

What Research Shows: NARTH's Response to the APA Claims on Homosexuality.¹

(Summary)

The American Psychological Association (APA) and other mental health organizations have objected to providing psychological care to those who are distressed by unwanted homosexual attractions² on a number of grounds. These objections include scientifically *un*supportable claims that:

1. There is no conclusive or convincing evidence that sexual orientation may be changed through reorientation therapy.
2. Efforts to change sexual orientation are shown to be harmful and can lead to greater self-hatred, depression, and other self-destructive behaviors.
3. There is no greater pathology in the homosexual population than in the general population.

In *What Research Shows*, we offer a landscape review of more than one hundred years of experiential evidence, clinical studies, and research studies that demonstrate that it is possible for men and women to diminish their unwanted homosexual attractions and develop their heterosexual potential; that efforts to change unwanted homosexual attractions are not generally harmful; and that homosexual men and women do indeed have substantially greater experiences of and risk factors for medical, psychological and relational pathology than do the general population. Based on our review of 600 reports of clinicians, researchers, and former clients—primarily from professional and peer-reviewed scientific journals, we conclude that reorientation treatment has been helpful to many and should continue to be available to those who seek it. Further, mental health professionals competent to provide such care ethically may do so.

I. There is substantial evidence that sexual orientation may be changed through reorientation therapy.

Treatment success for clients seeking to change unwanted homosexuality and develop their heterosexual potential has been documented in the professional and research literature since the late 19th century. *What Research Shows* reviews 125 years of clinical and scientific reports which document that professionally-assisted and other attempts at volitional change from homosexuality toward heterosexuality has been successful for many and that such change continues to be possible for those who are motivated to try. Clinicians and researchers have reported positive outcomes after using or investigating a variety of reorientation approaches.

Various paradigms and approaches have been used to treat homosexuality, including psychoanalysis, other psychodynamic approaches, hypnosis, behavior therapies, cognitive therapies, sex therapies, group therapies, religiously-mediated interventions, pharmacology, and others. In many cases, combinations of therapies have been

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² The terms *homosexuality* and *homosexual* are used throughout this report as per their historical and scientific usage. The authors are aware that the terms *lesbian* and *gay* are self-identifying labels chosen by some homosexuals.

used. There also have also been reports of spontaneous change, *i.e.* of persons experiencing various degrees of sexual reorientation without professional or pastoral guidance.

Critics of reorientation therapies commonly claim that since the quality of older research and clinical reports cited as evidence that reorientation is possible do not meet current standards of research, such evidence is not relevant and may be disregarded. We disagree. Older reports of successful change were predominantly made by individual clinicians as case studies of psychoanalytic/psychodynamic therapy. These reports were “state of the art” when published; they met the acceptable standards of professional and scientific study of their day. Also, newer, more methodologically rigorous studies support the same conclusions.

Recent studies offer objective measures of the clients themselves, investigate a variety of theoretical and clinical approaches to psychotherapy, and assess the experiences of multiple therapists in the same study. While we maintain that over a century of empirical evidence documents that homosexuality is mutable (*i.e.*, motivated individuals with unwanted homosexual behaviors and/or attractions have changed successfully with therapeutic or religiously-mediated help), we also agree that there needs to be even more methodologically sophisticated research on the various approaches to psychological care for those with unwanted homosexual behaviors and/or attractions.

There are two principal premises underlying the treatment of homosexuality: First, it is primarily developmental and adaptational in nature, with other contributing factors (such as predisposing constitutional/biological factors or learning through [non-] consensual sexual activity). Second, people with a homosexual adaptation can be helped to experience a more heterosexual adjustment.

A limitation of many reports is the difficulty of clearly defining what *sexual orientation*, *homosexuality*, *heterosexuality*, and “change” means, and the failure to clarify in a given study what definitions were used. A person’s sexuality includes a number of dimensions, including feelings, thoughts, fantasies, behaviors, self-identity and role expectations, and measuring any of these dimensions in a given study at a given moment—let alone repeatedly—over a period of months or years, requires a lot of human, financial and other resources. We hope to continue our efforts to identify, highlight, and promote more state of the art research into the causes, consequences, prevention, and treatment of unwanted homosexuality.

Those who have received help from reorientation therapists have collectively stood up to be counted—as once did their openly gay counterparts in the 1970s. The first time a formal demonstration against the American Psychiatric Association was protested against—not by pro-gay activists, but by a group of people reporting that they had substantially changed their sexual orientation, and that change is possible for others—was on May 22, 1994, in Philadelphia. A similar demonstration occurred at the 2000 American Psychiatric Association convention in Chicago and again at the 2006 American Psychological Association Convention in New Orleans.

The clinical and scientific literature to date documents homosexuality is more fluid than fixed and that sexual reorientation is possible for those who choose to participate in such psychological care. The best science to date supports the rights of persons to seek competent professional care to assist them in changing their sexual orientation, and the rights of mental health professionals to offer such care. There exists no sufficient scientific, professional, or ethical basis for denying such care. We cannot deny the call for such help, as long as that help is autonomous to the client and as long as the client remains free to change direction in therapy and to embrace whatever sexual identity s/he chooses.

II. Efforts to change sexual orientation have not been shown to be consistently harmful or to regularly lead to greater self-hatred, depression, and other self-destructive behaviors.

While several leading professional mental health organizations have warned that interventions aimed at changing sexual orientation can be harmful, such warnings find no support in the professional and scientific literature. To the contrary, empirical research during the past ten years by scientists such as Spitzer, Karter, Jones and Yarhouse have not found evidence of harm. The limited body of clinical reports that claim that harm is possible— if not probable— if a person simply attempts to change, typically were written by gay activist professionals. Ironically, the major empirical attempt (Shidlo and Schroeder) to document such harm discovered evidence that reorientation therapy was helpful to some.

We acknowledge that change in sexual orientation may be difficult to attain. As with other difficult challenges and behavioral patterns—such as low-self-esteem, abuse of alcohol, social phobias, eating disorders, or borderline personality disorder, as well as sexual compulsions and addictions—change through therapy does not come easily. Relapses to old forms of thinking and behaving are—as is the case with most forms of psychotherapy for most psychological conditions—not uncommon.

Even when clients have failed to achieve the level of change that they desired, other benefits commonly have resulted from their attempts. In the past decade, several studies or surveys (e.g., Nicolosi, Byrd, and Potts; Shidlo and Schroeder; Spitzer) of persons who had participated in therapeutic or religiously-mediated sexual reorientation processes found that many persons who failed to achieve their goal of sexual reorientation nevertheless found the process beneficial. For example, some reorientation “failures” reported being less depressed, feeling more masculine (if men) or feminine (if women), and having developed more intimate nonsexual same-sex relationships. We conclude that the documented benefits of reorientation therapy—and the lack of its documented general harmfulness—support its continued availability to clients who exercise their right of therapeutic autonomy and self-determination through ethically informed consent.

III. There is significantly greater medical, psychological, and relational pathology in the homosexual population than the general population.

Researchers have shown that medical, psychological and relationship pathology within the homosexual community is more prevalent than within the general population. This is supported by studies that demonstrate the life-threatening risk-taking of unprotected sex, violence, antisocial behavior, higher levels of substance abuse, anxiety disorders, depression, general suicidality, higher levels of promiscuity and of non-monogamous primary relationships, higher levels of paraphilias (such as fisting), sexual addiction, personality disorders, and greater overall pathology among homosexual vs. heterosexual populations. In some cases, homosexual men are at greater risk than homosexual women and heterosexual men, while in other cases homosexual women are more at risk than homosexual men and heterosexual women.

Overall, many of these problematic behaviors and psychological dysfunctions are experienced among homosexuals at about three times the prevalence found in the general population—and sometimes much more. Investigators using modern, state of the art research methods have documented that many different pathological traits are more prevalent in homosexual than in heterosexual groups. We believe that no other group of comparable size in society experiences such intense and widespread pathology.

An objective synthesis of the clinical and research literature derived from hundreds of sources reveals numerous scientific findings:

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

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

A client's desire to prevent or cease experiencing such a variety of serious medical, psychological, and relational health risks is sufficient reason for anyone to seek and receive competent psychological care to minimize or resolve the desires, behaviors and lifestyles associated with such increased risks. The concerns of parents, family members and friends of persons whose sexual behaviors and/or attractions leave him or her at risk for such harms are understandable and scientifically justified. Mental health professionals ethically may offer psycho-educational and therapeutic assistance to families with such concerns in a manner that respects their loved one's age-appropriate needs for autonomy, self-determination, and confidentiality and that otherwise preserves the integrity of the therapeutic relationship.

Conclusion:

In *What Research Shows*, over a century of experiential evidence, clinical reports, and research evidence demonstrate that it is possible for both men and women to change from homosexuality to heterosexuality; that efforts to change are not generally harmful; and that homosexual men and women do indeed have greater risk factors for medical, psychological and relational pathology than do the general population. Based on our review of 125 years of reports by clinicians, researchers, and former clients, we conclude that reorientation treatment has been shown to be beneficial—and not harmful—and therefore should continue to be available to those who seek it.

The APA's own Code of Ethics supports every client's rights to autonomy and self-determination in therapy and mandates that therapists either respect a client's practice of religion and sexual orientation or refer the client to a professional who will offer such respect. Clients who are not distressed about their sexual orientation should not be directed to change by mental health professionals. Conversely, clients who seek sexual reorientation deserve properly informed and competent psychological care from therapists who use interventions that have been scientifically demonstrated as helpful for achieving this goal.