A Comprehensive Response to Objections of the Treatment of Homosexuality by the American Psychological Association (APA) From The National Association of Research and Therapy of Homosexuality (NARTH)

The American Psychological Association (APA) asserts the following as their objections to the treatment of homosexuality:

(1) There is no conclusive or convincing evidence that such therapeutic attempts offer actual change.

(2) Efforts to change sexual orientation are shown to be harmful and can lead to greater self-hatred, depression and other self-destructive results.

(3) There is no greater pathology in the homosexual population than the general population (cite needed).

The Scientific Advisory Committee and the Board of Directors of The National Association for the Research and Therapy of Homosexuality (NARTH) presents the following data in response to these objections:

(1) Whereas, the APA states: There is no conclusive or convincing evidence that such therapeutic attempts offer actual change,

We contest that while there has been no published study that has sought a random population of clients to assess treatment success rates, outcomes of interventions aimed at changing sexual orientation have been widely documented within the literature since the late 18th-century. Various paradigms and approaches
have been applied and have shown various outcomes of changes in sexual orientation. Largely, however, the treatment of homosexuality has evolved from interventions aimed at changing sexual orientation to acceptance and normalization.

Well over a decade, there have been interventions with people aimed at changing their sexual orientation, along with documented outcomes. These paradigms are often referred to as conversion therapies, sexual reorientation therapies, reparative therapies, or ex-gay religiously mediated therapies. The methodology and techniques are varied. The outcome or treatment success, as they are sometimes referred to, are usually defined by a shift in sexual desire from homosexuality\(^1\) toward heterosexuality either through self-reporting or through measurements such as penile plethysmography, the 7-point Kinsey scale (Kinsey, Pomeroy, & Martin, 1948), the multi-item Klein Sexual Orientation Grid (Klein, 1978), and others (Sell, 1997). Since there is no consensus of what a successful outcome is, each author maintains his or her own autonomy in defining or not defining outcomes or successes. However, change has been measurable, and remains so.

As for the Kinsey scale, “An individual may be assigned a position on this scale, for each period in his life.... A 7-point scale comes nearer to showing the

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\(^1\) The term *homosexual* is used throughout this report as per its historical and scientific tenses. The authorship is aware that the terms *lesbian* and *gay* are preferred when referring to specific groups.
many gradations that actually exist” (Kinsey, et al., 1948, p. 656). The 7-points are as follows: 0- Exclusively heterosexual; 1- Predominantly heterosexual, only incidentally homosexual; 2- Predominantly heterosexual, but more than incidentally homosexual; 3- Equally heterosexual and homosexual; 4- Predominantly homosexual, but more than incidentally heterosexual; 5- Predominantly homosexual, only incidentally heterosexual; 6- Exclusively homosexual.

The Klein Sexual Orientation Grid (KSOG) refined the Kinsey scale. It remains with 7 intervals, but investigates sexual experience and fantasies in three times: the present (the most recent 12 months), the past (up to 12 months ago), and the ideal (which is as close as one can get to intention and prediction of future behaviors).

Klein allowed the concept that people’s sexuality can change over time. Nevertheless, these are not the only innovations Klein made. Even more important than considering that sexuality is fluid was Klein's introduction of many different factors that can influence identity. On the KSOG, subjects are also asked to consider the following in the present, past, and ideal: Sexual attraction (To whom are you sexually attracted?); sexual behavior (With whom do you actually have sex with?); sexual fantasies (Who do you fantasize about?); emotional preference (Who do you
feel more drawn or close to emotionally?); social preference (With whom do you like to socialize?); lifestyle preference (In which community do you prefer to send your time? In which do you feel most comfortable?); and self-identification (How do you label or identify yourself?).

Glover (1960) divided the degrees of treatment success into three categories: (1) cure, the abolition of conscious homosexual impulses and development of full extension of heterosexual impulse; (2) much improved, the abolition of conscious homosexual impulses without development into full extension of heterosexual impulse; and (3) improved, increased ego integration and capacity to control homosexual impulses.

Karten (2006) defined treatment success as: (a) increased sexual feelings and behaviors towards the opposite sex, (b) decreased sexual feelings and behaviors towards the same sex, (c) a stronger heterosexual identity, and (d) improvement in psychological well-being.

Some have taken a more simplistic, yet concrete view of success for example, religious-based interventions whereas celibacy is an acceptable outcome (Harvey, 1987, 1996). Even then, one does not necessarily change sexual orientation, but rather sexual identity. Others see change simplistically in other directions, for example in sexual performance only, as in the study Conrad and Wincze (1976) who treated 3 male homosexuals with masturbatory conditioning
(orgasmic reconditioning) whereas the 3 men were pleased with being able to perform with women and no longer had a need for male sexual partners. The men reported complete adjustment to their sexuality. Thus, the study was considered successful. This is not stated to consider endorsement, but rather as a means to say change is possible along with matching client self-determination.

As with any intervention, there are complete failure rates, relapses and potentials for perceived harm (Shidlo & Schroeder, 2002; Shidlo, Schroeder, & Drescher, 2001). Accordingly, of course, client-determined motivation in compliance to treatment foretells the greatest positive response in most therapeutic endeavors (Fine, 1987).

Some attempts to change sexual orientation have been invasive, for example, those using aversion therapies such as electroshock, which are now avoided given their ethical considerations, although they have shown documented treatment success in the past (Thorpe, Schmidt, Brown, & Castell, 1964; McConaghy, 1969; Hallam & Rachman, 1972). Even without intervention, studies have shown that sexual orientation is not a unitary, one-dimensional construct (Weinrich & Klein, 2002). Kernberg (2002) mentioned women, whom therapists find have an elective orientation: "a late onset homosexuality that usually is preceded by an extended

\footnote{References are listed in chronological order, from here out, unless otherwise indicated, a deviation from the \textit{Publication Manual of the American Psychological Association} (5\textsuperscript{th} ed.) which suggests alphabeticalization.}
heterosexual life style and that may revert to a heterosexual life style." (p. 16).

As far as non-clinical sexual fluidity, homosexuals have shown evidence of this within the literature. Self-reported homosexuals showed variance in their sexualities and experiences when measured on a continuum as found by Bell and Weinberg (1978). In that study, 65% of homosexual men and 84% of homosexual women reported heterosexual intercourse (Bell and Weinberg, 1978). In another finding, of the homosexual women interviewed, 70% said their first sexual experience was with a man (Paczensky, 1984 in Warczok, 1988). Another study found that 43% of homosexual men had more than once engaged in heterosexual intercourse (Dannecker and Reiche, 1974 in Warczok, 1988). Finally, seeing an attractive women "intensively" excited 13% of a sample of homosexual men as reported by Warczok (1988, p. 181).

It was clear that on comparisons of cross-preference scales among homosexual and heterosexual men, homosexual men were likely to accept cross-preference sexual feelings while heterosexual men were not. That is, the heterosexual men do not report thinking about sex with the same gender; but, the homosexual men, will on occasion think about women, sexually. Thus, a shift in erotic preference is more likely in homosexual men, but not in heterosexual men:
one-third found in homosexual men, none reported in heterosexual men
(Storms, 1980).

There is little documentation about shifts in erotic preferences of exclusively heterosexual men. While Greer and Volkan (1991) say that it is not unusual for heterosexual men to report “homosexual fantasies” (p. 109) in the course of psychoanalysis or intensive psychotherapy, erotic arousal was said to not accompany the fantasies. In their work with non-incarcerated men, Goyer and Eddleman (1984) reported that a previously self-identified exclusive heterosexual man changed his sexual preference as a result of being sexually assaulted by two men. According to Goyer and Eddleman,

Mr. K, age 22, felt that his change in sexual preference was related to his having been raped by two men ... He claimed that before the assault he had a heterosexual orientation. After the assault, he experienced sexual identity confusion and began engaging voluntarily in homosexual activity (p. 578).

To add clinical weight to this phenomenon, Goyer and Eddleman (1984) presented other cases like Mr K’s in their report.

Several approaches to report change in sexual orientation from homosexual to heterosexual have been documented in the literature using psychoanalysis,
hypnosis, behavior therapies, cognitive therapies, sex therapies, group therapies, religious-mediated interventions, pharmacology, spontaneous healing, unknown methods, combination of therapies, and others, which follow below.

Pre-Freudian

Charcot, in 1882 published a paper titled, *Inversion of the Genital Sense*. He united pristine psychiatry and congenital homosexuality through hypnosis. Charot, already famous for his treatment of hysterics through hypnotic induction, applied the same therapeutic modality to homosexual men and reported success in that "the homosexual patients became heterosexual" (Horstman, 1972, p. 5).

Albert von Schrenck-Notzing (1892) also recounted a case of treatment success using suggestion and hypnosis therapies. Prince (1898) reported treatment of sexual paraphilias, including homosexuality, and stated that 70% were essentially improved or cured (Fine, 1987). The terms *cured* and *improved* seemed to match those defined by Glover (1960).

Psychoanalysis

Sigmund Freud referred to homoeroticism as an *inversion*. Although many of his colleagues outright condemned homosexuality, Freud did not. He theorized that the etiology of the male homosexual occurred as a result of a rejecting father and a close, binding mother, which intensified the oedipal rivalry as to inhibit the choice of a female partner (Hunt, 1993). Freud felt that given these circumstances,
homosexuality (*inversion*), in some cases, could be successfully treated (Freud, 1920a, 1920b). Suggesting psychoanalysis, Freud offered that a homosexual could change orientation if desired; however, he felt it was not always predictable or necessary (Freud, 1951). As Mitchell (2002) has pointed out, Freud was rather pessimistic about the possibility of a full reversal from exclusive homosexuality to exclusive heterosexuality.

It was alleged that Jung inspired a male homosexual to conversion through dream analysis and the break down of the negative child-mother bond, which had so intensified his sexuality (Fordham, 1935).

Following the tradition of Freud, Gordon (1930) reported a case where his homosexual patient made a *heterosexual adjustment*. Again, there was the problem of what exactly adjustment consisted of. Stekel (1930) reported 3 cases of complete cure using psychoanalysis after a 1-year follow-up. Anna Freud (1949, 1952) referred to 4 cases of which she claimed led to complete heterosexual orientation.

London and Caprio (1950) reported successful psychoanalysis with 2 men whereas they allegedly became heterosexual. Caprio (1954) expressed that there was ample evidence in the scientific literature to show treatment success of homosexuality. After 18 years of treating lesbianism, although no specific numbers were given, Caprio reported that many patients who resolved former childhood conflicts had been restored to complete heterosexual adaptation.
Bergler (1956) cited his 30 years of practice in which he had successfully concluded analysis of 100 homosexuals and stated that real cure toward unfaked heterosexuality had occurred. Bergler and his associates, using psychoanalysis, reported a 33% cure rate; that is, these patients were able to function heterosexually whereas prior to treatment they were exclusively homosexual. Ellis (1956) showed distinct changes in orientation with 11 out of 40, or 28% of patients treated, while 48% showed considerable improvement. Eidelberg (1956) claimed 2 out of 5 cases as successful after a 3-year follow-up.

An unpublished report of the Central Fact-Gathering Committee of the American Psychoanalytic Association in 1956 showed 56 cases of homosexuality undergoing psychoanalysis by members of the association, which described eight in the completed group (which totaled 32 cured, 13 improved, and 1 unimproved). This constituted one-third of all the cases reported. Of the group of 34 that did not complete treatment, 16 were improved, 10 unimproved, 5 untreated, and 5 transferred. In all reported cures, follow-up communications indicted assumption of full heterosexual role and functioning.

Curran and Purr's (1957) study of 100 homosexuals demonstrated only 1 subject completely changed in orientation and 5 who made a change toward heterosexuality. Allen (1958) reported treatment success in a number of cases, although the total number was not clear. In Berg and Allen’s (1958) work, 3 out of
10 homosexual males showed successful treatment in terms of the diminution of homosexual interest and actions. Hadfield (1958, 1966) reported a 53% treatment success at a 30-year follow-up.

Robertiello (1959) gave a thorough report of a female homosexual, who after analysis with free association and dream interpretation, became aware of her unconsciousness, which led to oedipal resolution, whereas she became heterosexually adjusted. After a 2-year follow-up, she had not returned to her previous homosexuality. Beukenkamp (1960) treated a male subject with group psychoanalysis, which resulted in the subject's reorientation to heterosexuality in both behavior and experiences. Monroe and Enelow (1960) treated 4 men using psychoanalysis methods and after a 5-year follow-up found all of them heterosexually orientated.

Bieber et al. (1962) in a 9-year study of homosexual men, used an analyst team of 77 members, and provided information on 2 patient samples consisting of 106 homosexuals who undertook psychoanalysis. The results found 29 out of 106, or 27% of those completing treatment became exclusively heterosexual. Bieber (1967) found in a 5-year follow-up that 15 out of 20 subjects that they kept in contact with remained exclusively heterosexual. After 7 years, this success rate was still reported (Bieber, 1969). The subjects were followed for as long as 20 years, and treatment success defined by, exclusive heterosexuality, was still confirmed.
Coates (1962) treated 33 males and reported an outcome whereas 15% of the men resolved homosexual activity as a result of psychoanalytic intervention. Ovesey, Gaylin, and Hedin (1963) successfully treated 3 men and followed them as long as 7 years, reporting that all of them remained heterosexual. Cappon (1965) reported a 50% treatment success rate for males, and 30% for females. Mayerson and Lief (1965) reported that 47% of their 19 patients who had been in treatment at the Hutchinson Memorial Psychiatric Clinic of the Tulane University Department of Psychiatry and Neurology to be functioning heterosexuals after a follow-up with a mean of 4-1/2 years.

Mintz (1966) claimed to successfully treat 2 out of 10 patients during an 8-year period. Kaye et al.'s (1967) report of a research committee documented that 50% of homosexual women in treatment could be helped by the use of psychoanalysis. They also found that 56% of exclusive homosexual women treated made a shift to heterosexuality.

Socarides (1968) cited a 50% success rate in the psychoanalytical-based conversion treatment of homosexuals. Ten years later, treatment success was still supported; 20 out of 44 patients (44%) treated by psychoanalysis had developed to full heterosexual functioning, having no homosexual thoughts, behaviors, or fantasies (Socarides, 1978).
Jacobi (1969) referred to 60 patients treated in which 6 of them (10%) made a *definite* transformation to heterosexuality. Lamberd (1969), after a 1-year follow-up, reported 3 cases to be successfully treated. Ovesey (1969), after a 5-year follow-up, found 3 cases to be successful. Wallace (1969), after a 6-year follow-up, recounted that his subject reported continued heterosexuality; he married and led a normal heterosexual existence. While working with 12 homosexual women, Siegel (1988) found that more than half of them became fully heterosexual.

Berger (1994) described 2 cases of treatment success. One case "resulted in the patient marrying and fathering three children and living a heterosexually fulfilling and enjoyable life" (p. 255). The other was a "successful long-term psychodynamic psychotherapy treatment [which] helped relieve the patient of his original presenting symptoms and enabled him to become comfortably and consistently heterosexual" (p. 255).

Finally, a survey of 285 anonymous members of the American Psychoanalytic Association conducted by MacIntosh (1994) revealed that out of 1,215 homosexual patients analyzed by those members, 23% changed to heterosexuality from homosexuality, and 84% of the total group received significant therapeutic benefits.

**Behavior and Cognitive Therapies**

Behavioral-based therapies, not only have been used to treatment ego-
dystonic homosexuality, but used to treat, with said success, a variety of 
sexual conditions such as, impotence, frigidity, voyeurism, exhibitionism, 
transvestism, fetishism, and others (Rachman, 1961). Aversion therapies, aimed to 
change sexual behaviors of homosexuals have been used as early as the 1930s (Max, 
1935). Davison and Wilson (1973) rated over 200 behavioral therapists and found a 
mean of 60% claimed success in treating homosexuality.

By use of adaptational therapy, a 40-year-old man who practiced 
homosexuality for 22 years was successfully treated, whereas he ceased his 
homosexual behavior, married, and claimed complete cure (Poe, 1952). Albert Ellis 
(1959) by us of Rational-Emotive Therapy (RET), of which he made famous, 
reported a subject changed to heterosexuality after a 3-year follow-up. Shealy 
(1972) reported another patient changed from homosexuality to heterosexuality by 
use of RET.

Despite problematic behavioral intervention, Freund (1960) reported that 
26% of his patients treated reached heterosexual adaptation. Stevenson and Wolpe 
(1960) by use of assertiveness training reported treatment success of 2 homosexuals, 
which led to their establishment of heterosexuality. Treatment success was also 
confirmed at a 4-year follow-up. James (1962) reported successful treatment with 
the use of aversion therapy and a successful outcome in which the patient had no 
self-reported recurrence of homosexuality after an 18-month follow-up (James &
Early, 1963).

Schmidt, Castell, and Brown’s (1965) treatment outcome after assessment by independent raters found 30% of the study's exclusive homosexuals had been cured, similar to the definition by Glover (1960). Solyom and Miller (1965) treated 6 male homosexuals, all but 1 suffering from neurotic anxiety, with the use of a double (differential) conditioning technique in which a projection of a picture of a seminude male was accompanied by an electric shock, while a photograph of a female was positively reinforced by termination of a continuous electric shock. Using plethysmograph response for objective assessment of therapeutic results, no change was found in autonomic responses to male pictures but there was an apparent increase in responses to sexually stimulating female pictures.

Mather (1966) reported that out of 36 homosexuals treated with behavioral and aversion techniques, 25 were considered much improved on the Kinsey scale. Kraft (1967, 1970) treated 2 men with systematic desensitization and some psychoanalysis and found that they responded as heterosexuals after treatment. MacCulloch and Feldman (1967) treated 43 homosexual men with aversion therapy and dedicated a career in the treatment of homosexuals using aversion therapy. Larson (1970) after use of an adaption of MacCulloch’s and Feldman’s approaches (anticipatory avoidance learning) also reported treatment success, however without specific counts.
Serban (1968) reported treatment of 25 homosexuals using existential therapeutic approaches. He conducted a case review and concluded that after his subject's erotic perceptions were changed, so did the subject's sexual orientation.

Fookes (1969) summarized the clinical experience of 5 years of aversion treatment given in 27 cases of sexual disorders. Success ranged from 60% with homosexuality to 100% with fetishism-transvestism, and no harmful effects of aversion treatments were discernible. The patients were said to have welcomed the changes, which consisted of the loss of desire for the behavior (seen as a perversion). McConaghy (1969, 1970, 1975) and McConaghy, Proctor, and Barr (1972) found successful subjective and penile plethysmography responses with applied aversion therapy in the treatment of various male homosexuals.

In Bancroft's (1970) study, 5 out of 15, or 33% desensitized treated homosexuals yielded significant shifts toward heterosexual behavior. Hatterer (1970) found in a follow-up of his treatment of 143 homosexuals that 49 or 34% recovered completely, that is, achieved a heterosexual adjustment. Using covert sensitization techniques, Cautela and Wisocki (1971) recounted a 37% success rate after a 1-year follow-up.

Feldman and MacCulloch (1971) worked with 36 patients using anticipatory avoidance learning therapy. They found a 57% treatment success after a 1-year follow-up. Feldman, MacCulloch and Orford (1971) reported follow-up results on
research done between the years of 1963-1965 with 63 male homosexual patients. They reported that 29% of the patients who had no prior heterosexual experience had changed. Change was indicated by the cessation of homosexual behavior, only occasional homosexual fantasies or attractions, and strong heterosexual fantasy, behavior, or both. Van den Aardweg (1971) related that 9 out of 20 patients treated using exaggeration therapy were completely cured. Cured, meaning no homosexual fantasies or behaviors were reported.

Hallam and Rachman (1972) administered a course of electrical aversion therapy to 7 patients complaining of "deviant sexual behavior" including homosexual impulse, and 4 made discernible progress while 3 failed to respond. After treatment, significant changes in heart rate response to sexual stimuli were detected. The successful cases showed a significant increase in the time required to imagine sexual material. The results were seen as providing some support for the conditioning theory of aversion therapy, although the use of electrical aversion is seen as unethical today compared to the 1970s.

Barlow and Agras (1973) found a 30% decrease of homosexual behavior in patients up to 6 months in follow-up utilizing the flooding technique. Maletzky and George (1973) reported on 10 homosexual males who were treated with covert sensitization behavioral therapy; after a 12-month follow-up, they indicated a 90% success rate.
Utilizing avoidance conditioning, classical conditioning, and backward conditioning, McConaghy and Barr (1973) found one-fourth of their patients ceased homosexual behavior totally after a 1-year follow-up. Freeman and Meyer (1975) used behavioral approaches and reported a 78% successful treatment rate in patients who were exclusively homosexual after an 18-month follow-up.

McCrady (1973) presented his work with a 27-year-old male, using a behavioral technique involving slide images with the goal to increase heterosexual responses measured by penile circumference measurements and the Sexual Preference Rating Scale. The client had been aware of homosexual attractions since about age 14. Initially, the client became fully aroused only at increments 19-22 (increment 20, for example, is the fading point where the nude female slide was only 10% visible and the nude male slide was 90% visible). As treatment (sessions 2-12) progressed, the penile circumference measures indicated that the client became sexually aroused earlier in each fading sequence. In sessions 9 and 10, peak erection occurred, on average, at increment 6 (the fading point where the nude female slide was 75% visible and the nude male slide was 25% visible). However, the client's degree of sexual arousal based on the Sexual Preference Rating Scale (done in sessions 1 and 13) was unchanged toward females and slightly increased toward males. Thus, no conclusive statements about change in attraction could be made.

The discrepancy may be due to an unintended conditioning. Initially, the
client became aroused only once the slide of the highly arousing male was fully visible. After a while, the client's earlier arousal while seeing the female slide may have been due to that slide signaling that the male slide would increasingly be appearing, and thus he became aroused in anticipation. During and after treatment, two other changes occurred. First, the client began to identify himself as no longer being homosexual. In the group therapy that he attended, he "frequently used or implied the phrase, 'When I used to be homosexual'" (p. 260). He also reported numerous occasions of heterosexual fantasy. No heterosexual sexual activity was reported, and there was no evident change in homosexual behavior or fantasy. Thus, all that can be said for certain is that the client's self-identification changed and heterosexual fantasies had either started or increased. Since no explicit statements were made about the prior existence of such fantasies, it is not clear which of the two is more accurate.

Cantón-Dutari (1974, 1976) used desensitization, aversion, and contraction-breathing technique to help active homosexual males to control their sexual arousal to homosexual images. Out of 54 patients, 48 were considered successfully treated, as they had attained the primary goal of controlling sexual arousal in the presence of a homosexual stimulus. Forty-four of 49 were able to perform adequately during heterosexual intercourse. Twenty-two were followed for an average of 3-1/2 years. Eleven of them remained exclusively heterosexual; the other 11 masturbated to
homosexual imagery but did not involve themselves in homosexual behavior. Four of the patients married.

Herman (1974) studied the use of classical conditioning of sexual response to female stimuli, using slides and films with homosexual content in 3 homosexual identified men using single subject experimental designs. Critical variables in the classical conditioning procedure were systematically introduced and removed while objective and subjective measures of homosexual and heterosexual behavior were recorded (e.g., penile responses and self-reports of sexual urges and fantasies). Subjects completed the Sexual Orientation Method before and after each experimental phase. In 2 subjects, classical conditioning was an effective procedure for increasing heterosexual arousal. In a 3rd subject, classical conditioning was not effective.

Orwin, James, and Turn (1974) reported the effective reorientation of a male homosexual by using electric aversion therapy. Tanner (1974) assigned 8 men who identified themselves as homosexuals to an automated aversive conditioning group (shock) and eight others to a waiting list control group following a pre-training assessment. At the end of 8 weeks, all subjects participated in a second assessment. The aversive conditioning group showed significant decreases in erectile response to slides of male nudes in self-rated arousal to male slides and on the Masculinity-
Femininity Scale (Mf) scale of the Minnesota Multiphasic Personality Inventory (MMPI), while showing significant increases in reports of frequency of sex with females, frequency of socializing with females, and the frequency of sexual thoughts about females versus males.

Tanner (1975) assigned 10 males completing avoidance training to modify homosexual behavior to either a booster or a nonbooster condition. Booster subjects received 5 additional sessions during the year following termination, while the control subjects had no contact during that year. One year after termination, subjects returned for an evaluation consisting of erectile response to slides of nudes, self-report of arousal while viewing the slides, the Mf of the MMPI, self-report of frequency of sex with men and women, frequency of thoughts about sex with men and women, frequency of socializing with men and women, and number of categories of sexual behavior engaged in with both sexes. No significant difference was found between the groups for any of the measures. When repeated measurement tests were used, however, 5 of 7 tests attained significance at the .05 level or beyond, indicating that the avoidance training per se was effective, but that the booster sessions did not increase the effectiveness of the procedure.

Using covert sensitization methods over a period of several years, Callahan, Krumbolz, and Thoresen (1976) reported at the 4-1/2 year follow-up that his client
said there was "no problem with homosexual arousal and that he has a good sexual relationship with his wife" (p. 244). According to measurement on the Kinsey scale, he was considered predominantly heterosexual. Others using covert sensitization also reported successful outcomes of shifts from homosexual behavior to heterosexual behavior (Mandel, 1970; Kendrick & McCullough, 1972; Segal & Sims, 1972).

By use of systematic desensitization, Phillips, Fischer, Groves, and Singh (1976) reported a successful behavioral outcome of a male patient. Their definition of success meant that the man was able to initiate heterosexual contact with an 18-month follow up with no homosexual activity. Similar behavioral results using systemic densitation were reported by Kraft (1967), Ramsey and van Velzen (1968), Bergin (1969), Huff, (1970), and S. James (1978).

McConaghy, Armstrong, and Blaszczynski (1981) attempted to evaluate behavior therapy for homosexuals in response to ethical objections of such treatment. Twenty subjects requesting behavior therapy to reduce compulsive homosexual urges were randomly allocated to either receive aversive therapy using electric shocks, covert sensitization, or both. Both groups were studied for 1 year. There was no consistent trend for one therapy to be more effective than the other in reducing the strength of compulsive homosexual urges, and the response to both was
similar to that reported in previous studies. It was suggested that aversive therapies in homosexuality does not work by establishing a conditioned aversion or by altering subject’s sexual orientation. The authors concluded that they reduced aversive arousal produced by behavior completion mechanisms when subjects attempt to refrain from homosexual behavior in response to stimuli that have repeatedly provoked such behavior in the past.

Pradhan, Ayyer, and Bagadia (1982) demonstrated that by utilizing behavioral modification techniques, 8 out of 13 male homosexuals showed a shift to heterosexual adaptation that was maintained in a 6-month and 1-year follow-up. Van den Aardweg (1986a, 1986b) reported treating over 100 homosexuals using cognitive approaches and found that one-third of them had been *radically changed* in heterosexual adaptation.

As Throckmorton (1998) discussed, many behavioral counselors, largely from the 1970s era, have advocated for the use of a variety of behavioral techniques to achieve sexual shifts toward heterosexuality (Barlow, 1973; Barlow & Durand, 1995; Bergin, 1969; Blitch & Haynes, 1972; Freeman & Mayer, 1975; Gray, 1970; Greenspoon & Lamal, 1987; Hanson & Adesso, 1972; Marquis, 1970; Rehm & Rozensky, 1974; Tarlow, 1989; Wilson & Davison, 1974).³

³ References listed in alphabetical order.
Finally, the level of success in decreasing homosexuality, claimed by behavioral therapists is essentially a third or more in reported cases (Birk et al. 1971; Bancraft, 1974). As stated previously, a high percentage of behavioral therapists surveyed said they were successful when they had a goal of helping them achieve heterosexual shifts (Davison & Wilson, 1973). The rates of success may be quantitatively available for behavioral therapy outcomes; however, ethical issues, and advances in psychotherapy, prohibit the use of aversion procedures.

Group Therapies

Eliasberg (1954) presented an account of group therapy with 12 homosexuals and found 3 members who were able to experience a shift from homosexuality to heterosexuality. Thus, group techniques (group analyses of dreams) in 3 cases were considered successful. Hadden (1958) reported in the American Journal of Psychiatry that he treated 3 homosexual subjects where 1 experienced a shift to heterosexual adjustment. Smith and Basin (1959) treated 2 men in group therapy and noted 1 as having had marked improvement while the other sought heterosexual adjustment.

According to Litman (1961), a homosexual man was reported to have changed sexual orientation facilitated by group therapy. Hadden (1966) reported after treating 32 homosexuals in group therapy a 38% success rate in which subjects progressed to an exclusively heterosexual pattern of adjustment and showed marked
improvement in, or disappearance of, other *neurotic* traits after follow-up. Birk, Miller, and Cohler (1970) also reported a similar success rate of 33% and claimed significant improvements in a number of cases.

T. Bieber (1971) related over a 40% success rate by use of group therapy. Hadden (1971) confirmed a one-third success rate. Pittman and DeYoung (1971) expressed that 2 out of 6, or one-third of homosexuals treated received maximum benefit and established the goal of heterosexuality.

Truax and Tourney (1971) related that group treatment of 30 patients compared to 20 untreated controls increased heterosexual orientation, decreased homosexual preoccupation, reduced neurotic symptomatology, improved social relations, and increased insight into the causes and implications of homosexuality. Changes in sexual behavior included increased heterosexual dates, decreased homosexual experiences, and increased heterosexual intercourse. More improvement was seen in the associated neurotic symptomatology than in the homosexual orientation, although this latter parameter of functioning improved with further therapy.

Birk (1974) reported a 38% success rate after a 6-year period from a sample of 26 subjects (16 from the earlier study). Birk (1980) reported that 10 of 14, or 71% of men in treatment for over 2-1/2-years, and who were exclusively homosexual prior to treatment, were heterosexually adjusted (married) at follow-up.
Group therapy combined with other therapies has shown various, yet consistent, treatment successes over a 10-year period (Ross & Mendelsohn, 1958; Finny, 1960; Buki, 1964; Mintz, 1966; and Miller, 1968). Like behavioral therapy reports, group therapy reports a treatment success rate of one-third or more of cases making a shift in orientation.

**Sex Therapies**

Alfred C. Kinsey reported treatment of more than 80 homosexual men who had made satisfactory heterosexual adaptation (Pomeroy, 1972). Conrad and Wincze (1976) treated 3 male homosexuals with masturbatory conditioning (orgasmic reconditioning) whereas the 3 men were pleased with being able to perform with women and at the same time had no thought or a need for male sexual partners. The men reported complete adjustment to their sexuality. Thus, the study was considered successful.

In Masters and Johnson's (1979) treatment of 90 homosexuals, a 28.4% failure rate was reported after a 6-year follow-up (Schwartz & Masters, 1984). Masters and Johnson chose to report failure rates to avoid vague concepts of success. Although the failure rate was not equated in terms of success rate, it seemed valid to compare the success of their work with those reported in other studies dealing with change of orientation, according to Diamant (1987).
Hypnosis

As reported earlier, Charcot (1882) applied hypnotic induction to homosexual men and reported success whereas "the homosexual patients became heterosexual" (Horstman, 1972, p. 5). Albert von Schrenck-Notzing (1892) had similar findings (Fine, 1987). Cafiso (1983) related successfully treating a homosexual man by strengthening his ego through hypnosis. This corresponds with the positive reports of hypnosis from Regardie (1949), Alexander (1967), and Roper (1967).

Pharmacological Interventions

Owenshy (1940) reported 6 patients ceased all homosexuality due to the use of Metrazol. Similar findings with the use of Brevital, in conjunction with Wolpe's relaxation methods, were found in Kraft's (1967) report. Golwyn and Sevlie (1993) reported adventitious change in the sexual orientation of a 23-year-old homosexual male. After receiving Phenelzine for shyness and anxiety, the man reported he no longer had sexual interest in other men. The authors concluded, "Social phobia may be a hidden contributing factor in some instances of homosexual behavior and that Phenelzine, like other dopaminergic agents, might facilitate male heterosexual activity" (p. 40).

Other Interventions

Being coerced into therapy does not seem to work as in the case reported by
Fry and Rostow (1942) whereas 16 established homosexual men were pressured by Yale University to consult therapists which led to a *not at all* satisfactory outcome.

Woodward (1958) asserted 28 of the 48 patients who completed forensic treatment no longer had homosexual impulses. Seven of them moved to the full heterosexual category of the Kinsey scale. Whitener and Nikelly (1962) relate that 30 homosexual college students in treatment showed good results in one-third of selected cases. The Braaten and Darling (1965) study, also conducted on college students, showed that out of 76 male homosexuals treated in a college setting, 29% moved toward a heterosexual reorientation. There was no follow-up, however.

Martin (1967) reported on a 36-year-old homosexual man who was diagnosed with "character disorder" and received 2 years of individual therapy (two-year group therapy and aversion therapy) without success. After using LSD and working through an aggressive love-hate relationship with his mother, which eventually resolved through transference and a mystical experience, he was able to develop a strong heterosexual relationship with a woman he later wished to marry.

Experiential electrode brain stimulation, with the purpose to change sexuality, did not gain popularity past the 1970s, and the literature on the procedures remained scant. Moan and Heath (1972) conducted experiential septal stimulation on a 24-year-old, clinical, fixed, overt homosexual male patient with the purpose to
explore the possibility of using it to bring about heterosexual behavior. After completing the procedure’s protocol, the patient’s mood improved, he was more relaxed, and he became sexually interested in heterosexuality (he began watching heterosexual pornography), and later he participated in sexual intercourse with a female.

Liss and Welner (1973) recounted a client who received supportive therapy after failed attempts with aversion therapy. They reported that there was a complete reversal in his sexual behavior and that he became attracted to women. The authors did not disclose whether the client had homosexual fantasies or whether his attraction to men remained. The Kinsey writers acknowledged that some homosexual adults have allegedly been “cured” by brain surgery to destroy “inappropriate” sexual response centers (Bell, Weinberg, & Hammersmith, 1981, p. 219).

Eighty-six men who attended a non-clinical, experiential weekend retreat aimed at ameliorating same-sex attractions titled Journey into Manhood responded to a multi-question survey initiated by the organization (People Can Change, 2006). The men were asked what described their sexual feelings both before and after the weekend. The results showed that after the weekend retreat there was a 6% increase in the men reporting sexual feelings as "exclusively heterosexual, with no homosexual or interest at all" and a 13% increase in men reporting feelings that were
"primarily heterosexual, but with some slight homosexual feelings or interests." There was also a 4% decrease of men who described themselves as exclusively homosexual and having no heterosexual feelings or interests before the weekend, whereas they shifted to another category of describing themselves as having at least slight heterosexual feelings or interests after the retreat.

Dr. Nicholas Cummings is past president of the American Psychological Association and served for years as Chief of Mental Health with the Kaiser-Permanente Health Maintenance Organization. During the 20 years he was at Kaiser-Permanente (1959-1979) in San Francisco, he saw over 2,000 patients with same-sex attraction, and his staff saw another 16,000. Of those they saw in psychotherapy, 67% had good outcomes. They did not attempt to reorient same sex attraction to heterosexuality unless the patient strongly indicated this as the therapeutic goal. Twenty percent of the 67% successful psychotherapies did so reorient.

Spontaneous Change

Wolpe's (1969) patient, who was in treatment for assertiveness training, reported a spontaneous shift to heterosexual behavior even when the focus was not on changing it. Fluker (1976), a medical doctor treating gay-identified men for sexually transmitted diseases (not homosexuality) learned from one of his patients,
who was not in conversion therapy, that he no longer had homosexual inclinations and was happily married to a woman. Cameron and Crawford (1985) discovered that 2% of their random sample claimed they had once been homosexual which was not reportedly due to any intervention. Nichols' (1988) study mentioned a client who had spontaneously developed heterosexual interest and became bisexual to heterosexual in mid-life. Shechter (1992) reported spontaneous change in a male client who had been in psychoanalysis with her (not for treatment of homosexuality). She reported that he broke up with his male lover and was no longer actively homosexual. He began to fantasize exclusively about women. He got a girlfriend and said, "I can't keep my eyes or hands off of her, and she loves it" (p. 200). No clear statement was made about self-identification, except a quote by him where he asked, "Can someone like me suddenly be heterosexual?" (p. 200).

Michael, Gagnon, Laumann, and Kolata (1994) found that based on a national survey, some people even change their sexual orientation without psychotherapy. As mentioned previously, even without intervention, studies have shown that sexual orientation is not a unitary, one-dimensional construct (Weinrich & Klein, 2002).

Ex-Gay or Religiously Mediated Therapies

Christians view recovery from homosexuality as early as biblical times citing,
"… and this is what some of you (homosexuals) were” (1 Corinthians 6:11, New International Version, emphasis added). Exodus International, a parent Christian ministry for a coalition of more than 100 ministries and Christian counselors worldwide, offers individual, group, and educational therapy. Consiglio (1993) offered an overview of religiously mediated therapy for homosexuals and reported that Exodus International had evidenced 85% of the people it served as experiencing sexual reorientation.

Robinson (1998) provided a report about the results of interviews with 7 men from Evergreen, a ministry affiliated with the Church of Jesus Christ of Latter Day Saints (LDS). Robinson associated “change” of the subjects with 9 components, one was that they adopted a new interpretive framework concerning the causes and implications of their same-sex attraction, and another was that they no longer identified themselves as gay.

Pattison and Pattison (1980) reported successful religiously mediated change of 11 homosexual men while they participated in a Pentecostal fellowship. They used both pre and post surveys. On the post-change survey, 5 of the 11 participants reported no homosexual fantasies, behaviors, or impulses (0 on the Kinsey Scale). Three men reported a Kinsey rating of 1; and 3 other men reported a rating of 2.

Mesmer (1992) surveyed more than 100 people participating in an ex-gay ministry who had reported leaving the homosexual lifestyle and found 41% of them
had achieved complete heterosexual orientation.

Ponticelli (1996, 1999) conducted a qualitative study looking at the workings of Exodus International from the years of 1992-1994. She took a dual role in the study as both an observer and a participant. She interviewed 15 women and read testimonies of 12 women. She noted more about the women’s change in their sexual identities and social supports, along with more positive spiritual outcomes, rather than a change in actual sexual orientation, per say. Erzen (2006) and Wolkomir (1996, 2006) found similar findings in their ethnographical studies of ex-gay residential programs.

Schaeffer, Hyde, Kroencke, McCormick, and Nottebaum (2000) surveyed 248 men and women at an Exodus International Annual Conference to determine if they were experiencing success in changing their sexual orientation and found a statistically significant effect based on changes over time. On both the feeling and behavior scales, participants rated their current sexual orientation as significantly more heterosexual than when they were 18 years of age. However, the study was severely limited as there was a lack of a detailed sexual history to verify the participants’ self-rating or to determine whether there were significant shifts in behavior or feeling in the periods before and after age 18. In a follow-up study of 140 of the original participants, Schaeffer, Nottebaum, Smith, Dech, and Krawczyk (1999) found that 61% the male and 71% of the female participants had maintained
abstained from any same gender sexual contact in the past year of the study. Twenty-nine percent of this sample indicated that had changed their sexual orientation (0 on the Kinsey scale) in the past year of the study, and 65% said they were in the process of change.

Extending on the previous studies, Nottebaum, Schaeffer, Rood, and Leffler (2000) compared a 105 gay-identified sample with a sample of Exodus participants. The 2 groups reported good mental health, but the gay-identified group scored higher in that area. Both groups reported similar same-sex identities prior to age 18, but in the present study, the Exodus group reported more current heterosexual identification.

Anecdotal Accounts of Change

A number of personal stories of change have been produced over the years, mostly found through religious channels. Aaron (1972) wrote, "For twenty years I was homosexual ... Today, years away from all that ... I am functioning heterosexually and enjoying it" (p. 14). Offering spiritual guidance to others, Worthen (1984) shared his personal conversion out of homosexuality, as did Konrad (1987), Comiskey (1988), and Judkins (1993).

Breedlove, Plechash, and Davis (1994) also gave personal accounts of religiously mediated change as did, Strong (1994) who provided an account of his personal experience. Along these lines, Davies and Rentzel (1993) offered
testimonies of change in both male and female homosexuality.

Assemblies of Persons Claiming Sexual Orientation Can Be Changed

Ex-gays have collectively stood up to be counted. On May 22, 1994, in Philadelphia, for the first time in history, the American Psychiatric Association was protested against, not by pro-gay activists, but by a group of ex-gays claiming that change was possible (Davis, 1994, May 22). This was repeated at the 2000 convention in Chicago (Gorner, 2000, May 18) and at the 2006 American Psychological Association Convention in New Orleans (Foust, 2006, Aug 14).

Meta-Analyses

Clippingher's (1974) meta-analysis of the treatment results of homosexuality demonstrated that out of 785 homosexuals treated, 307 (40%) were cured or at least made some heterosexual shift.

James (1978) concluded that when the results of all research studies, up until that time, were combined, approximately 35% of the homosexual clients recovered, 27% improved, and 37% did not recover or improve. Based on this finding, she concluded that pessimistic attitudes about the prognosis for homosexuals changing their sexual orientation are not warranted, saying: “Significant improvement and even complete recovery [from a homosexual orientation] are entirely possible …” (p. 183).

Goetze (1997) brought together 17 studies and found a total of 44 subjects
total, who where exclusively or predominately homosexual, experienced a shift of some sort to heterosexual adjustment. Again, the issues of definitions were found to vary.

Jones and Yarhouse (2000) used meta-analysis to review 30 studies conducted between the years of 1954-1994. Of the 327 subjects from all the studies, 108 or 33% of them were reported to have made at least some heterosexual shift.

Byrd and Nicolosi (2002) used the meta-analytic technique for 146 studies evaluating treatment efficacy. Most studies were published prior to 1975, and 14 of which were published between 1969 and 1982 were used for the outcome analysis. The analysis revealed that the treatment for homosexuality was significantly more effective than alternative treatments or control groups for homosexuals. They concluded that the average patient receiving treatment was better off than 79% of those undergoing alternative treatments or when compared to pretreatment scores on several outcome measures.

Surveys of Consumers

Nicolosi, Byrd, and Potts (2000), with large efforts from the National Association for Research and Therapy of Homosexuality (NARTH), retrospectively surveyed 882 dissatisfied homosexuals with a 70-item, client-answered scale. After receiving therapy or engaging in self-help, 20-30% of the participants said they shifted from a homosexual orientation to an exclusively or almost exclusively
heterosexual orientation. Of the 318 who identified as exclusively homosexual before treatment, 56 or 17.6% reported that they viewed themselves as exclusively heterosexual at the time of the study.

With a smaller sample, Becksttead (2001) used a structural interview with 18 men and 2 women who claimed to have benefited from sexual orientation therapy. He reported that while their sense of peace and contention improved, he was not convinced of a change in sexual orientation. He stated, "Overall, a change in how to define sexual identity seemed to occur rather than a direct change in sexual orientation" (p. 103).

Shidlo and Schroeder (2002) interviewed (via 90-minute interviews, either in person or by telephone) 182 men and 20 women who were consumers of sexual orientation conversion interventions to find out how they perceived its harmfulness and helpfulness. The researchers recruited participants by advertising on gay and lesbian websites, in e-mail lists and newspapers, in non-gay newspapers, and via direct mailings to gay and ex-gay organizations. Of the 202 participants, 176 were considered as having failed conversion therapy and 26 as having been successful. Twelve were still struggling in that they reported "slips" or some incidences of homosexuality; 6 were still not struggling with same-sex attractions in that they were managing them; and 8 were termed to be in a "heterosexual shift period" (p. 253), whereas they rated 3 or less on the 7-point Kinsey scale, self-labeled as
heterosexual, reported having heterosexual behaviors and in a heterosexual relationship, and denied homosexual behavior.

Spitzer (2003), from Columbia University, interviewed 200 subjects who had participated in sexual reorientation processes by using a telephonic sexual orientation interview consisting of 114 closed-ended questions. Prior to intervention (using the Sexual Attraction Scale, “PRE”), 46% of the males and 42% of the females reported exclusive same-sex attraction. After intervention, (using the Sexual Attraction Scale, “POST”) 17% of the males and 54% of the females reported exclusive opposite-sex attraction. By way of his findings, Spitzer stated, "Thus, there is evidence that change in sexual orientation following some form of reparative therapy does occur in some gay men and lesbians" (p. 403).

Karten's (2006) dissertation examined the sexual reorientation efforts of 117 dissatisfied same-sex attracted men who had undergone some type of intervention to change orientation. Using a 7-point sexual self-identity scale with 1 indicating exclusive homosexuality and 7 indicating exclusive heterosexuality, he found that on average at the onset of intervention, men reported a mean score of 2.57 (2 = almost entirely homosexual; 3 = more homosexual than heterosexual), and at the time of the study (after intervention), they reported a mean score of 4.81 (4 = equally homosexual and heterosexual; 5 = more heterosexual than homosexual). The shift was statistically significant.
Finally, a compilation and average of 3 recent consumer survey reports (Nicolosi, Byrd, & Potts, 2000; Shidlo & Schroeder, 2002; and Spitzer, 2003) can be found in Table 1, which yielded a 31% success rate. There was a huge disconnect in the success rates between the Nicolosi et al, 2000 and Spitzer, 2003 studies compared to the Shidlo and Schroeder, 2002 study. This was likely due to the researchers’ methods of sampling. Nicolosi et al, 2000 and Spitzer, 2003 used samples from sources that would likely give positive results (e.g from organizations such as NARTH), while Shidlo and Schroeder, 2002 used samples from gay sources, more likely to yield negative responses to reparative therapies. Nevertheless, in the end, the average still yielded a 31% success rate.

Limits of Studies

These outcomes studies, like all studies have limits. Particularly, the single case studies have limits because the data is objective, based on an individual therapist’s reports, and not generalized to a larger body. Anecdotal accounts, are just that, and are not well received when more scientific means of study are available. While some studies rely on larger samples, they are often limited by self-reported data, non-randomization, retrospective issues, and other issues such as cognitive dissonance and social desirability. Many studies are limited due to the absence of control groups and correlative values, while many studies are criticized for lacking ideal measuring techniques, having methodological flaws, and
inadequate longitudinal and replicative factors.

Additionally, studies are weakened because sexual orientation is generally not clearly defined or understood (Gonsoriek, Sell, & Weinrich, 1995; Sell, 1997). For example, one may define himself or herself as *heterosexual*, yet still have homosexual tendencies; while another person may define himself or herself as *heterosexual* and have no homosexual tendencies. Yet, both may describe themselves as *heterosexual*. As for reporting success rates, complications remain. For example, in some reports, clinicians state success in that a client had heterosexually married, however as we know being married does not mean one is necessarily straight.

According to Schneider, Brown, and Glassgold (2002), *sexual orientation* is perplexing because one’s self-identified sexual orientation may not be congruent with his or her sexual behavior. They say sexual orientation is best conceptualized as a continuum, rather than as a category.

General Commentaries

In a review of treatment successes, Karpman (1954) stated, "Every psychotherapist of experience must have in his records at least a few cases of analysis of homosexuality, exhibitionism, transvestitism, etc. that he has treated and cured or improved" (p. 390). Johnson (1955) related that change of sexual orientation, or homosexual to heterosexual, is possible with the best prospects for
counseling being the younger and motivated patients. These factors were also affirmed by Mendelsohn and Ross (1959). Bergler (1956) said, "The homosexual's real enemy is his ignorance of the possibility that he can be helped" (p. 176). Rubinstein (1958) reviewed his 10-year delivery of psychoanalytical treatment to persons desiring to diminish homosexuality and reported that a fair number of his patients were helped and improved well beyond original expectations. Fried (1960) verified previous analytical studies and reports that homosexual patients can and have been treated successfully.

Tarail (1961) stated that homosexuals could change through reconditioning therapy, physical and environment withdrawal psychotherapy, and motivation therapy, while Hastings (1963) optimistically stated that homosexuals treated with psychoanalysis may very well be cured of homosexuality. Ellis (1965) stated, "Fixed homosexuality is definitely curable ... Every homophile who truly wants to learn how to enjoy (and not merely tolerate) heterosexual relations can, with the help of a good therapist, do so" (p. 265).

Other authorities felt that change in orientation would follow once the patient disputed faulty assumptions of his distorted views through the use of existential analysis process (Brenda, 1963; Wolman, 1967). Doyle (1967) stated that treatment success can be obtained if the patient does not resist change and if the patient willingly works with an analyst for a sufficient period of time. According to Frank
(1967), homosexuals can be appreciably helped through psychotherapeutic techniques. Mohr and Turner (1967) plainly stated that all treatment of homosexuality was possible but unsuccessful if the patient was not motivated for change. Hadden (1966) found that "[Homosexual patients] give every indication of processing toward a reversal pattern" (p. 15).

Janov (1970) verified behavioral treatment of homosexuality and stated that by offering reality and educational type therapies, homosexuals could be cured. Newman, Berkowitz, and Owen (1971) stated, "We've found that a homosexual who really wants to change has a very good chance of doing so. Now we are hearing all kinds of success stories" (p. 22). In a Lacanian analytic perspective, Dor (2001) asked, “What happens when certain analysts make the disappearance of the patient’s homosexuality the primary aim of treatment?” (p. 70). He offered the answer that, “only an ideological argument implicitly based in sexual norms can underlie such a practice…[however] the only norms that exist in clinical psychoanalysis are those that govern the space of the treatment….this being the case, heterosexuality is a possible outcome of the treatment of a homosexual patient” (p. 70).

Frank (1972) stated in a paper to the National Institute of Mental Health, "A large number of case reports and systematic studies report that some homosexuals can be successfully treated" (p. 63).
West (1977) stated in an objective format that many studies performed on conversion from homosexual to heterosexual orientation have produced success not less than 30% for behavioral therapies, and about 25% for psychoanalysis. West went on to state that if facilities were more available and more practical, and if social and moral climates allowed it, statistics on treatment success would improve.

According to Marmor (1975), "There is little doubt that a genuine shift in preferential sex object can and does take place in somewhat between 20 and 50 percent of patients with homosexual behavior who seek psychotherapy with this end in mind" (p. 1519). According to Kronemeyer (1980), about 80% of homosexual men and women in his practice have been able to free themselves and achieve a healthy and satisfying heterosexual adjustment. Wolpe (1982), a world famous behaviorist, reported in a 20-year retrospect, successful behavioral therapy in treating several conditions, including homosexuality. Fine (1987) reported that regardless of the type of treatment, a motivated and willing patient will yield a large percentage of success. Nicolosi (1991, 1993) gives practical methods for treating the male homosexual and cites his and other's evidences of treatment success. Throckmorton (1998) reviewed the outcome literature, up until 1998, and concluded that, change in orientation was possible, but then said he did not know if he ever successfully helped anyone change sexual orientation because he did not know how
to define it. What he did admit to was that he saw clients who were attracted primarily to the same gender later declaring they were primarily attracted to the opposite gender.

Barnhouse (1984) related that psychiatrists and psychologists who state that changing orientation is untrue are falsifying scientific data. Wilson (1979) expressed, "Treatment using dynamic individual psychotherapy, group therapy, aversion therapy, or psychotherapy with an integration of Christian principles will produce object-choice reorientation and successful heterosexual relationships in a high percentage of persons ... Homosexuals can change their orientation" (p. 167).

Within the religious domain, Moberly (1983) expressed that change is possible with the help of religious motivation. Consiglio (1991), who worked with homosexuals for more than 15 years, also supported religious mediated change in his work. Keefe (1987) stated, "I have seen some homosexuals in treatment and have met more former homosexuals (including those who were exclusively so) ... who now respond physically and emotionally as heterosexuals in successful marriages" (p. 76). Courage, an apostolate of the Roman Catholic Church follows a simplistic, yet concrete view of success whereas celibacy is an acceptable outcome: "By developing an interior life of chastity, which is the universal call to all Christians, one can move beyond the confines of the homosexual identity to a more complete one in Christ" (Courage, 2007, ¶ 2).
While claiming that homosexuality is untreatable, Hemphile, Leitch, and Stuart (1958) did not offer scientific data as to why this is true but based their findings on the Curran and Purr (1957) study which failed to define what specific technique(s) was used and only claimed 1 case of sexual reorientation.

Past critics of sexual reorientation success allege that they lack conclusive evidence (Acosta, 1975); such evidence is not confirmed (Tripp, 1975); is unethical (Davison, 1976); immoral (Davison, 1978); unconvincing (Coleman, 1978); has methodological flaws (Haldeman, 1991); and has high failure rates (Murphy, 1991). The Kinsey Institute has long stopped their prior endorsement of interventions aimed changing sexual orientation. The explanation that the Kinsey Institute gave about treatment endeavors, however, was that the studies’ reported, "varying success rates" (Reinisch, 1990, p. 181) and that it was not socially acceptable (Bell, Weinberg, & Hammersmith, 1981). Other famous sexologists did not follow the Kinsey Institute’s path rather stated that, with effective therapy, “very often a man’s latent heterosexuality will blossom” (Helen Singer Kaplan in an interview with D. Klein, August 1981, p. 92). Kaplan made it clear that, “…with modern methods – many homosexuals can change to a heterosexual orientation if they want to do so” (p. 92).

Dr. Nathaniel McConaghy, whose many behavior therapy reports are mentioned herein, feels that predominantly omosexual men do not seek to be cured,
whereas it is mainly anxious, socially intimidated males at the fringe of heterosexual orientation who adopt a black-versus-white posture and seek professional help (Letters, July 2000). In Bancroft's (1970) study, 5 out of 15, or 33% desensitized treated homosexuals yielded change in orientation and behavior, however in Bancroft's own opinion, homosexuality did not need to be cured (Brancroft, 1975).

Duberman (1991, 2001), a gay-identified writer, wrote about his own negative experiences in reorientation therapy and generalized that it is impossible for anyone to pursue successful change. Along the same fashion, Ford (2001) and Moor (2001) told their own stories of unsuccessful attempts and self-perceived harm. Shidlo and Schroeder (2002) in their empirical study learned from several consumers who received reorientation therapies “that they were plagued by serious psychological and interpersonal problems during the therapy and after its termination” (p.254), however this was from consumers who were recruited for the purposes of documenting harm.

Beckstead (2001) said, "Hopes of experiencing heterosexual attractions and eradicating homosexual attractions may turn into disappointments" (p. 106). According to Beckstead, for those who fail therapy, the time spent in it is often perceived as painful. However, this draws from partisan opinion verses empirical data. Drescher (2001) criticized reparative therapists saying they only reinforce the
stigma of homosexuality that was present prior to the removal of homosexuality from the Diagnostic and Statistical Manual (DSM) in the 1970s. He felt they have moved toward embracing conservative religious dogma in their attempts to change homosexuals, therefore "stifling dissent" (p. 22). Schneider, Brown, and Glassgold (2002) asserted that mental health professionals who made a pathological diagnosis from homosexuality, “promulgated risky and often harmful 'treatments' aimed at creating sexual conformity” (p. 273).

Schroeder and Shidlo (2001) criticized the practice of therapies aimed at changing sexual orientation as not being ethically sound and feel they are of poor practice. Forstein (2001) does not believe it necessary to change a person's sexual orientation, but says there is no scientific proof that reparative therapies are necessarily harmful and unethical. However, he offered methodological questions for therapists to consider and provided basic guidelines for ethical intervention.

Ethics of the clinical use of reorientation-based interventions have been the primary concern of the major mental health organizations and professionals (Yarhouse, 1998; Throckmorton, 1998). In terms of ethical alternatives, "until the scientific debate is settled", Lasser and Gottlieb (2004) offer the following:

Despite the obvious risks associated with conversion therapy, there are two possible advantages to treating the patients in this manner. First,…we must accept that in some isolated
and rare circumstances, conversion therapy might be effective. Second, even if the treatment is not successful, the patient may benefit in at least three ways. First, a genuine failed attempt may help the patient accept his or her sexual orientation. Second, the treatment may foster gains in other areas as a by-product. Third, the patient-therapist relationship is maintained, whereas a refusal to consider conversion therapy has the potential to prematurely terminate the patient-therapist relationship. (p. 198).

Even when therapies have shown failure of changing sexual orientation, secondary relieves such as discovery of sexuality identity, increased social supports, spiritual awakening, decreased anxiety, and other psychological benefits have been seen (Erzen, 2006; Karten, 2006; Lasser & Gottlieb, Nicolosi, et al, 2000, Schroeder & Shidlo, 2001; Spitzer, 2003).

Conclusion

Although there had been variants of treatment modes and attitudes, across various disciplines, towards the treatment of homosexuality (Lamberd, 1971), much of the premise for therapy of homosexuality had been that the homosexual condition was developmental in nature (hence, psychoanalysis) or learned (hence, behavioral
therapies) and could be changed to heterosexual adjustment. The outcomes of interventions aimed at changing sexual orientation varied. The outcome measures or success rates were generally defined by a shift in sexual desire toward heterosexuality either through self-reports, therapist reports, or through measures such as penile plethysmography, the 7-point Kinsey scale, the multi-item Klein Sexual Orientation Grid, and others.

Various paradigms and approaches have been used, such as: psychoanalysis, hypnosis, behavior therapies (including aversion), cognitive therapies, sex therapies, group therapies, religious-mediated interventions, pharmacology, spontaneous/unknown, combination of therapies, and others. The problem with most reports is the lack of clearly defining sexual orientation, homosexuality, heterosexuality, and what change means.

The reviews of psychoanalysis have shown that outcomes vary. Usually a consistent one-third success rate is synthesized from reports of behavior, cognitive, and group therapies. A 31% success rate was drawn from 3 recent consumer report studies (Nicolosi, Byrd, & Potts, 2000; Shidlo & Schroeder, 2002; and Spitzer, 2003).

As mentioned in the General Commentaries section above, some advocates of these therapies claimed they were helpful, and that change, in some cases, was fixed. Many have agreed that sexuality is fluid (Bell & Weinberg, 1978; Weinrich
& Klein, 2002; Kernberg, 2002). Critics of these specific therapies claim they can be harmful, while anecdotal accounts say the same (Duberman, 1991; Shidlo, Schroeder & Drescher, 2001; Shidlo & Schroeder, 2002). But, as Forstein (2001) said, "There are no studies … to provide these data" (p. 177). Largely, however, the shift of the treatment of homosexuality, due to its removal from diagnostic criteria as a mental illness, has evolved from amelioration to acceptance and normalization. The topic of sexual conversion has largely reduced to a social debate recently with medias like People magazine, the Montel Williams Show, and CNN making it a public forum, rather confusing, bias, and unscientific. Non-scientific advocacy groups such as the Human Rights Campaign, set out to discredit reorientation therapies without the credentials to do so (Human Rights Campaign, 1998, August).

We trust that this comprehensive compilation of studies will highlight that there is documentation that change in sexual orientation is possible matching client’s self-determination. The main limit of this report however, is that while we presented a narrative chronological review of the literature, we did not provide much in the way of a discussion of the studies’ weaknesses and strengths. Overall, we will say that the research literature is limited by sampling, assessment, and follow-up issues, however despite the methodological limitations of individual studies, there is nonetheless compelling body of evidence that some individuals can shift identity and
behavioral components of their sexual orientation after undergoing intervention. Most of the research has been conducted on men, however a number of theorists have argued that women’s sexuality is more fluid and situationally influenced than men’s sexuality. A gold standard study on interventions to change sexual orientation would be to include a randomized design, however, until we are at that point, we cannot conclude that change is not possible and therefore deny a client’s right to treatment and self-determination. We must admit that once the 1973 decision to remove homosexuality as a mental disorder from The Diagnostic and Statistical Manual II, there has been a shortage of research in the area of homosexual identity development and treatment. As far as treatment, even gay-identified scholars state clearly that clinicians “have the ethical obligation...[that] regardless of pathology, cultural trends, or current political rhetoric, mental health issues for homosexuals remain clinically significant and, like all others, must be addressed by the clinician with competence” (Monachello, 2006, p. 56). The American Psychological Association (APA) code of ethics states, “Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination” (APA code of ethics (2003), General Principles, Principle E). While homosexuality is no longer considered pathology per DSM, distress concerning sexual orientation is still considered as a DSM-IV subcategory, Sexual Disorders Not Otherwise Specified. Therefore, “The
developmental issues that contribute to ‘the persistent and marked distress’ about one’s sexual orientation are valid areas of investigation (Morin & Rothblum, 1991, p. 3).

As one gay-idenified scholar has put it, “We should defend the homosexual client’s right to choose professional support and assistance toward fulfilling his/her goals in therapy according to the client’s own values and tradition. We should be committed to protecting our homosexual client’s right to autonomy and self-determination in therapy” (Monachello, 2006, p. 57).
Table 1
Compilation and overall average outcome of recent consumer surveys

<table>
<thead>
<tr>
<th>Survey</th>
<th>N</th>
<th>No. reporting exclusive opposite sex attraction shift: fully successful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicolosi et al. (2000) (1)</td>
<td>318</td>
<td>114</td>
</tr>
<tr>
<td>Schroeder &amp; Shidlo (2002)</td>
<td>202</td>
<td>8</td>
</tr>
<tr>
<td>Spitzer (2003) (2)</td>
<td>183</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>703</td>
<td>218 (31%)</td>
</tr>
</tbody>
</table>

(1) There was a total N=883 for the entire study; however, only 318 reported being exclusively homosexual pre-treatment and 114 exclusively heterosexual post-treatment.

(2) There was a total N=200 for the entire study; however, only 183 were calculated in the PRE and POST values to determine exclusive opposite sex attraction.
References


homosexuality. *Psychological Reports, 90*, 1139-1152.


therapy: Ethical, clinical, and research perspectives (pp. 167-179).


Smith, A., & Bassin, A. (1959). Overt male homosexuals in combined group and


