995).

The second, larger group of psychoanalytic writers (e.g., Isay, Lewes, Cornett, O'Connor & Ryan, and Rubinstein) emphasises the prevalence of homophobia in society, within the psyche and in the consulting room. Lewes (1988) retains classical developmental ideas and offers a new interpretation of the Oedipus complex. By exploring the vicissitudes of identification and object of desire, Lewes describes 12 equally valid outcomes (6 homosexual, 6 heterosexual) rather than one 'successful' heterosexual outcome.<sup>25</sup> Other postmodernist writers, i.e. O'Connor and Ryan (1993), claim the Oedipus complex is obsolete and create a view of sexuality that is fixed for life, whereas Schwartz (1995) argues for a severing of the tie altogether between the erotic and the gendered body. Goldsmith (2001) rejects the notion of a 'negative Oedipal' explanation for the homosexual boy, suggesting instead that the configuration of father as love object and mother as rival is the normative experience for the homosexual boy and should be considered his positive triangulation experience. To avoid confusion in terms, Goldsmith proposes the name 'Orestes complex', after the Greek figure who murders his mother to avenge the death of his father.

Isay (1986, 1987, 1989) believed that sexual object choice precedes development of gender identity. This is based on substantive research identifying homoerotic fantasies in gay men from the ages of three, four, and five years, with all subjects reportedly having felt 'different' from other boys. He proposed that this experience of being different and an outsider becomes a screen for conflicted preconscious

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<sup>25</sup> Lewes (1988) described 12 different possible Oedipal constellations for the boy, depending upon whether his attachment is anaclitic or narcissistic, whether he takes himself or his father or mother as object, whether this mother is phallic or castrated, whether he identifies with father or (phallic or castrated) mother, and whether his own sexual stance is passive or active.

same-sex fantasies. Isay conceptualises this period as analogous to the Oedipal stage of heterosexual boys, except that the primary sexual object appears to be their fathers. He asserts that the period of childhood homoerotic sexual attachment to the father is when a boy acquires his homosexual identity, stating: “I see no evidence either in the nature of the transference or in the nature of the sexual object choice of these men of a defensive shift in erotic interest from their mothers to their fathers” (Isay, 1986, p. 474). Isay reworked Freudian theory, suggesting that a distant relationship between a father and his homosexual son was not the cause of the homosexuality, but the result of the father’s discomfort with his son’s difference. Ensuing consolidation of homosexual identity often occurs later than in heterosexual identity development due to internalised social restraints causing the homosexual to deny his sexuality with greater vigour. Continuing conscious recognition and subsequent integration of the homosexuality throughout adulthood culminates in enhanced self-esteem, a greater sense of wellbeing and, usually, to increased productivity (Isay, 1986).

Cornett (1995) has developed an approach grounded in trauma theory and self-psychology. Utilising Kohutian principles, he recognised the deleterious effects of biased socialisation that cause narcissistic injuries and selfobject failures, and acknowledges resistances where gay men’s hope for acceptance has been overshadowed by experiences of rejection and alienation. From this perspective, the therapist becomes a consistent, soothing, and mirroring selfobject for the developing ‘gay-self,’ generally buried beneath layers of culturally fostered self-deception, and offers a relationship that affirms that authentic self. This seeks to preserve the positive selfobject transference in which the client feels understood, held and affirmed, and in which the stalled psychological growth might be resumed (Stansfield & Younger, 2006). Peterkin and Risdon (2003) underscore the importance of eliminating the therapist’s power base in therapy, suggesting that therapists who practise from an expert-centred modality<sup>26</sup> should consider its

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<sup>26</sup> Expert-centred modality refers to a practice where the therapist’s power, silence, and knowledge are central to the creation of transference.

implications. Many gay men in the past have experienced the silence, knowledge, and power of society, culture, and religion as persecutory. Therefore, a traditional analytic stance of rigid neutrality can be experienced as re-traumatising by certain gay clients and may need to be moderated. Lebolt (1999) supports Cornett's view that a more actively affirming stance in psychotherapy helps counter the effects of homophobic upbringing. However, Izzard (2000) argues that psychoanalytic neutrality is more helpful than affirmation, even when working with gay clients.

Psychodynamic approaches to working with ego-dissonant gay clients rely not only on the client's understanding of society's prejudicial and discriminatory influences but also on the analysis of family background and dynamics. In terms of object relations, Rubinstein (2003) suggests that the avoidance-approach pattern of the rapprochement stage (Mahler, 1972) might be characteristic of gay individuals who are unable to accept their sexual orientation and experience a permanent position of emotional conflict. On feeling close to another man, they are happy, hopeful, and stay with him ('shadowing'). Yet, on realising the relation has the potential to succeed, they regress and avoid, since intimacy is threatening for them ('darting away'). Once they have escaped, they feel alleviated and free from the last complication, only to feel lonely and miserable again. Loneliness pushes them into a new romance with the same disastrous consequences. The reason for their rejection is an underlying self-hatred for not being the man their family, and society, expected of them.

### ***Cognitive-Behavioural therapy approaches***

Beckian cognitive-behavioural therapy (CBT) has no explicit tradition of pathologising homosexuality<sup>27</sup> and takes a morally neutral standpoint on sexuality.<sup>28</sup> CBT acknowledges the role of environmental factors and looks at maladaptive coping patterns as 'survival strategies', rather than being due to some

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<sup>27</sup> Beckian CBT comes from a stance of humanistic empiricism.

<sup>28</sup> This is in contrast to Ellis's (1959) older rational-emotive therapy, which comes from a more heterosexist position.

psychopathology of the client. It emphasises that the one thing all gay men have in common is that they are taught to be ashamed of their sexual desire (Gray, 2000).

‘Early maladaptive schemas’<sup>29</sup> (EMS), which are unconditional, self-perpetuating, dysfunctional (leading to distress), triggered by the environment, and linked to high affect, are believed to be established in the first few years of life (Young, 1990). EMS include fundamentally held views of the self as worthless, bad, unlovable, or unacceptable. Schema-focused cognitive therapy (SFCT) has particular relevance for working with gay clients, as feeling ‘different’ is a central theme of many gay men’s early experiences. Gay people often experience attack and erosion of self-worth linked to their growing awareness of being part of a stigmatised group. A minority will develop negative schema that interfere with their capacity to function and enjoy life and, in particular, relationships. There is limited research into the prevalence of EMS in gay individuals; however, a study by Rivers (1995) demonstrating a significant relationship between homophobic bullying and later relationship difficulties supports the hypothesis that many gay people show evidence of strong negative schema.

CBT explores clients’ beliefs about their sexuality and its formation, and then employs cognitive restructuring techniques to challenge their negative belief system. With gay clients treatment is often longer, with greater emphasis placed on the relationship as the presence of entrenched negative schema impedes or prevents the development of the therapeutic alliance. Psychodrama and Gestalt techniques can be employed and integrated into an explicit CBT framework to confront self-defeating schema. Empirical evidence supports the effectiveness of CBT for many clinical problems including self-acceptance and identity-integration (Gray, 2000; Marszalek et al., 2004).

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<sup>29</sup> Early maladaptive schemas are hypothesised to be the persistent dysfunctional core beliefs that are thought to underlie enduring psychological problems.

### ***Group therapy approaches***

A central theme within a gay-affirmative approach is that the 'problem' needs to be reformulated in terms of self-acceptance (Smith, 1985). Once individual psychotherapy has brought about initial movement towards self-acceptance, group therapy can be beneficial in helping the client progress to a more adaptive adjustment of homosexuality in the area of peer socialisation.

Group therapy is an effective method for consolidating sexual identity and promoting peer-identification in both gay and mixed group therapy (Lebolt, 1999). Participation in gay groups may increase clients' awareness of the diversity of gay people and help individuals learn to deal with the vicissitudes of being gay. Participants more advanced in self-acceptance and self-disclosure may model healthy behaviour for those less far along the path to full adaptive functioning. Lebolt added, "The use of group dynamics to challenge and confront dilutes the transference directed towards the solo therapist and promotes self-reliance" (p. 402). In mixed groups, clients experience their issues as human rather than exclusively gay, which helps them develop the skills and self-confidence required to integrate into the predominantly heterosexual environment. The level of integration may vary depending on the individual's subculture. For example, Maori clients might need to overcome feelings of alienation or confusion about connection with whanau and iwi, requiring therapists to acknowledge and work alongside communal or extended family groups (Durie, 2003). With mixed group therapy, lessons learned from the development of feminist therapeutic practice, which confronts the hegemony of straight white males in the social and epistemological arena, have been valuably integrated.

### ***Religious programmes***

"There is no more divisive subject in any denomination today than the issue of homosexuality" (Culbertson, 2000, p. 190). Mahaffy (1996) found that the main source of conflict in many gay people was early religious identity (pre-coming-out). This served as a predictor to dissonance due to homosexuality being viewed as 'bad',

which was likely to be introjected. Studies show that over two-thirds of gay people felt that in order to accept their sexuality they had to reject religion (Mahaffy, 1996; Schuck & Liddle, 2001; Wagner, Serafini, Rabkin, Remien, & Williams, 1994). This has caused the anti-religion backlash that exists in the gay community. For some individuals it is easier to come out as gay in their communities of faith than it is to come out as religiously orientated in the gay community. In their quest to be simultaneously gay and Christian, these individuals often experience conflict with feelings of guilt, shame, depression, self-loathing, and suicide ideation.

Increasingly, literature from emergent religious groups calls for a more sensitive and constructive attitude towards gay Christians seeking pastoral assistance. Many authors disagree with traditional interpretations of homosexuality in the Bible (Culbertson, 2000; Gomes, 1996; Helminiak, 2000; Miner & Connoley, 2002; Scroggs, 1983; Wink, 1999). They argue it is not the authority of the Bible they challenge but the authority of the culture of interpretation, which they feel has evolved from an obsolete, patriarchal tradition that serves to legitimise its doctrinaire prejudices. This has resulted in scholars addressing the hermeneutical problem of how to translate the content of ancient texts into the language and life-context of 21<sup>st</sup> century individuals. More recently, some denominations have become more tolerant to gay members of their congregation, or splinter groups<sup>30</sup> have opted to cut off from mainstream churches to cater to members normally cast away because of their sexuality. These gay-affirmative religious groups advocate that committed gay relationships are equally as able to fulfil 'God's design for creation' and aim to help clients explore their sexuality and religious identities, evaluate their conflicts, and come to individual resolutions and choices. Rodriguez and Ouellette (2000) found that 72% of participants attending gay-friendly congregations reported less internalised homophobia, a reduction of anxiety around their conflict, and signs of increased mental health, wellbeing, and identity-integration.

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<sup>30</sup> Dignity/USA (Catholic), Integrity (Episcopal), Metropolitan Community Church (Interdenominational), Evangelicals Concerned, More Light (Presbyterian), and Association of Welcoming and Affirming Baptists.

Stuart (1997) suggests that in considering spiritual core values, religiously conflicted gay individuals must start with their own experience, from which revelation occurs. Helminiak (2000) describes this “core of spirituality as basic integrity where spiritual development is translated into affirming oneself rather than being bound by religious expectations” (p. 441). Research indicates that participants claim the main resolution to their conflict lies in the alteration or re-education of their core belief system. This was achieved by considering themselves spiritual (an intrinsic belief system) rather than religious (an external institutionalised authority) and involved re-interpreting previously damning biblical texts and reappropriation of scripture by those who felt excluded from it (Barret & Barzan, 1996; Rodriguez & Ouellette, 2000).

### ***Queer therapy***

There is a growing body of literature on this relatively new perspective that has emerged from gay-affirmative philosophy. Over the past two decades, gay-affirmative therapists have been narrowing the perceived differences between gays and straights as a necessary tactic to achieve a degree of acceptance within the field of mental health. Queer ideology shifts the focus away from similarities towards recognising the important differences (Roughton, 2002). ‘Queer therapy’ represents a rainbow coalition of non-normative sexualities that extends the politics of sexuality beyond sex and sexual minorities to include anything countercultural. “Queerness depends on identificatory alliances; with a coming together through the embracing and welcoming and opening up of difference, rather than the closing down of identity” (Stansfield & Younger, 2006, p. 6).

### **Evaluation and critique**

Growing empirical evidence shows the efficacy of a gay-affirmative approach (Hogan, 2002; Lebolt, 1999; Marszalek, 1999; Milton & Coyle, 1999; Miranda, 1986; Tozer & Hayes, 2004) and research suggests that most contemporary therapists provide gay-affirmative therapy over alternative treatments (Kilgore, Sideman, Amin, Baca, & Bohanske, 2005; MacIntosh, 1994). However, much of the

literature remains anecdotal and further empirical research is needed to underpin the effectiveness of the various conceptual approaches to working with gay clients.

Phillips, Ingram, Smith and Mindes (2003) highlight the consistently low percentage of gay empirical and theoretical publications in mainstream journals and note that 54% of 119 articles they reviewed were empirical. Of those, the majority were survey/analogue studies and most used convenience samples. 48% of the empirical articles provided no theoretical framework for their hypothesis. Bowman (2003) asserts, “Articles created from inductive reasoning alone do not tell the whole story, as they often do not provide a framework with which to explain the findings” (p. 67). In addition, Bieschke et al. (2000) note researchers’ tendency to use white, educated men as participants, which is not reflective of all gay men. Further quantitative studies with a more diverse gay population – in particular bisexual, transgender, and people of colour – to explore empirically their experiences of affirmative psychotherapy are needed.

The American Psychological Association (1992) calls its members to respect “the fundamental rights, dignity, and worth of all people...including those due to... religion...[by]... respecting the rights of others to hold values, attitudes, and opinions that differ from their own” (p. 5). Yarhouse (1998) argues that gay-affirmative practitioners may be comfortable with more liberal expressions of spirituality, while fundamental expressions of religion often appear to be overlooked as an aspect of diversity. Gay-affirmative therapists must take seriously the experiences of religious clients, refraining from encouraging an abandonment of their spiritual traditions in favour of a more gay-affirmative doctrine or discouraging the exploration of alternative options. Such an approach can impose sexual orientation over religiosity, neglecting the primary task of integrating all aspects of identity (Haldeman, 2002).

Developmentally, the heterosexual adolescent may experiment with homosexuality but remain predominantly heterosexual, just as the homosexual adolescent

experiments with heterosexuality but remains predominantly homosexual (Isay, 1989). Gay-affirmative therapists need to venture discerningly in order to distinguish the struggling homosexual client from the heterosexual client who is confused about their sexuality because of a phase they may be going through. Viewing all clients as suffering from internalised homophobia limits access to treatment that might facilitate unbiased inquiry and exploration, exacerbating clients' distress.

The identities of gay men vary as widely as any other group in society. They may share a common journey of self-acceptance, but the map for each individual on that particular journey is unique (Younger, 2007). In an attempt to affirm and validate, gay-affirmative therapy runs the risk of stifling the plurality of sexual meaning-making. A 'blanket' approach aimed solely at supporting those who experience homosexuality as ego-dissonant may deprive individuals of the opportunity to make radically different sense of their pursuits. If gay-affirmative therapy is to be generative, then it must be prepared to be critical and facilitative of the process of unique meaning-making. Simply validating the perspective of the client, where that perspective and its implications are the cause of their distress, is obviously problematic (Cross, 2001).

### **Summary**

Gay-affirmative therapists assert that the target of change is not the individual, but rather the culture. They argue that if there were no discrimination against gay people, there would be no need for gay-affirmative psychotherapy. However, in a society where gay men continue to experience prejudice and oppression, this model provides a way of healing familial and social wounds. Current research indicates that gay-affirmative therapy helps the majority of people who experience their homosexuality as ego-dissonant to achieve an increased sense of identity integration and wellbeing. Yet, there is a small group of individuals who value all aspects of their identity equally, and do not wish or are not ready to choose a conventional gay-affirmative approach for fear that their sexuality might be validated at the expense of competing values

or beliefs. Chapter Six explores emerging integrative solutions appearing in the literature that offer an alternative treatment option to such individuals.

## **CHAPTER SIX**

### **EMERGING INTEGRATIVE SOLUTIONS**

#### **Introduction**

Chapters Four and Five have examined two contrasting psychotherapies: conversion therapy and gay-affirmative therapy. Each approach values something essential to the ego-dissonant gay client – the endorsement of personal beliefs/values and sexual orientation. The ongoing debate between conversion and gay-affirmative theorists about the appropriateness and efficacy of these psychotherapies has, however, rendered dichotomous explanations insufficient for some clients for whom neither model is appropriate. This chapter elucidates comparisons and common themes from both sides of the argument and explores if it is possible, or even appropriate, to depolarise the debate. Emerging integrative solutions are examined, following which I propose a Kleinian model as a way to think about and work with clients who are unable to come to terms with their sexual orientation or integrate their sexual feelings with competing aspects of their identity.

#### **Is change of sexual orientation really possible?**

Complicating this area of research is disagreement on what sexual orientation actually is. While social constructionism and essentialism fuel the nature versus nurture debate over the aetiology of homosexuality, research does not yet clearly support one particular perspective. Some researchers (Gonsiorek et al., 1995; Spitzer, 2003) have attempted to examine sexual orientation change; however, no consensus about accurate assessment and measurement of sexual orientation has been reached. If theorists are uncertain as to what sexual orientation is, then it is understandable that there is disagreement on whether or not it can be changed (Yarhouse & Burkett, 2002).

Worthington (2004) cautions against the tendency to fall into simplistic or dualistic thinking about sexuality and argues that dichotomous notions of sexual orientation

must be challenged. Distinguishing between sexual orientation, sexual identity, and sexual orientation identity creates clearer understandings of how patterns of sexual behaviour, affiliation, and identification might change, even significantly, over time. Current research does not support the idea that persons can convert their core sexual orientation, and data indicates individuals were unable to change their core sexual arousal patterns regardless of how hard they tried (Gonsiorek et al., 1995). Thus, perceived sexual identity and sexual orientation identities have been the focal points of most individuals' reports in research (Phillips, 2004).

Increasingly, contemporary conversion therapists acknowledge that their target of change is sexual identity and that sexual orientations are essentially immutable (Yarhouse, 1998). They defend the practice without trying to establish the pathology of homosexuality and instead appeal to the individual preferences of those who are dissatisfied with their sexual dispositions (Murphy, 1992).

### **Thoughts about depolarising the debate**

The American Psychological Association (1992) calls on clinicians to respect individuals' diverse aspects of identity; however, they do not address situations where competing aspects of identity collide. So what is meant by their request for 'respect'? Respect in this sense does not mean therapists have to agree with every belief, value or expression of the client, but rather why that person chooses to accept and engage in the various expressions that make up their identity (Yarhouse & Burkett, 2002). For example, understanding why a conservatively religious, gay person chooses not to engage in same-sex behaviour.

Haldeman (2004) notes that the depth with which religious identity can be embedded in the psyche cannot be underestimated and can serve as a central organising aspect of identity that some individuals cannot relinquish. Psychology is in no position to negate clients' religious or other affiliations. Respecting a conservative religious person's view of homosexuality is not tantamount to supporting inappropriate heterosexism: "There is a difference between moral evaluation of same-sex

behaviour as volitional conduct and prejudice against another for his or her race or sex. Some gay-affirmative theorists (e.g., Stein) acknowledge this distinction” (Yarhouse & Burkett, 2002, p. 238). These writers postulate that the middle ground is perhaps to recognise that in a diverse and pluralistic society, gay-affirmative therapy, reorientation therapy, and alternative approaches may all be viable options.

While these options might suit persons who have a choice, i.e. bisexuals and individuals who identify as heterosexual but engage in homosexual behaviour, there are serious problems with this position for gay people, not least of which is that the situation is fraught with ethical malpractice risks (Gonsiorek, 2004). Gonsiorek challenges the assumptions underlying the idea of ‘unlimited client choice’. Clients struggling with issues around sexual orientation could make treatment requests based on naïveté, immaturity, interpersonal coercion and social pressure, social desirability, misinformation, personal psychopathology, misunderstanding, curiosity, or any number of other factors. It is the therapist’s professional responsibility to ensure clients are provided with enough information about recommended treatment options and appropriate ethical practice to be able to give informed consent. “It is nonsense to assert that, in requests for conversion therapy, respect for diversity requires that psychology abdicate these complex duties and considerations” (Gonsiorek, 2004, p. 755).

Furthermore, Beckstead and Morrow (2004) argue that the benefits gained by participants of sexual reorientation could have been experienced in therapies other than conversion therapies and the potential risks of harm are significant. In honouring the ethical code, ‘First, do no harm’, and harm seems likely, “we have an ethical obligation to investigate the actual risk to patients *before* offering them an intervention” (Herek, 2003, p. 439).

A key issue surrounding why the present debate resists resolution is that conservative religious ideologies typically are based on values from a separate philosophical paradigm (faith-based), which can be incompatible with principles of

scientific inquiry and professional psychological practice. Conversion therapies seek to legitimise the use of psychological techniques and behavioural science to enforce compliance with theology and religious orthodoxy. In other words, conversion therapists are asking psychology to endorse and sanction the theologically based creation of psychological distress in gay individuals. Avoiding polarisation is a worthy goal, but not at any price. “The stakes in the ‘conversion therapy’ controversy are high: psychology’s soul is in peril” (Gonsiorek, 2004, p. 758).

Miville and Ferguson (2004) raise the issue of ‘choice’ when an individual is “caught between conflicting social worlds” (p. 767). To ensure optimal psychological functioning, psychotherapists need to continue working on alternative ways to help clients as they navigate conflicts to achieve the highest level of identity synthesis possible. Thus, some authors (Beckstead & Morrow, 2001; Haldeman, 2004; Throckmorton & Yarhouse, 2006) have proposed integrative models to tackle the complexities of often-conflicting aspects of sexual identity and competing values or beliefs, such as religiosity. These do not presume a direction for the religiously conflicted gay person but instead enable the individual to explore and, if need be, change fundamental core aspects of identity without subscribing to either conversion therapy or gay-affirmative therapy. It provides guidelines to practitioners “who wish to facilitate clients setting their own therapeutic agenda, often in the face of social pressure in one direction or another” (Haldeman, 2002, p. 268).

### **An integrative model**

Emerging integrative solutions share the view that all aspects of an individual’s identity are worthy of respect and that the therapeutic goal is “to assist the client in finding a solution in which different components will find some place at the table” (Gonsiorek, 2004, p. 752). For clients who are gay and conservatively religious, effective therapy cannot focus solely on only one of those aspects, but must work to integrate both if it is to be beneficial and effective. Conflict resolution, for example between homosexuality and religiosity, is an endeavour of psychotherapeutic practice and consistent with gay-affirmative perspectives. However, this approach

differs in that, instead of the client and therapist agreeing that the goal is integrating a gay identity, this model advocates a discernment process. It should be noted that some contemporary gay-affirmative therapists do operate from such a perspective. Haldeman (2004) proposes three general stages to an integrative approach: *assessment, intervention, and integration.*

Assessment involves evaluating the client's current sexual behaviour and fantasy life, including a thorough investigation of existential implications of the person's sexual orientation and psychosocial forces that might affect the way sexual identity and expression are viewed. Advanced informed consent<sup>31</sup> provides the framework for eventual goal development whereby the client may come to his own direction. Worthington (2004) raises concerns of potential ethical malfeasance where highly polarised proponents on either side of the debate might adopt only those aspects of their approach that are consistent with and confirm previously held biases.

Following assessment comes a choice point for the client. This might lead to the goal of 'prioritising' one identity element over another, and strategies employed in the intervention phase are dependent on the identified direction of treatment. Often a psycho-educational/experimental phase ensues in which the individual is involved in social or affiliative exploration or 'trying on' of the chosen lifestyle. Alternatively, the task of the therapist may be to facilitate an 'integration' of the competing elements of identity. Rawls (1971) describes a similar process – 'reflective equilibrium' – beginning with considered judgements (intuitions) arising from a 'sense of justice' that is both a source of moral judgement and moral motivation. If our judgements are in some way conflicted, we proceed by adjusting our various beliefs until they are in equilibrium, meaning they are stable, not in conflict, and provide consistent practical guidance. For example, a gay man in therapy moves towards integrating a gay identity and so relinquishes his conservative home

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<sup>31</sup> Advanced informed consent helps the individual understand the effects of their social environment and know what appropriate treatment options are available while remaining a value-neutral enterprise (Haldeman, 2004).

community of faith for a more inclusive, gay-friendly religious environment, or the other way around.

Often conflicts contain a 'should' side saying, "do this", and a 'want' side saying, "I don't want to". Although never addressing this particular issue, Yontef's (1995) concept of the Gestalt two-chair approach is useful for gay clients faced with this type of conflict. The client role-plays both sides, speaking from the 'should' side and then the 'want' side, switching back and forth until some integration has been reached. Integration occurs because both sides begin to see some sense in the other side. "Changes in the 'should' side particularly facilitate integration because the should side moves from talking in 'shouldistic' language to expressing hopes and fears" (Bohart, 1995, p. 125). Instead of, "You shouldn't be gay," it says, "I'm worried if you're gay, you'll never be happy." However long this intervention phase lasts, the therapist must provide support and resources when requested, but act neither as cheerleader nor sceptic.

The integration phase presents a resolution of the conflict. Information gathered during intervention leads the individual to determine the course that will most likely embrace the previously conflicting elements of identity. This is an informed and fully conscious choice and the client, supported by the therapist, can access the necessary resources to make this a realistic integration. This final phase also provides an opportunity to review and evaluate the entire process. The therapist's task with such individuals is not to provide advice or direction but a safe holding environment in which the client is free to explore the many challenging questions associated with identity conflicts. Freud (1918) emphasised the importance of such a client-centred approach:

We refused most emphatically to turn a patient who puts himself into our hands in search of help into our private property, to decide his fate for him, to force our own ideals upon him, and with the pride of a Creator to form him in our own image and see that it is good...we cannot accept (the) proposal either – namely that psycho-analysis should place itself in the service of a particular philosophical outlook on the world and should urge this upon the patient for

the purpose of ennobling his mind. In my opinion, this is after all only to use violence, even though it is overlaid with the most honourable motives. (p. 164)

### *The sexual identity management model*

But what of the individual who after careful examination still feels committed to exploring sexual reorientation? Even with data indicating that conversion therapy is not a legitimate solution to this complex problem, therapists would be hard-pressed to deny individuals the treatment or spiritual interventions they seek. Throckmorton and Yarhouse (2006) have proposed strategies of sexual identity management under specific conditions in which a client maintains adherence to their personal values and/or faith and, while recognising same-sex attractions, develops ways to control or avoid unvalued sexual behaviour. Goals may include attempting to change sexual orientation, aspiring to celibacy, or managing homoerotic impulses and feelings in the context of a heterosexual identity. This might be achieved by expanding social networks and specific settings to those supportive of the desired sexual identity, or avoiding sexual behaviour until there is significant level of comfort with and desire for this activity. With this approach, it is essential that therapists continually monitor the impact that sexual identity interventions have on the client's mental and emotional status.

Sexuality and religion are two issues most capable of eliciting emotional responses for both client and therapist. Given these complexities, it is vital that therapists examine and re-examine their own feelings, beliefs, experiences, values, and assumptions, and be especially vigilant that their feelings about either or both of these areas do not lead to countertransference reactions that could exacerbate the client's confusion. Therapists' behaviours that could be an extension of countertransference are usually expressed as prejudice against clients considering a possible course of action. In the case of therapists who find themselves disappointed by a client's choices or feel challenged about maintaining facilitative neutrality in the face of a client choice, referral should be made.

### **The negative therapeutic reaction**

Friedman and Downey (1995) speculate on a clinical subgroup of conflicted gay clients in context of what Freud (1923) termed the ‘negative therapeutic reaction’.<sup>32</sup> Certain types of transference reaction – frequently a manifestation of unconscious guilt, sometimes reinforced by unconscious envy – make some clients unable to accept supportive gay-affirmative interventions. They envy the therapist for being free of the tormenting conflicts from which they suffer and may experience any primary love object as destructive. These clients seem ‘wrecked by success’ and have difficulty allowing others to be helpful to them, with histories of being success-avoidant and undermining relationships with others. Psychodynamic assessment reveals early childhood feelings of self-hate, “which was condensed into internalised homophobic narratives conducted during later childhood” (Friedman & Downey, 1995, p. 107).

Treatment strategies generally need to then move from supportive psychotherapy to a more uncovering approach. A supportive approach with ego-dissonant gay clients who express self-hatred for being gay for no logical reason might encourage individuals to express rather than attempt to suppress their sexuality. In contrast, an uncovering approach seeks to explore with clients their negative feelings about the representation of themselves as homosexual. Instead of confrontation, clarification, and psycho-education, an exploratory approach would more likely present a relatively unstructured, although empathic and accepting, therapeutic stance to facilitate regression and transference distortion. Often, symptoms represent relationships with lost objects from childhood, and, over time, the therapist would attempt to alter the balance between the client’s unconscious wishes and fears through interpretation and other techniques. If symptoms are embedded in self-destructive character pathology, treatment is likely to be lengthy and arduous, and the treatment outcome uncertain.

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<sup>32</sup> Freud (1923) describes this phenomenon sometimes occurring during the work of analysis when the analyst speaks hopefully to the analysand or expresses satisfaction with the progress of treatment, the patient shows signs of discontent and their condition invariably becomes worse.

## **A Kleinian Model**

There are a handful of clients for whom none of the above models will work; their wish to maintain both sides – sexuality and opposing values/beliefs – means that neither comfortable resolution of the conflict nor a choice of a side seems possible (Haldeman, 2004). With this in mind, I would like to elaborate on Klein's (1946) concept of the paranoid-schizoid and depressive positions<sup>33</sup> as a possible way to think about and work with individuals who are unable to integrate or choose between these competing aspects of their identity. These clients often split off conflicting aspects of themselves in a defensive manoeuvre aimed at protecting idealised fantasies of how life 'should' be. In the early stages of the therapeutic process these clients are in the paranoid-schizoid position, characterised by persecutory anxiety. Splitting allows the individual to keep contradictory feelings and impressions separate, so that they can hate and love safely, without their good parts being destroyed by their perceived bad parts. This, however, inhibits the individual's ability to be congruent.

If, in time, assessment reveals all other treatment options are unsuitable, the therapist explores with the client how it might be for them to tolerate the paradox created by their conflict, or, as the person moves into the depressive position, they themselves find matters appear differently. A shift occurs as the conflicted individual becomes able to tolerate ambivalence and, thus, to integrate both the loved and hated aspects of themselves. This painful but more realistic move to the depressive position is characterised by sadness, longing, and grieving. As the ego's tolerance for its aggressive impulses increases, its need for splitting and projection decrease, persecutory anxiety diminishes, and the ideal and persecutory aspects are allowed to come closer. In this instance, the paradox must be accepted, not resolved. For some ego-dissonant gay clients, helping them learn to increase their capacity to 'hold' ambivalence might be the best the therapist can hope for. For others, this might be

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<sup>33</sup> According to Klein's (1946) theory, during the first year of life the infant develops two 'positions': the 'paranoid-schizoid' position, assumed during the first 3 or 4 months of life due to the inability of the immature ego to integrate the death and life instincts, and the 'depressive' position, which develops when the infant ego is somewhat more mature and better capable of integration.

an essential step in reaching a place of self-acceptance, facilitating a more favourable response to a gay-affirmative approach in time.

The following vignette attempts to illustrate part of this process. After detailed assessment and examination into his experiences and motives, Matt had still been unable to fully integrate a gay-identity.

*C1: Everything points to me accepting it, and yet, there's something that stops me. I just can't take that final step. It just blows everything right out the water, again!*

*T1: You are unable to feel truly settled.*

*C2: Yup. It just seems so futile – like why keep trying? (Client becomes teary)*

*T2: It feels like an impossible position to be in.*

*C3: Yup, there aren't answers are there? ...At least not for me.*

*T3: How would it feel if there weren't any answers?*

*C4: It would just feel really... disappointing (Silence). Other people seem to manage somehow. Why can't I just accept it and be happy? ...But I can't.*

*T4: Maybe all you can do right now is accept that there are no answers, and that your faith and being gay is who you are.*

*C5: (Client sighs) It's not what I was hoping for.*

*T5: A resolution to the problem?*

*C6: Yeah, part of me really finds that hard to accept – not having an answer (Silence) ...But, in a way, it somehow feels better than constantly fighting what seems an uphill battle that just isn't going anywhere.*

In following sessions, Matt came to grieve the loss of what seemed to be an impossible dream: that of finding a definitive answer to his conflict, which he had spent most of his adult life searching for. Feelings of disillusionment and vulnerability evoked an outpouring of sadness. Yet recognition of and connection with his overwhelming disappointment created a shift beyond his 'need' to resolve this paradox. Winnicott (1968) believed that, in this instance, success in analysis

must include the 'delusion' of failure. This paradox needs to be allowed. From a psychoanalytic perspective, the analyst must be able to accept the role of failure as he accepts all other roles that arise from the client's neuroses and psychoses. Many analysts have failed at the end because they could not allow a delusional failure due to their personal need to prove the truth of psychoanalytic theory through 'curing' the client.

### **Summary**

Emerging integrative solutions offer individuals who do not wish to relinquish their sexuality or competing values and beliefs a treatment option that is aimed at valuing both. This approach assists clients to reach their own choices and offers a model of treatment based on their decision to either integrate or prioritise competing elements of their identity. For those individuals still committed to exploring sexual reorientation, a sexual identity management model is briefly discussed. Finally, for a handful of people who do not respond to any of the aforementioned approaches, a Kleinian model has been suggested as a way to increase these individuals' capacity to tolerate the ambivalence caused by their conflict.

## CHAPTER SEVEN

### CONCLUSION

This dissertation has explored the issue of working with ego-dissonant gay male clients. In an attempt to address diversity, this study began with the somewhat naïve idea that examining conversion therapy versus gay-affirmative therapy might yield a single treatment option for conflicted gay clients that neither endorses homophobic treatments nor negates opposing values and beliefs. What is evident is that people are uniquely individual, and a ‘one-size-fits-all’ approach to these kinds of conflicts is not advocated, because the variety and nature of issues brought by ego-dissonant gay clients defies generalisations. Investigation into the literature reveals that any ready-made, content-bound form of intervention will ultimately disenfranchise the client. Therefore, rather than attempt to synthesise the results from completely opposing paradigms, this study has consecutively looked at three different approaches – conversion therapy, gay-affirmative therapy, and emerging integrative solutions – each of which caters to different needs of individuals. A Kleinian-based model has been suggested for those individuals for whom none of the aforementioned modalities is appropriate.

#### **Findings**

First, research advocating the efficacy of conversion therapy is mostly outdated, non-empirical in nature, and samples used are either not representative of individuals who identify as predominantly gay, or reported change refers to sexual identity rather than an individual’s core sexual orientation. Despite evidence indicating that individuals seeking sexual reorientation are acting out of social pressure, a small number of therapists and clients believe some change is possible for certain individuals who are motivated enough to pursue it, even if such change realistically represents controlled homosexual behaviour or celibacy. These motivated individuals often have strong religious affiliations and do not wish to relinquish their

traditional doctrinal beliefs. The correlation between religiosity, homo-negativity, and the propensity to seek sexual reorientation has been well documented.

Second, current research suggests that the majority of gay clients who struggle to integrate their sexual feelings and personal values or beliefs benefit from gay-affirmative therapy. Using gay-affirmative therapy, clients have come to recognise that their conflicts, stemming from societal prejudices that they have internalised, are symptomatic manifestations of homophobia, heterosexism, insufficient social support and lack of gay role models, social stigma, and the association of a gay identity with negative stereotypes. For gay clients who enter therapy considering sexual reorientation, the goal of gay-affirmative therapy is to help these individuals realistically assess their 'impossible dream'. Literature suggests that the ensuing insight and clarity that follows gay-affirmative therapy allows the majority of clients to experience a decrease in their levels of distress and increase in self-acceptance, identity cohesion, and emotional congruency. Individuals with more advanced gay identities have a lower propensity to seek sexual reorientation. Furthermore, self-disclosure arising from increased self-acceptance has been shown to decrease ego-dystonicity.

Third, the reciprocal nature of behaviour, psychology, and health has long been recognised and recent research investigating this relationship has demonstrated the salience of religiosity as a mediator of the therapeutic alliance, client psychological health and wellbeing, and treatment outcomes. Many clients perceive spirituality to be appropriate within the therapeutic setting. Fear of their religious beliefs and values not being respected stops some religiously conflicted gay individuals from seeking professional help.

Filling this gap, emerging integrative solutions that give equal credence to an individual's spirituality and sexuality offer alternative treatment options to those who do not wish or are not yet ready to choose between traditional conversion and gay-affirmative psychotherapies. Available literature on integrative models, however,

is limited, and largely from a gay-affirmative perspective. More research and discussion is required regarding religious integrative identity models for same-sex attracted individuals and how they reconcile conservative religious doctrines with same-sex attraction.

There are a few remaining individuals for whom none of the three aforementioned modalities work; the conflict and the wish to maintain both sides of the conflict mean that neither comfortable resolution of the sides nor choice of a side are feasible. A model using Klein's concepts of the paranoid-schizoid and depressive positions has been suggested as a way to think about and work with ego-dissonant gay clients who are unable to accept, change, or integrate competing aspects of their identity. Increasing these individuals' capacity to hold ambivalence can decrease anxiety, eventuating in a shift that can better equip them to tolerate their conflicts. For some, this may be a transitional phase until they are ready to respond more favourably to a more affirmative approach in time.

Key to furthering the present discussion is the need to develop agreed methods to assess and measure sexual orientation. Additionally, empirical research is required to describe the variables that benefit and harm clients who seek both conversion therapy and gay-affirmative therapy. Furthermore, a broader array of treatment models need to be developed that test the efficacy of proposed integrative solutions in helping clients develop a positive identity and self-integration. As locally available literature is limited, research in New Zealand in all the aforementioned areas is needed to provide information regarding treatment of ego-dissonant homosexuality from a local perspective.

### **Personal learning**

As a gay Christian, this research has been challenging and beneficial, both personally and professionally. Through this study my capacity to grapple with who I am authentically, with all my competing parts, and accept my identity as rich, complex, and valuable has undergone noticeable development. Understanding

myself more fully offers hope of providing a relationship to clients that supports them in understanding themselves. Acceptance of my own contradictions has enabled me to offer clients an environment that allows them to explore and ultimately accept theirs. I have learned to remain open as I explore with clients how they make sense of and give meaning to their individual experiences. I have come to appreciate the delicate balance required in providing a safe, neutral and holding environment in which clients can fully explore and ultimately make autonomous choices regarding treatment options while being kept informed of appropriate ethical practice. I am more aware of my own contributions – assumptions, reactions, and agendas – and how these can affect therapeutic outcomes, and I have learned to be more patient and reflect on how my countertransference – anger, disappointment, feeling challenged, and the narcissistic need to cure – might enhance my capacity to understand and *meet* each client.

### **The challenge**

Through this study I have come to believe that an impartial stance regarding sexual reorientation risks underemphasising its potential for harm, and that as mental health professionals, we have an ethical responsibility to decrease the perceived need for conversion therapy. One answer to this lies in the building of respectful relationships among those who disagree about moral issues surrounding sexuality and conservative religion. This would require therapists to work alongside ministries, out in the community, so that psycho-education is not just with the individual but also at a societal level. Our role as therapists extends beyond the confines of the therapy room towards a commitment to social justice, and to enable this we must look to our leaders – professional bodies and psychotherapy schools – to lead the way. Our aim as therapists should not be concerned with what changes sexual orientation but what changes society so that all individuals can be who they are, and be valued for it.

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## APPENDIX A

### DATABASE REFERENCE SOURCES AND SEARCH WORD COMBINATIONS

**TABLE 1: PsycINFO**

<b>SEARCH WORDS</b>	<b>RESULTS</b>	<b>USEFUL</b>
Conversion \$therapy	51	33
And homosexual\$ and gay\$	27	4
And treatment\$ and outcome\$	3	0
Conversion therapy and ethic\$	28	7
Conversion therapy and attitude change	2	0
Conversion therapy and dissonan\$ and homosexual\$	0	0
Reparative \$therapy	67	11
And homosexual\$ and gay\$	57	1
Reparative therapy and ethic\$	16	1
Sexual reorientation therapy	9	0
And homosexual\$ and gay\$	10	1
Reparative therapy and dissonan\$ and homosexual\$	1	0
Sexual reorientation therapy and ethic\$	7	0
Sexual reorientation and attitude change	0	0
Gay affirmative therapy	19	12
And treat\$ and outcome\$	1	0
Dissonan\$ and homosexual\$ and gay\$	8	5
Homosexual\$ and gay\$ and conflict and dissonan\$	1	0
Gay affirmative therapy and attitude change	0	0
Homosexual\$ or gay\$ and religio\$ or spiritual\$ conflict\$	12	6
Homosexual\$ and dissonan\$ and religio\$ conflict\$	0	0

**TABLE 2: PSYCHOANALYTIC ELECTRONIC PUBLISHING (PEP)**

<b>SEARCH WORDS</b>	<b>RESULTS</b>	<b>USEFUL</b>
Conversion therapy and homosexual*	17	7
Homosexual* and treat*	1000	refined search
Adult homosexual* and treat*	259	9
Sexual reorientation and adult homosexual* conflict*	85	1
Sexual reorientation and ego-dystonic	20	3
Reparative therapy and homosexual*	19	5
Homosexual* and ego-dystonic	102	refined search

<b>SEARCH WORDS (PEP CONTINUED)</b>	<b>RESULTS</b>	<b>USEFUL</b>
Adult homosexual* and ego-dystonic	6	1
Gay affirmative and homosexual*	24	2
Homosexual* and patient harm	85	refined search
Adult homosexual* and patient harm	5	1
Freud and homosexual*	1000	refined search
Freud and adult male homosexual*	28	2
Freud and adult male homosexual* and treat*	1	0
Sexual reorientation treat* and Freud	69	0
Homosexual* and ethic* treat*	58	1
Homonegativity and treat* outcome*	1	0
Internalized homophobia and heterosexism	6	0
Adult homosexual* and religio* or conflict*	3	0

**TABLE 3: PROQUEST DISSERTATIONS AND THESES – FULL TEXT**

<b>SEARCH WORDS</b>	<b>RESULTS</b>	<b>USEFUL</b>
Conversion therapy	4	2
Reparative therapy	2	0
Sexual reorientation therapy	5	1
Dissonan* and homosexual* and outcome*	13	2
Gay affirmative therapy	9	1
Treat* and adult homosexual*	4	0
Gay identity and sexual reorientation	0	1
Homosexual* and sexual orientation change	2	0
Adult homosexual* and religio* and conflict*	53	2

**TABLE 4: MEDLINE (EBSCO, OVID, AND PUBMED)**

<b>SEARCH WORDS</b>	<b>RESULTS</b>	<b>USEFUL</b>
Conversion therapy and homosexual* and gay*	7	1
Reparative therapy and homosexual* and gay*	7	2
Sexual reorientation therapy	4	0
Gay affirmative therapy	0	0
Homosexual* or gay* and treat* and affirmat*	6	0
Homosexual* and dissonan* and conflict	9	1
Sexual orientation change	2	1

**TABLE 5: WILEY INTERSCIENCE (Medical Sciences and Psychology)**

<b>SEARCH WORDS</b>	<b>RESULTS</b>	<b>USEFUL</b>
Conversion therapy	1433	refined search
And homosexual* and gay*	4	0
Gay affirmative therapy	9	0
Dissonan* and homosexual* and treatment*	1	0

**TABLE 6: HAND-SEARCHES AUT LIBRARY JOURNALS AND INTERLOANS**

<b>SEARCH</b>	<b>USEFUL</b>
Forum (New Zealand Association of Psychotherapists)	1
AUT Library Catalogue (books)	10
St Johns Theological College Library	4
AUT Interloans (articles, books)	37
Borrow direct (articles, books)	11

