TREATMENT OF HOMOSEXUALITY: A REANALYSIS AND SYNTHESIS OF OUTCOME STUDIES

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PREFACE

Recent years have witnessed a growing controversy with respect to the subject of homosexuality. An increasingly vocal segment of the population is advocating "gay rights" accompanied by the implication that sexual reorientation is unnecessary, undesirable, and probably impossible. Such persons are interested in therapy or research that improves the adjustment of homosexuals, but usually oppose programs designed to reorient them. Contrary to that position, the present review attempts to establish the facts concerning the likelihood of therapeutic change by means of various treatments, for the sake of the many practitioners and clients who continue to value reorientation of sexual preference.

Chapter 1

INTRODUCTION

The extensive literature on the treatment of homosexuality reveals a vast array of differing opinions regarding outcome. At one end of the spectrum, a report of the Wolfenden Committee (1963) in Great Britain is strikingly pessimistic: "We were struck by the fact that none of our medical witnesses were able . . . to provide any reference in medical literature to a complete change" (p. 110). These researchers logically conclude that "a total reorientation from a complete homosexuality to complete heterosexuality is very unlikely indeed" (p. 110). Similarly, a letter from Freud (1935/1951) to a concerned mother, provides little further encouragement:

> By asking me if I can help, you mean, I suppose, if I can abolish homosexuality and make normal heterosexuality take its place. The answer is, in a general way, we cannot promise to achieve it. In a certain number of cases we succeed in developing the blighted germs of heterosexual tendencies which are present in every homosexual, in the majority of cases it is no more possible. (p. 787)

At the other end of the spectrum some therapy results are remarkably promising in contrast. van den Aardweg (1972), for example, maintains a 50% recovery rate for completed cases where cure is defined according to relatively stringent criteria: "The extinction of homosexual impulses (feelings and fantasies) and the restoration of normal ones, for an extended period of time. . . . something more than a so-called 'heterosexual adapation', which

takes place without a major change in feelings" (p. 63). Not only are individual authors reporting encouraging results, but entire schools of thought are sometimes equally optimistic. For example, a learning paradigm for the development and maintenance of homosexuality, implies a favorable prognosis for recovery. Kinsey demonstrated that sexual excitement to the presence of yellow rubber gloves occurs in cats who have been routinely masturbated with such gloves. "Homosexuality is no more inborn in man than sexual attachment to yellow rubber gloves is in cats. It is in both cases a learned behavior, reinforced by the experience of sexual satisfaction" (Alexander, 1967, p. 122). It follows, then, that the learning of appropriate, heterosexual contingencies is a key toward sexual reorientation.

Numerous complexities and inconsistencies in the existing literature on the treatment of homosexuality make the task of analysis and synthesis difficult. Yet such an endeavor is imperative if meaningful comparisons between studies are to be achieved and the state of the field evaluated. However, Feldman and MacCulloch (1971) make the all-too-valid observation:

> Only indirect comparisons can be made, and inevitably these must be between widely differing samples of patients, treated by different therapists, and using often unstated variations of the various possible techniques. Anyone attempting to review the literature on treatment is thus circumscribed by the unsatisfactory nature of almost the entire published literature. (p. 1)

As will be seen, the present review clearly documents this observation.

Treatment Variables

The therapist's conceptualization of homosexuality, as well as his view of man and pathology in general, influences markedly his mode of intervention. The numerous theoretical orientations that have been proposed since the time of Freud are therefore reflected in a review of the treatment of homosexuality. In point of fact, the past 48 years have produced an incredible range of treatments, making the task of comparing outcomes difficult. A partial list might begin with traditional dynamic therapies such as psychoanalysis (Bieber, Dain, Dince, Drellich, Grand, Gundlach, Kremer, Rifkin, Wilbur, & Bieber, 1962; Deutsch, 1932; Kaye, Berl, Clare, Eleston, Gershwin, Gershwin, Kogan, Torda, & Wilbur, 1967; London & Caprio, 1950; Socarides, 1969; Stekel, 1930; Thorner, 1949), psychoanalytically oriented psychotherapy (Berg & Allen, 1958; Ellis, 1956; Gordon, 1930; Hadfield, 1958; Hatterer, 1970; Jacobi, 1969; Monroe & Enelow, 1960), and psychodynamic psychotherapy from an adaptational framework (Ovesey, Gaylin, & Hendin, 1963).

A variety of other verbal psychotherapeutic approaches are prevalent in the literature: rational psychotherapy (Ellis, 1959), exaggeration therapy (van den Aardweg, 1972), fixed role therapy (Skene, 1973), and unspecified psychotherapy (Braaten & Darling, 1965; Mayerson & Lief, 1965).

Some therapists describe the use of homogeneous or heterogeneous groups in the treatment of homosexuality: psychoanalytically oriented groups (Eliasberg, 1954; Mintz, 1966), experientially oriented groups (Beukenkamp, 1960), and unspecified groups (Birk, 1974; Smith & Bassin, 1959; Truax & Tourney, 1971).

No list would be complete without a representative sampling of behavioral techniques. One subset of approaches relies heavily on an aversive element, such as electrical aversive conditioning (Bancroft & Marks, 1968; Hallam & Rachman, 1972; Thorpe & Schmidt, 1964), "rubber band" aversion (Mastellone, 1974), chemical aversion (Freund, 1960), anticipatory avoidance conditioning (Feldman & MacCulloch, 1971; Tanner, 1973, 1974, 1975), aversion relief (Mandel, 1970), covert sensitization (Barlow, Agras, Leitenberg, Callahan, & Moore, 1972; Cautela, 1967; Ince, 1973; Segal & Sims, 1972), and "assisted" covert sensitization (Maletzky & George, 1973).

Other behavior therapies employed with the aim of sexual reorientation include systematic desensitization (Di Scipio, 1968; Kraft, 1967; LoPiccolo, 1971), masturbatory conditioning (Conrad & Wincze, 1976; Marquis, 1970), intra-cranial septal stimulation (Moan & Heath, 1972), shaping (Quinn, Harbison, & McAllister, 1970; Sandford, Tustin, & Priest, 1975), fading (Barlow & Agras, 1973; McCrady, 1973), biofeedback (Barlow, Agras, Abel, Blanchard, & Young, 1975), positive classical conditioning (Herman, Barlow, & Agras, 1974a), exposure (Herman, Barlow, & Agras, 1974b), and assertiveness training (Stevenson & Wolpe, 1960).

Finally, it is noteworthy that intervention procedures other than the relatively well-known techniques already listed are occasionally found in the outcome literature. Several examples include hormones (Myerson & Neustadt, 1946), metrazol (Owensby, 1940), convulsive shock therapy (Thompson, 1949), hypnosis (Alexander, 1967; Roper, 1967), and simple counsel and environmental adjustment (Curran & Parr, 1957).

Lest this lengthy enumeration be misleading, it is critical to note that in recent years many authors, particularly those of a behavioral bent, view a combination of procedures as optimal (Blitch & Haynes, 1972; Gray, 1970; Hanson & Adesso, 1972; Kendrick & McCullough, 1972; Rehm & Rozensky, 1974; Rutner, 1970; Salter & Melville, 1972; Shealy, 1972). An observation by Hanson and Adesso (1972) illustrates one rationale for this multifaceted approach: "One may have to deal with multiple components of homosexuality: reducing the attraction value of homosexual stimuli, increasing the attraction value of heterosexual stimuli, reducing heterosexual anxiety, and helping the client establish new heterosexual social skills" (p. 323). Rehm and Rozensky (1974) then, provide an organizational framework for this multidimensional trend in treatment: "The principle is that techniques should be chosen and applied according to the topography of the various responses to be modified. This contrasts with approaches which deal with homosexuality as a single behavior complex" (p. 56).

Client Variables

In addition to the vast array of therapy techniques, other complicating factors need to be mentioned. Patients receiving treatment range from adolescents to middle-aged persons; from latent to practicing homosexuals; from those with only weak homosexual fantasies to those who engage in a variety of homosexual behaviors; from individuals seeking superficial encounters to others desiring deeply meaningful and lasting relationships; from clients engaging in exclusively homosexual behavior to others, albeit a slim minority,

exhibiting exclusively heterosexual overt behavior; from those fully involved in the homosexual subculture to those whose life only incidentally mixes with it. Of course, a survey of homosexuals in therapy would also reveal wide differences in intelligence, motivation for treatment, referral source (e.g., self-referred, pressure from family or friends, court-referred), personality variables, concomitant pathology, and so forth. We are not dealing with a homogeneous patient population. As Hadden (1972) succinctly states: "There is no such thing as a typical homosexual, any more than there is a typical heterosexual. Each individual is different, and to each his homosexual orientation has different meaning. . . . Consequently, treatment must be individualized to be effective" (p. 271-272).

Therapist Variables

Similar heterogeneity exists amongst therapists. Aside from the diverse orientations already specified, there are remarkable differences in the therapist's experience, knowledge, and skill in utilizing psychotherapeutic techniques, as well as radically differing attitudes toward homosexuality and the patients being treated. "The therapist who dislikes handling a certain type of disorder or patient or who holds the view that a particular aberration cannot be successfully treated will inevitably communicate such feelings to the patient, handicapping, often insurmountably, the therapeutic effort" (Hadden, 1966, p. 13).

While the issue of therapist attitude is discussed at some length in Chapter 4, two representative contrasting positions are provided here by way of introduction.

Freud (1920/1959) typifies the pessimistic attitude of some therapists with his terse remark: "To undertake to convert a fully developed homosexual into a heterosexual is not much more promising than to do the reverse, only that for good practical reasons the latter is never attempted" (p. 207). Furthermore, "many of the psychoanalytic authors do not regard it as desirable to attempt to lead homosexual patients to an exclusively heterosexual type of adjustment, so that any claims of success are, of necessity, rather modest" (Kraft, 1967, p. 815). At the same time these therapists generally consider the lifestyle of the exclusive homosexual to be deviant, despite their limited expectations for change.

However, recent years have seen the emergence of diverse viewpoints. One example is the "free-choice" position of Johnson and O'Brien (1975), who reiterate the importance of therapist attitude:

> Since the value system espoused by the therapist is important, his own expectations and goals for the client need to be explored. . . . Is the emphasis on changing the homosexual behavior or adjusting to it? Perhaps neither! Willis (1969) articulates the position to which we ascribe ". . . The primary object is to free the patient from the tyranny of his own unconscious so that he is able to make rational choices and to continue in human relationships characterized by fidelity and the ability to receive and give love and care regardless of the gender of his partner" (p. 124). The basic purpose of our therapeutic intervention is the creation of an atmosphere within which the client can examine alternatives and decide which are most appropriate for him. The effort has not been to effect change necessarily but to promote self-learning. (p. 23)

Such therapists generally view homosexuality as simply an alternative

lifestyle, not a pathological nor even inferior mode of sexual interaction.

In the first quote by Freud, a pessimistic prognosis for sexual reorientation is accompanied by a clear assumption of heterosexual superiority. The second viewpoint implies a more optimistic position with respect to outcome; but at the same time, movement toward heterosexuality is not necessarily encouraged, nor even considered desirable. Clearly, other therapist attitudes may fall somewhere between these two positions, or may involve elements of an entirely different nature. In any case, these examples illustrate an important concept: Therapist variables, particularly attitude toward and conceptualization of homosexuality, have an impact on not only the nature, but also the outcome, of treatment.

Outcome Variables

Numerous other variables directly affect therapy outcome, variables that once again offer no consistency across studies. Duration of treatment extends from one session of simple counsel (Curran & Parr, 1957) to hundreds of hours of psychoanalysis (Beukenkamp, 1960); from chemical aversion crowded into an intensive 28-session, 5-day course (McConaghy, 1969) to individual psychotherapy spanning a period of 9 years (Mayerson & Lief, 1965).

The means for assessing these outcomes are necessarily equally diversified, most studies using a variety of measures. Tools range from objective personality tests such as the Minnesota Multiphasic Personality Inventory (Tanner, 1974, 1975) to projective instruments such as the Rorschach Inkblots or Thematic Apperception

Test (Levin, Hirsch, Shugar, & Kapche, 1968); from measures of overt behavior (e.g., heterosexual intercourse) to those of covert events (e.g., heterosexual fantasies) (Maletzky & George, 1973); from well-known, broadly-used instruments like Kelly's Rep Grid (Thorpe, Schmidt, Brown, & Castell, 1964), to tests developed for use in a single study like the Special Scale to evaluate sexual orientation (Levin et al., 1968); from vague, subjective judgments of "better functioning in some area of life" (Ross & Mendelsohn, 1958) to specific objective measurements by a penile plethysmograph (Sandford et al., 1975). No fewer than 50 varieties of tools or measures were counted in scanning the assessment procedures of 101 studies dealing with the treatment of homosexuality!

To complicate matters still further, the criterion for the inclusion of a given individual in a study's outcome data seems to be uniquely determined by each writer. Thus, while Bancroft (1970) includes dropouts in most of his calculations, Ellis (1956) eliminates those clients seen for fewer than five sessions, and Mintz (1966) excludes all patients who received less than two years of treatment!

Along a similar vein therapy outcome may be determined while treatment is still in progress, at termination, three weeks later, or at any undetermined interval following termination! Some studies evaluate the clients at the time of writing, thus cutting across patients at all stages of therapy (Bieber et al., 1962). Other researchers, imposing controlled conditions, move their subjects through treatment at an equivalent pace, and report their results

at a given, consistent point, such as three weeks following termination. Criteria for improvement range from vague statements to precise definitions. One nebulous description of "Considerable Improvement" provides an example of the former: "Clearly recognizable improvement in behavior, or a substantial decrease in intrapsychic conflicts as measured by psychological testing or the therapist's impression" (Ross & Mendelsohn, 1958, p. 261-262). In stark contrast, the precise measurement of penile circumference to male and female stimuli yields a specific score that facilitates within and between subject comparisons.

Finally, standards for "cure" range from lenient (e.g., "heterosexual intercourse was far more frequent than homosexual intercourse," Freund, 1960, p. 317), to stringent, as typified by van den Aardweg's (1972) demands for both the elimination of homosexual urges and the establishment of heterosexual impulses. Obviously, it is difficult to make accurate comparisons across studies when a single outcome rating, such as "recovered" or "cured," is applied to such varying degrees of change with respect to sexual reorientation.

Values Variables

As we consider client and therapist variables, a word about values is in order, since it has been demonstrated that most professionals are more liberal in their moral values than the clients they serve (Lilienfeld, 1965) or the public at large (Henry et al., 1971; Bergin, 1978). In polling views on virginity, masturbation, and premarital sexual experience, Lilienfeld found that patients'

opinions were almost diametrically opposite those of the experts. As a result, a number of the intervention procedures reviewed in this study may be offensive to the client despite the support they receive from some therapists. For example, masturbatory conditioning and *in vivo* desensitization through the use of surrogate partners are two procedures that may violate the moral beliefs of patients and concerned others. Needless to say, therapists must be sensitive to the value systems not only of their clients but also the social context in which they are working. Clinical intervention cannot be isolated from social realities.

A second precaution is indicated, since the vast majority of therapists cited throughout this study equate becoming heterosexual with engaging in sexual intercourse. In light of the importance of therapist personality variables, including attitude, this is an unfortunate emphasis. There is no question but that the encouragement of heterosexual/heterosocial activity is highly appropriate when it refers to dating and developing relationships based on warmth, trust, and commitment. Certainly, romantic gestures, when congruent with the client's feelings, attitudes and values, are likewise beneficial, desirable responses to be promoted. However, all too frequently therapists hold up genital behavior as the ultimate evidence of heterosexual adjustment, ignoring the consequences of such behavior for the client's value system or the relationship itself. One gets the impression that therapists are apologetic and even derogatory toward clients who become emotionally and romantically attached to members of the opposite sex, but refuse coital experience on religious or moral grounds. In such cases the

encouragement of sexual intercourse is not only unethical, but is also unwarranted in light of the observation that the ability to "perform" is not necessarily related to a change in sexual orientation. Furthermore, some individuals present themselves for treatment having never engaged in overt homosexual behavior because of moral beliefs. Similarly it would seem inappropriate to recommend genital experimentation with members of the opposite sex or any other activity if this would violate their value systems.

Justification and Purpose

It is readily observable that the existing literature on the treatment of homosexuality is not only abundant, but also very complex. Numerous inconsistencies across studies in terms of patient, therapist, and outcome variables prevent a straightforward integration and comprehension of the literature. Gene V. Glass (1976) addressing himself to the same lack of uniformity in the field of educational research accurately describes the situation: "The findings are fragile; they vary in confusing irregularity across contexts, classes of subjects, and countless other factors. . . . ten studies . . . may fail to show the same pattern of results twice. This is particularly true of . . . outcome evaluation" (p. 3). Verbal synopses of various studies and superficial reviews yield overly simplistic generalizations at best. More often, however, the hundreds of studies "defy simple summary. Their meaning can no more be grasped in our traditional narrative, discursive review than one can grasp the sense of 500 test scores without the aid of techniques for organizing, depicting, and interrelating data" (p. 4). As a

result, researchers generally review the treatment of homosexuality by selecting a relatively few, oft-quoted outcome studies which can more easily be managed (e.g., Acosta, 1975; Frank, 1972). But "the armchair literature review in which one cites a couple dozen studies from the obvious journals can't do justice to the voluminous literature . . . that we now confront" (Glass, 1976, p. 4). Indeed, a systematic organization, analysis, and synthesis of all available data is the only means by which knowledge can be extracted and substantial conclusions drawn. Quoting T. S. Eliot, Glass addresses the problem: "'[W]here is the knowledge we have lost in information?' We are inundated with information. . . . Our problem is to find the knowledge in the information. We need methods for the orderly summarization of studies so that knowledge can be extracted from the myriad individual researches" (p. 4).

This, then, was the purpose of the present review--to "find the knowledge in the information." In other words, a method was outlined and systematically followed in order to integrate the findings of all available relevant studies on the treatment of homosexuality. The analysis was limited to those studies dealing with change in sexual orientation to some degree rather than strong commitment to helping the client adjust to society's "pressures." Furthermore, throughout this paper it must be remembered that male homosexuals provided most of the data upon which the quantitative analysis and descriptive synthesis were derived. The techniques described in the review of the literature were likewise oriented primarily toward the male patient (e.g., male slides were assumed to be homosexual stimuli).

1. Studies on the treatment of homosexuality published 1929 through 1976 were examined and included for the present analyses according to specific criteria outlined in Chapter 3.

2. Basic tables were developed from information reported in the 101 studies retained for analyses: Author(s), date of publication, number and sex of subjects, number of dropouts, degree of homosexuality, goal(s) of treatment, therapy technique(s), criteria and outcome, length of treatment, and follow-up data were provided for each study in the tables.

3. The overall outcome for homosexual clients participating in therapy was calculated across combined studies--namely, percent "Recovered," "Improved," and "Not Improved" in terms of sexual reorientation.

4. The effects of specific variables on therapy outcome were discussed and their statistical significance determined through chi square analyses: (a) Sex of client (male vs. female), (b) degree of homosexuality, (exclusively homosexual vs. bisexual), (c) duration of treatment (short-term vs. long-term), and (d) therapy technique (aversive vs. positive conditioning; single vs. multiple aims; behavioral vs. traditional approaches).

5. Studies were examined for basic principles that could be extracted in moving toward a comprehensive approach in the treatment of homosexuality. The following factors were examined in some depth: prescriptive treatment, therapist attitude, the "common principle," multiple levels of analysis, broad spectrum emphasis, and an integration of behavioral and traditional concepts and procedures.

The present study also provides (a) a descriptive summary of the numerous treatment techniques aimed at sexual reorientation, (b) an overview of the inconsistencies, complexities, and problems that beset this segment of the therapy outcome literature, and (c) a recommended report format for future research to alleviate the difficulties that currently exist.

In summary, the present study was conducted in the belief that

> A good review is the intellectual equivalent of original research. . . . we need more scholarly effort concentrated on the problem of finding the knowledge that lies untapped in completed research studies. We are too heavily invested in pedestrian reviewing where verbal synopses of studies are strung out in dizzying lists. The best minds are needed to integrate the staggering number of individual studies. This endeavor deserves higher priority now than adding a new experiment or survey to the pile. (Glass, 1976, p. 4)