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RETROSPECTIVE SELF-REPORTS OF CHANGES IN HOMOSEXUAL ORIENTATION: A CONSUMER SURVEY OF CONVERSION THERAPY CLIENTS[1]

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Summary.—We present the results of a survey of 882 dissatisfied homosexual people whom we queried about their beliefs regarding conversion therapy and the possibility of change in sexual orientation. There were 70 closed-ended questions on the survey and 5 open-ended ones. Of the 882 participants, 726 of them reported that they had received conversion therapy from a professional therapist or a pastoral counselor. Of the participants 779 or 89.7% viewed themselves as "more homosexual than heterosexual," "almost exclusively homosexual," or "exclusively homosexual" in their orientation before receiving conversion therapy or making self-help efforts to change. After receiving therapy or engaging in self-help, 305 (35.1%) of the participants continued to view their orientation in this manner. As a group, the participants reported large and statistically significant reductions in the frequency of their homosexual thoughts and fantasies that they attributed to conversion therapy or self-help. They also reported large improvements in their psychological, interpersonal, and spiritual well-being. These responses cannot, for several reasons, be generalized beyond the present sample, but the attitudes and ideas are useful in developing testable hypotheses for further research.

The treatment of homosexuality has a long history in the psychiatric and psychological professions. Beginning with Sigmund Freud at the turn of the 20th century, many clinicians since then have attempted to help homosexual clients Psychoanalysis, psychoanalytically oriented psychotherapy, a wide variety of behavioral therapies, and a variety of group psychotherapy approaches have all been utilized to help homosexual clients. Reviews of the literature on the outcome of such therapies indicate that therapists reported considerable success at helping homosexual people minimize and overcome their homosexual behaviors and attractions (e.g., Birk, 1974; Clippinger, 1974; Rogers, Roback, McKee, & Calhoun, 1976; Adams & Sturgis, 1977; James, 1978).

Despite these reports of therapeutic success, during the late 1970s the treatment of homosexuality and research evaluating its efficacy came to a

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virtual halt. The major reason for this is that on December 14, 1973, the Board of Trustees of the American Psychiatric Association voted to remove homosexuality as an abnormal diagnostic category from the association's Diagnostic and Statistical Manual (DSM). In January 1975 the governing body of the American Psychological Association voted to support the American Psychiatric Association's decision (Conger, 1975, p. 633). With the removal of homosexuality from the DSM, many mental health professionals felt it was no longer necessary to treat homosexuality, and most researchers lost interest in investigating whether homosexual orientation could be changed.

The changing professional perceptions of homosexuality have led to the development in the past couple of decades of gay affirmative therapy (e.g., Browning, Reynolds, & Dwordin, 1991; Fassinger, 1991; Shannon & Woods, 1991). Gay affirmative therapists believe that psychotherapy with homosexual clients should focus on helping the clients (1) become more accepting and affirming of their homosexual feelings and identity, (2) negotiate and cope with the often difficult and lengthy "coming out" process, and (3) become more happy and fulfilled in their homosexual lifestyle. During the past decade, gay affirmative therapy has become the dominant therapy model within the psychiatric and psychological professions (May, 1977; Martin, 1982; Stein & Cohen, 1986; Baron, 1991; Buhrke & Douce, 1991; Fassinger, 1991; Shannon & Woods, 1991; Hancock & Cerbone, 1993).

In response to requests for assistance from dissatisfied homosexually oriented people; that is, from people who do not value the gay lifestyle and culture and who desire assistance in controlling and changing their homosexual attractions and behavior, some mental health professionals and pastoral counselors have persisted in providing sexual reorientation or conversion therapies (Consiglio, 1991; Dallas, 1991; Nicolosi, 1991; Byrd, 1993). All conversion therapy approaches have in common the goal of attempting to help dissatisfied homosexually oriented people learn to resist and minimize their homosexual behaviors, thoughts, and feelings so that they can live more happily within the mainstream heterosexual culture which they value. The approaches differ in terms of their theoretical orientation, techniques, and view of the origins of homosexuality. There are several contemporary approaches to conversion therapy, including psychoanalytic (e.g., Socarides, 1979; MacIntosh, 1994), psychodynamic (e.g., Nicolosi, 1991), and Christian or pastoral (e.g., Consiglio, 1991) approaches. Some therapists also use an integrative approach that combines elements from psychodynamic, cognitive-behavioral, family systems, and spiritual therapy perspectives (e.g., Byrd, 1993).

During the past several years, a number of professionals have provided a theoretical and ethical defense of why conversion therapies are needed in contemporary society (e.g., Consiglio, 1991; Dallas, 1991; Nicolosi, 1991; Byrd, 1993; Satinover, 1996). Essentially, they have argued that all homosex-

ual people have the right to choose and pursue their own values and lifestyle. If people wish to affirm their homosexuality and pursue a gay lifestyle, they have the right to seek gay affirmative therapy. If they wish to minimize their homosexual tendencies and pursue a heterosexual lifestyle, dissatisfied homosexually oriented people have the right to seek conversion therapy. Theoretical rationales which articulate why conversion therapies are effective and clinical guidelines describing how to do it have been provided (e.g., Consiglio, 1991; Dallas, 1991; Nicolosi, 1991; Byrd, 1993). There is also some clinical evidence which supports the efficacy of conversion therapies (e.g., Dallas, 1991; MacIntosh, 1994; Nicolosi, 1991, 1993; Byrd & Chamberlain, 1993).

During the past two decades, conversion therapists have sometimes been criticized as being unenlightened, prejudiced, homophobic, and unethical (Davison, 1976; May, 1977; Silverstein, 1977; Bayer, 1981; Martin, 1982; Socarides, 1988). Some professionals have argued that the only ethical treatment option for all homosexual people is gay affirmative therapy (e.g., Haldeman, 1994). Some gay activists within the American Psychological Association have publicly acknowledged that it is their desire to have the APA Council of Representatives declare conversion therapies as unethical on the grounds that such therapies are harmful to homosexually oriented people (e.g., Hancock & Cerbone, 1993).

On August 14, 1997, the Council of Representatives of the American Psychological Association adopted a resolution on "appropriate therapeutic responses to sexual orientation" (American Psychological Association, 1997). The resolution begins by suggesting that "some gay, lesbian, bisexual and questioning individuals [are] at risk for presenting for conversion treatment" and calls into question the "ethics" and "efficacy" of therapies that "seek to reduce or eliminate same-gender sexual orientation" (American Psychological Association, 1997, p. 1). It also reaffirms that the association does not regard homosexuality as a mental disorder, that psychologists should respect the rights of others to hold values that differ from their own, and that they should not engage in discrimination based on sexual orientation. Following this lead, in March, 1998, the governing council of the American Counseling Association also adopted a similar resolution called "On Appropriate Counseling Responses to Sexual Orientation" (Throckmorton, 1998).

What is less widely known about these two resolutions is that the original versions of both opposed and censured mental health professionals who practice conversion therapy (Stern, 1998; Throckmorton, 1998); however, due to debate and protests from some members of the associations' governing bodies, both resolutions were revised and stopped short of outlawing conversion therapies. Although some mental health professionals have hailed these resolutions as an important step in that direction (e.g., Herek, 1997, The APA resolution on appropriate therapeutic responses to sexual orienta-

tion: a comment by Gregory M. Herek, Ph.D. [Available on-line: http://psychology.ucdavis.edu/rainbow/html/resolution97_comment.html]), others have pointed out that they allow for "the full range of ethical and appropriate therapeutic approaches" (Stern, 1998, p. 3), including conversion therapies.

In the on-going professional debate about the ethical appropriateness and effectiveness of conversion therapies, it is crucial for additional research to be done with these approaches. As mentioned above, some clinical and antidotal evidence already indicates that conversion therapies are helpful to some people (Dallas, 1991; Nicolosi, 1991, 1993; Byrd & Chamberlain, 1993; MacIntosh, 1994). However, in light of continuing allegations that conversion therapies are harmful, and that no evidence exists to support their efficacy (Haldeman, 1994; American Psychological Association, 1997), additional studies are needed that investigate and document what types of people have been helped by such therapies, and in what way they have been helped. Such studies may help therapists sort out "fact from fiction" in this controversial area.

The purpose of this article is to report the results of a survey in which we asked a large sample of dissatisfied homosexually oriented people who have attempted to change their sexual orientation about their experience with conversion therapy. We asked participants to share their experiences about a variety of issues, including (1) whether conversion therapy has been helpful to them, (2) what types of changes have they experienced in their sexual orientation, (3) what types of emotional and psychological changes have they experienced since making efforts to change their sexual orientation, and (4) what influences were most helpful in their efforts to change. By surveying a large number of people who have made efforts to change their sexual orientation, the present survey allowed us to examine the ways people who have actually experienced conversion therapy believe that they have been helped or harmed.

Method

Survey Description

The first page of the survey explained that the purpose of the survey was to "explore the experiences of individuals who have struggled with homosexuality during a time in their lives, were dissatisfied with that orientation, and have since sought and experienced some degree of change." It also explained that "participation in this study is completely voluntary and anonymous. You may choose not to participate, and you have the right to refuse to answer any question." The survey participants were also instructed to mail the completed survey directly to the first author.

There were 70 questions on the survey. Participants were asked to provide (1) basic background and demographic information, (2) information

about their past and current sexual orientation, behaviors, and experiences, (3) information about their experiences with conversion therapy, (5) information about self-help change efforts they had made, and (5) information about their past and current psychological functioning. In making the ratings about their past functioning, participants were asked to recall the time in life when they were most strongly experiencing homosexual thoughts, feelings, or behaviors and to rate how they perceived their sexual and psychological functioning at that time. They were then asked to rate their current sexual and psychological functioning. These ratings were all made on 7-point Likert type scales, which gave participants the opportunity to provide a full range of responses (very poor to very good, very little to very much, very much to none). Thus, the items and responses were worded so as not to bias participants' responses in a positive or negative direction. There were also five open-ended questions that asked participants to share their perceptions about the therapy they had received, e.g., what about it was helpful, the self-help change efforts they had engaged in, and the changes they had experienced.

Procedure

Because dissatisfied homosexually oriented people who have or are making efforts to overcome their homosexual tendencies usually do so privately and quietly, such people are part of a hidden population who are difficult to identify and survey. Given the difficulties associated with surveying such people, we were forced to rely heavily on word of mouth to recruit participants.

During 1996, the first author sent copies of the survey to conversion therapists and clients throughout the United States who he was able to identify through personal acquaintance and membership roles of the National Association for Research and Therapy of Homosexuality (NARTH). He asked therapists to pass out copies of the survey to their clients and former clients and to other therapists they knew who practiced conversion therapy. These therapists and clients were also asked to give surveys to therapists and clients they knew. Many surveys were also distributed at ex-gay ministry groups, e.g., Courage, Exodus International, Evergreen International, and Homosexuals Anonymous. Advertisements were also placed in newsletters of these organizations and announced at their conferences.

All potential participants were assured that their anonymity and confidentiality would be safeguarded. They were instructed not to write their names on the surveys. Participants mailed the completed surveys directly to the first author.

The sampling procedures did not permit the researchers to keep a count of the number of people who were invited to participate in the survey, and so it is not possible to estimate response rates. Thus, it is important to keep

in mind that the results of this survey cannot be meaningfully generalized beyond the present sample. The survey also does not allow us to draw conclusions about what percentage of dissatisfied homosexually oriented people who experience conversion therapy find it helpful or unhelpful. All we can confidently conclude is that the survey enabled us to find out more about the beliefs and attitudes of this specific sample of dissatisfied homosexually oriented people.

Statistical Analysis

Basic descriptive statistics, i.e., means, medians, frequencies, percentages, were computed to describe the characteristics of the participants. Chi-square tests and paired *t* tests were used to assess whether the frequency of the participants' homosexual behaviors and their perceptions of their psychological, interpersonal and spiritual well-being changed.

As a measure of clients' deterioration, all participants who indicated that they were doing more poorly after conversion therapy than before treatment on three or more of the well-being items were identified (even if they indicated they were doing better after treatment on the rest of the well-being items). Given that critics say conversion therapy harms clients, we felt it was important to examine the data carefully for evidence of possible harm or deterioration; hence, our rather stringent criteria of clients' deterioration.

We also qualitatively analyzed the participants' written responses to the open-ended questions using the constant comparison method (Erlandson, Harris, Skipper, & Allen, 1993). First, each written response was typed and coded. This yielded 280 pages of responses. We then printed two copies of all participants' responses. One remained intact, while the third author cut up the other one with scissors into meaningful units. The second step was emergent category designation. During this step, the third author took the units of data from Step 1 and sorted them into categories or themes. He followed this procedure until all units had been assigned to a category, one of which was a miscellaneous category. In this study, we considered major themes those in which the majority (at least 60%) of the participants provided relevant comments.

Participants

Eight hundred and eighty-two people returned the survey.[2] Six hundred and eighty-nine (78%) were men and 193 (22%) were women. The average age of the participants was 37.6 yr. and the median age was 37. Seven hundred and fifty-nine (86%) participants were Caucasian (probably mostly Euro-American) and 122 (14%) were of some other racial or ethnic

[2]The numbers do not always add up to 882 because not all participants responded to every question.

background, e.g., African-American ($n = 17$), Asian ($n = 32$), Hispanic ($n = 31$), Native American ($n = 16$).

Of the participants 530 (60%) were Protestant, 103 (12%) Catholic, 79 (9%) Mormon, 8 (1%) Jewish, and 159 (18%) were some other religious faith. Eight hundred and forty-three (96%) participants said that religion or spirituality was very important to them, 35 (4%) said it was somewhat important, and 4 said it was not important. In light of this demographic finding, it is clear that the results of our survey cannot be generalized to *nonreligious* dissatisfied homosexually oriented people.

Dissatisfied homosexually oriented people from throughout the United States responded to the survey. The largest number of participants, 93 (12%), lived in California, 82 (11%) were from Texas, 44 (6%) were from New York, 43 were from Washington (6%), and 34 (5%) were from Florida. One to four percent of the rest of the participants were distributed throughout the other states. The participants were well educated as a group: 236 (27%) of the participants had a graduate degree, 95 (11%) had some graduate school training, 261 (30%) had completed a bachelor's degree, and 185 (21%) had some college education. Two hundred and eighty-one (32%) participants were married, 65 (7%) divorced, 12 (1%) separated, and 509 (59%) said they had never been married.

The average age when participants first became aware that they had homosexual tendencies was 12.4 yr. ($Mdn = 12.0$). Five hundred and twenty (60%) participants said they experienced homosexual contact when they were a child; 351 (40%) said they did not. The average age of the participants' first homosexual contact with another person was 10.9 yr. ($Mdn = 10.0$). The average age of the person with whom the participants experienced their first homosexual contact was 17.2 yr. ($Mdn = 14$). The average number of homosexual contacts with a partner reported by the participants was 120.5 ($Mdn = 25.0$).

Two hundred and sixteen participants said they had participated in conversion therapy *only* with a professional therapist, 229 said they had participated in conversion therapy with *both* a professional therapist and a pastoral counselor; 223 said they had received treatment *only* from pastoral counselor. Another 156 said they had never received conversion therapy from a therapist or counselor but had made efforts to change on their own by doing things such as reading self-help literature, talking to friends and family, and attending conferences and meetings provided by Exodus, Evergreen International, and ex-gay ministries.[3] One hundred and eighty-eight participants said that their most helpful therapist was a pastoral counselor,

[3]These numbers do not add to 882 because some participants reported that they have received therapy from both professional and nonprofessional therapists/counselors.

134 said a psychologist, 78 said a marriage and family therapist, 63 said a licensed clinical social worker, 25 said a psychiatrist, 13 said a psychoanalyst, and 155 did not know the training. Participants were not asked to speculate about their therapists' theoretical orientation.

The average age that the participants entered conversion therapy was 29.9 yr. ($Mdn = 28.0$ yr.). Five hundred and fifty-nine (84%) participants said their primary reason for entering therapy was their homosexuality; 110 (16%) said it was for other problems. The average length the participants said they had received therapy was 3.4 yr. ($Mdn = 2.0$).

Results

Table 1 indicates that as a group the participants reported retrospectively that they had experienced major changes in their sexual orientation, thoughts, and behaviors. Over 67% of the participants indicated they were exclusively homosexual or almost entirely homosexual at one time in their lives, whereas only 12.8% of them indicated that they now perceived themselves in this manner. Before treatment or change, only 2.2% of the participants perceived themselves as exclusively or almost entirely heterosexual, whereas after treatment or change 34.3% perceived themselves as exclusively or almost entirely heterosexual. As a group, the participants also reported statistically significant decreases in the frequency of their homosexual behavior with a partner from before to after treatment or change.

Of the 318 participants who viewed themselves as exclusively homosexual in their orientation before treatment or change, 56 (17.6%) reported that they now view themselves as exclusively heterosexual in their orientation, 53 (16.7%) now view themselves as almost entirely heterosexual, and 35 (11.1%) of them view themselves as more heterosexual than homosexual. Thus, 45.4% of the exclusively homosexual participants retrospectively reported having made major shifts in their sexual orientation. The exclusively homosexual participants also reported large and statistically significant decreases in the frequency of their homosexual behavior with a partner from before to after treatment or change.

There was evidence that the changes in sexual orientation reported by many of the participants were long lasting. The average length of time that had elapsed since the participants reported the changes in their sexual orientation was 6.7 yr. ($Mdn = 5.0$; range = less than 1 year to 40 years). Twenty-three percent of the participants said that it had been 10 or more years since they had experienced the changes in their orientation.

Table 2 documents the participants' self-reported perceptions of their psychological, interpersonal, and sexual status before and after treatment or change. The magnitude of retrospective change reported by the participants was large, ranging from 1 to 3 standard deviation units. Higher numbers in-

TABLE 1
RETROSPECTIVE SELF-REPORTED SEXUAL ORIENTATION AND BEHAVIOR CHANGE DATA FOR TOTAL SAMPLE AND EXCLUSIVELY HOMOSEXUAL PARTICIPANTS

Variable	Before[a]		Current[a]		χ^2	p
	n	%	*n*	%		
Total Sample						
Homosexual Orientation					201.3	<.00001
1. Exclusively homosexual	318	36.6	40	4.6		
2. Almost entirely homosexual	269	31.0	71	8.2		
3. More homosexual than heterosexual	192	22.1	194	22.3		
4. Equally homosexual and heterosexual	39	4.5	95	10.9		
5. More heterosexual than homosexual	32	3.7	171	19.7		
6. Almost entirely heterosexual	8	0.9	15	18.1		
7. Exclusively heterosexual	11	1.3	141	16.2		
Frequency of Homosexual Behavior With a Partner					84.1	<.00001
1. Very Often	253	29.6	8	0.9		
2.	127	14.8	11	1.3		
3.	144	16.8	19	2.2		
4.	84	9.8	23	2.7		
5.	53	6.2	44	5.1		
6.	80	9.3	125	14.6		
7. Never	115	13.4	626	73.1		
Exclusively Homosexual						
Homosexual Orientation						
1. Exclusively homosexual	318	100.0	37	11.6		
2. Almost entirely homosexual			36	11.3		
3. More homosexual than heterosexual			77	24.2		
4. Equally homosexual and heterosexual			22	6.9		
5. More heterosexual than homosexual			37	11.6		
6. Almost entirely heterosexual			53	16.7		
7. Exclusively heterosexual			56	17.6		
Frequency of Homosexual Behavior With a Partner					34.7	<.001
1. Very Often	117	37.1	1	0.3		
2.	44	14.0	3	1.0		
3.	56	17.8	4	1.3		
4.	30	9.5	6	1.9		
5.	13	4.1	16	5.1		
6.	23	7.3	35	11.1		
7. Never	32	10.2	250	79.4		

[a] Participants retrospectively rated their sexual orientation and behavior at a time in their lives *before* they had entered therapy or sought to change, and then rated their perceptions of their *current* sexual orientation and behavior.

dicate better functioning and so the participants reported that they were doing much better psychologically, interpersonally, and sexually after treatment or change. The magnitude of the change reported by the exclusively homosexual participants also ranged from 1 to 3 standard deviation units, again suggesting both statistically and clinically significant retrospective change and improvement (Lambert & Bergin, 1994).

TABLE 2

RETROSPECTIVE SELF-REPORTED SEXUAL, PSYCHOLOGICAL, AND INTERPERSONAL CHANGES FOR TOTAL SAMPLE AND EXCLUSIVELY HOMOSEXUAL PARTICIPANTS

Variable	*N*	Before[a]		Current[a]		*t*
		M	*SD*	*M*	*SD*	
Total Sample						
Self-acceptance	870	2.1	1.3	5.2	1.2	56.4
Self-understanding	873	2.0	1.1	5.6	1.1	72.1
Trust of opposite sex	873	2.9	1.8	4.8	1.5	30.2
Personal power	852	2.3	1.5	5.0	1.3	40.4
Self-esteem	865	2.0	1.3	5.0	1.3	56.1
Satisfying relationships	869	2.7	1.6	5.0	1.4	40.2
Emotional stability	867	2.3	1.4	5.1	1.3	48.3
Spirituality	867	2.8	1.6	5.6	1.2	42.0
Relationship with church	851	3.0	1.9	5.5	1.5	31.1
Relationship with God	863	2.8	1.7	5.7	1.3	41.9
Relationship with family	858	3.2	1.5	4.8	1.4	29.2
Depression	865	2.6	1.6	5.2	1.3	40.7
Frequency of homosexual thoughts	873	6.4	1.1	3.4	1.5	48.5
Intensity of homosexual thoughts	868	6.4	1.0	3.2	1.5	52.4
Frequency of masturbation (with homosexual fantasies)	865	5.6	1.7	2.6	1.5	43.3
Interest in heterosexual dating	756	2.4	1.7	4.4	2.1	22.5
Belief in the possibility of heterosexual marriage	751	2.9	2.1	5.3	1.9	27.4
Exclusively Homosexual						
Self-acceptance	319	2.0	1.3	5.2	1.1	36.0
Self-understanding	321	1.9	1.1	5.6	1.0	42.0
Trust of opposite sex	321	2.8	1.9	4.8	1.5	18.5
Personal power	315	2.1	1.4	5.0	1.3	27.4
Self-esteem	321	1.8	1.2	5.0	1.3	36.1
Satisfying relationships	319	2.4	1.6	5.0	1.5	25.7
Emotional stability	317	2.0	1.3	5.1	1.3	33.6
Spirituality	319	2.5	1.5	5.7	1.3	30.7
Relationship with church	308	2.5	1.8	5.7	1.5	24.3
Relationship with God	317	2.5	1.6	5.8	1.3	30.6
Relationship with family	313	2.9	1.5	4.7	1.5	19.6
Depression	318	5.6	1.5	1.7	1.2	29.5
Frequency of homosexual thoughts	321	6.7	0.7	3.4	1.5	35.3
Intensity of homosexual thoughts	319	6.7	0.7	3.1	1.5	38.9
Frequency of masturbation (with homosexual fantasies)	318	6.0	1.4	2.5	1.6	31.3
Interest in heterosexual dating	289	1.7	1.4	4.1	2.1	15.3
Belief in the possibility of heterosexual marriage	290	2.0	1.7	4.9	2.1	19.4

Note.—All comparisons were significant at $p < .001$. [a] Participants retrospectively rated their sexual, psychological, and interpersonal functioning at a time in their lives *before* they had entered therapy or sought to change their sexual orientation and then rated their perceptions of their *current* sexual, psychological, and interpersonal functioning. Rating scale was a 7-point Likert scale.

A case by case analysis indicated that 34 (7.1%) of those participants who had received conversion therapy or both conversion therapy and pastoral counseling reported that they were doing worse on three or more of the psychological, interpersonal, and spiritual well-being items after treatment than before treatment. Thus, we concluded that these participants had deteriorated in some ways, at least, during their participation in conversion therapy.

Our qualitative analysis of the participants' responses to the open-ended questions yielded three major themes (at least 60% of the participants commented on each of these themes). We labeled Theme 1, "*Participants' views of homosexuality.*" Within this theme, participants shared a variety of their beliefs about homosexuality: (1) homosexuality is wrong (sinful); (2) homosexuality is not in-born; (3) homosexuality is a learned or acquired behavior; (4) homosexuality is caused in part, at least, by a poor relationship with one's same-sex parent; (5) sexual abuse may contribute to the development of homosexual tendencies; (6) persons who struggle with homosexual thoughts and attractions are not perverted, evil, or defective; (7) homosexual behaviors are addictive and extremely difficult to overcome; and (8) persons who are strongly motivated can minimize and sometimes completely overcome their homosexual tendencies.

We labeled Theme 2, "*Perceived benefits of conversion therapies.*" Within this theme, participants described specific ways they felt they had been helped by conversion therapies: (1) therapy helped them grow in self-esteem, self-understanding, and self-acceptance; (2) therapy helped free them from feelings of shame, guilt, self-condemnation, and unworthiness; (3) therapy helped them feel more accepted and loved; (4) therapy helped them feel more intimate—physically and emotionally—with their spouse; (5) therapy helped them decrease their homosexual thoughts and behaviors to varying extents (from "some reduction" in homosexual thoughts and behavior to "completely free" from such thoughts and behaviors); (6) therapy helped men feel more masculine and women more feminine; and (7) therapy helped them enjoy healthier relationships with others.

We labeled Theme 3, "*Mechanisms of change.*" Within this theme, participants identified a number of specific influences that helped them heal and change: (1) support they received in group therapy; (2) individual counseling (professional and/or pastoral); (3) their personal spirituality and faith, e.g., scripture study, confession to spiritual leader, faith in God, prayer, experiencing God's love, acceptance, and forgiveness; (4) being accountable for one's behavior to friends, support groups, pastors; (5) understanding better the causes of their homosexuality and their emotional needs and issues; (6) developing nonsexual relationships with same-sex peers, mentors, family members, friends; (7) learning to maintain appropriate boundaries; (8) read-

ing books, tapes, and conferences about homosexuality and change; (9) participating in organizations such as Evergreen and Exodus International; and (10) having a desire to change.

Finally, although we did not ask about this and it did not emerge as a major theme, approximately 3% or 4% of the participants expressed their frustration with previous psychotherapists who had devalued and ignored their wish to overcome their homosexual tendencies and who had attempted to impose gay affirmative therapy on them.

Discussion

This study was of self-reported data, which places some limitations on the conclusions that can be drawn. It is possible that the participants may have exaggerated the magnitude of the changes they have experienced due to social desirability or seeking approval. However, the anonymous nature of the survey may have helped minimize this possibility.

Due to the retrospective design, some participants may also have had difficulty accurately remembering how they were functioning before seeking treatment and change which could also have caused to them overestimate the benefits of conversion therapy or self-help. The nonrandom sample also limits our ability to generalize the findings of the survey. We cannot safely generalize our findings to all dissatisfied homosexually oriented people or to all people who have experienced conversion therapy. We can only safely draw conclusions about responses of the 882 participants whom we surveyed.

We also cannot draw any conclusions about what types of conversion therapy may be most helpful, e.g., psychoanalytic, reparative, cognitive-behavioral, spiritually oriented, etc. This question was beyond the scope and purpose of this survey, which was simply to document whether or not there are *any* dissatisfied homosexually oriented people who believe they have been helped by conversion therapy and to gain some insight into what ways they perceive that they have been helped.

The limitations acknowledged above do not mean that this survey has no scientific value. For most surveys given to clients in psychotherapy the sample of clients is nonrandom; the results have limited generalizability. Such surveys are still valuable, however, because they allow researchers to learn more about the attitudes of at least some clients and provide documentation about whether and how the clients believe a particular therapy was helpful to them (Seligman, 1995). Such surveys allow researchers to assess whether there are *any* clients who believe that a specific type of therapy has helped them. It also allows researchers to gain some insight into what types of people are helped by the therapy and in what ways they believe it has benefited them. Over time, as numerous nonrandom studies such as this

are done, a data base accumulates that collectively begins to give researchers and clinicians a clearer picture about the effectiveness and limitations of a given therapy approach.

Thus, despite the fact that we cannot safely generalize beyond our specific sample, this study is important because it documents the existence of a group of dissatisfied homosexually oriented people who experienced conversion therapy from professional therapists and pastoral counselors and perceived that they benefited. It provides clear *prima facie* evidence that conversion therapies and pastoral counseling do help at least *some* dissatisfied homosexually oriented people. Given the fact that 96% of the participants in our sample indicated that religion or spirituality was very important to them, we can only confidently conclude that some *religiously or spiritually devout* dissatisfied homosexually oriented people perceive that they have been helped by conversion therapy. We cannot say much about the question of whether nonreligious dissatisfied homosexually oriented people have been helped by such therapies. Research must address this question.

Our finding that approximately 20% to 30% of the participants said they shifted from a homosexual orientation to an exclusively or almost exclusively heterosexual orientation is consistent with numerous studies done in the 1960s and 1970s in which changes in homosexual orientation were reported as possible (Birk, 1974; Clippinger, 1974; Rogers, *et al.*, 1976; Adams & Sturgis, 1977; James, 1978). It is also consistent with a more recent survey of 285 psychoanalysts who reported that 23% of the 1,215 homosexual patients they had treated made the transition to heterosexuality (MacIntosh, 1994). Additional evidence that people can change their sexual orientation is underscored by a recent national survey on sexuality which indicated that some people change their sexual orientation even without psychotherapy (Michael, Gagnon, Laumann, & Kolata, 1994) and by our finding that some of the respondents to our survey perceived that they had changed through self-help efforts alone.

Our finding that the vast majority of the participants we surveyed reported that they are functioning better emotionally after receiving conversion or pastoral therapy is consistent with MacIntosh's (1994) finding that 85% of the 1,215 homosexual patients treated by the psychoanalysts he surveyed experienced a significant increase in their overall well-being. This should help allay concerns raised by some that conversion therapies are necessarily psychologically harmful—to the contrary, most of the participants in our study said it was psychologically beneficial. Even those clients who had experienced minimal changes in their sexual orientation most often reported that conversion therapy benefited them psychologically, interpersonally, and spiritually.

Not only did many participants report that they made significant

changes in their sexual orientation and improvements in their interpersonal and psychological functioning, many reported that these changes were long lasting. The average reported length of time since the changes in sexual orientation and psychosocial growth had occurred was 6.7 yr., with many participants reporting that the changes had lasted much longer. This finding conflicts with the claims of critics who say that conversion therapies lift self-esteem and psychological well-being only superficially and temporarily by fostering conformity with social norms rather than psychological integration.

Our findings suggest that conversion therapies may be psychologically harmful for some people, which is of course true of all forms of psychotherapy (Lambert & Bergin, 1994). The finding that a small percentage (7.1%) of the participants we surveyed reported that they were doing worse in some ways after receiving conversion therapy underscores this point. Conversion therapy is not appropriate for all clients. Clients who have decided they wish to affirm a gay identity and lifestyle could feel shamed and emotionally hurt if therapists attempted to impose conversion therapy on them. Conversion therapy is also inappropriate for clients who are ambivalent about their homosexual tendencies and who have not yet made a decision whether to affirm or overcome them. Gay affirmative therapy is also inappropriate for such clients. As with all forms of psychological and medical treatment, therapists must carefully assess whether a treatment is indicated or contraindicated for a given client at the beginning of treatment and over time as treatment progresses.

The finding that approximately 30% to 40% of the participants we surveyed reported that they continue to struggle to some extent with unwanted homosexual behaviors and thoughts, despite treatment and efforts to change, highlights the often reported clinical observation that overcoming homosexuality is not easy for many people (Nicolosi, 1991, 1993; Byrd & Chamberlain, 1993). Our finding that the average length the participants had received therapy was 3.4 years further underscores this point. The change process is often difficult and lengthy, but many of the participants in our survey and in other studies (e.g., Byrd & Chamberlain, 1993; Nicolosi, 1993) have reported that to them it is worth it. As part of informed consent procedures, we think therapists need to tell prospective conversion therapy clients that the change process may be difficult and lengthy.

Our finding that 96% of the participants we surveyed said that religion or spirituality is very important to them was of interest. It is well known that most of the major world religions teach that homosexual behavior is contrary to God's will (Richards & Bergin, 2000). Many dissatisfied homosexually oriented people reject the gay lifestyle for religious and moral reasons and seek conversion therapy to help them cope better with their unwanted homosexual tendencies.

Some people have criticized dissatisfied homosexually oriented people's rejection of the gay lifestyle by arguing that they do so because they have internalized society's homophobia and that therapists who assist them in their efforts to change are only fostering this homophobia. Such critics, however, do not acknowledge the possibility that many people with unwanted homosexual tendencies reject the gay lifestyle, not because they are "homophobic" but because they have decided that they do not value it, and because they believe that God does not want them to pursue such a lifestyle. They have made an autonomous and difficult choice to let their religious beliefs and values take priority over their sexual urges and desires, often after failing in their efforts to accept a gay identity and find fulfillment in the gay lifestyle (Byrd & Chamberlain, 1993; Nicolosi, 1993).

The American Psychological Association's ethical guidelines explicitly include religion as one type of diversity that psychologists are obligated to respect (APA, 1992, p. 1601; Shafranske, 1996; Richards & Bergin, 1997, 2000). If clients decide to reject the gay lifestyle and seek conversion therapy for religious or spiritual reasons, psychotherapists must respect their value choice rather than labeling such beliefs as homophobic and attempting to impose an alien value framework upon them. Trying to coerce dissatisfied homosexually oriented people who desire assistance in coping with and minimizing their homosexual tendencies into gay affirmative therapy is a violation of one of the mental health profession's most widely agreed upon ethical guidelines: respect for people's self-determination and autonomy [American Psychological Association, 1992, p. 3 (Principle D); Yarhouse, 1998].

Implications for Practice of Psychotherapy

In light of our finding that some dissatisfied homosexually oriented people believe that conversion therapy has helped them sexually, psychologically, socially, and spiritually, we think conversion therapy should remain a treatment option for clients who desire it (Yarhouse, 1998. Psychotherapists should not impose gay affirmative or conversion therapy on their clients, but rather they should do their best to provide a professionally noncoercive environment that gives clients maximum freedom to express, explore, and clarify their values and beliefs about homosexuality.

When clients acknowledge that they have homosexual tendencies, we think that therapists should carefully assess their clients' beliefs and values about homosexuality to assess whether gay affirmative or conversion therapy is indicated. Clients who have made a decision that they would like to affirm and pursue a gay identity and lifestyle are probably most suitable for a gay affirmative therapy approach. Clients who for religious, spiritual, or other personal reasons have made a decision that they do not value the gay lifestyle and would like help in minimizing and overcoming their homosexual

tendencies may benefit from a conversion therapy approach. When clients are ambivalent or uncertain about their sexual orientation, therapists should be especially careful not to assume or dictate what type of treatment would be best for them, but help them, if they wish, to explore and clarify their beliefs and values until they can decide for themselves what treatment option they would prefer.

We also think that therapists should openly and honestly discuss available treatment options with dissatisfied homosexually oriented clients (American Psychological Association, 1992). They should inform clients that many professionals believe that homosexuality cannot be changed and that the best treatment option is gay affirmative therapy. They should also inform clients that many other professionals believe that homosexuality can be minimized and overcome and that the best treatment option is conversion therapy. Therapists can also inform their clients that research is needed to demonstrate more convincingly the effectiveness of both gay affirmative and conversion therapy, and caution clients that not all people who participate in either gay affirmative or conversion therapy benefit from it. Therapists explain to their clients that there are no guarantees and that probably the best criteria clients can use for deciding which type of therapy they would prefer is to select the approach that is most consistent with their values and goals.

Therapists should adhere to the American Psychological Association's ethical guideline to obtain "training, experience, consultation, or supervision necessary to ensure the competence of their services" when they encounter "differences of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status" that "significantly affect" their work (American Psychological Association, 1992, p. 1601). Psychotherapists should not only "ensure the competence of their services, or . . . make appropriate referrals" for gay people but should also do so for religious and other dissatisfied homosexually oriented people (American Psychological Association, 1992, p. 1601; Yarhouse, 1998). In addition to receiving education and training in gay affirmative therapy and assumptions, we think therapists should also seek out education and training in conversion therapy. At the least, they should be prepared to refer sensitively and appropriately dissatisfied homosexually oriented clients to conversion therapists.

During the past couple of decades, mental health professionals have made great strides in becoming more sensitive to the needs and concerns of members of the gay community. Gay affirmative therapy was and is needed to protect the rights of homosexual people who have made the decision to affirm a gay identity and live the gay lifestyle. Conversion therapy is needed to protect the rights of dissatisfied homosexually oriented people who wish assistance in coping with and minimizing their unwanted homosexual tendencies. We think that it is time for mental health professionals to preserve

the rights of *all* homosexually oriented people, gay or dissatisfied, religious or nonreligious, to choose and pursue their own values and lifestyle.

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