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

We find a fair assessment is that both qualitative and quantitative studies have their value. It can be, for example, that therapy succeeds brilliantly for a few
individuals, but not others surveyed. The generalization that therapy rarely works would be highly misleading. It would be highly unethical to deny the use of therapy to all informed and volunteering clients, even if it were shown to fail for most of them. A drug which cured cancer in 1% of those who took it, but failed with 99% of clients, and in the short term made them nauseous as well, would not be banned but ethically endorsed as at least worth a try. Those using the therapies under discussion are anecdotally asserting considerably higher success rates than 1% (Throckmorton, 1998, 2002).

In the last few decades of the twentieth century, therapies diversified to the extent that proper sociological tests were very difficult to implement. This occurred because the modest numbers of clients for each therapy denied most sociological tests adequate statistical power. The few studies that were carried out lumped many different therapies together. Alongside this, post-modern philosophy insisted in the continuing validity of individual testimony. Thus, it implicitly endorsed both positive and negative stories of therapy without attempting to supply an objective means of resolving the conflict between them.

Three studies using sociological techniques were: Shidlo and Schroeder (2002); Spitzer (2003); and Karten (2006). Shidlo and Schroeder (2002) assembled negative instances for five years and the latter two papers assembled positive instances in much shorter time periods. Although this is tentative, the trend is for
negative instances to be much harder to find than positive outcomes. Shidlo and Schroeder (2002) chiefly collected stories of harm from therapy reported by individuals, presenting as many descriptive statistics as they could. The former two present stories of varying degrees of success of therapy with similar statistics. Since none of the papers from a sociological point of view could comment on the number who were temporarily in therapy but did not continue, the value of these three papers (as attested by their authors) is restricted to saying that, some people report positive results while some report negative results. This is almost certainly what an objective observer would probably conclude as well. An accurate success rate or harm rate is not attainable from these studies, and both rates might conceivably be extremely small, or quite substantial.

Nicolosi, Byrd, and Potts (2000), in their survey of 882 clients, found that in only 7.1% of cases clients said they were worse on three or more items of a list of negative consequences, which suggests minor sequela for those who stayed in therapy.

Undue harm as a result of reparative therapy is not supported by the literature. Brown (1996) declared reparative therapies to be “clear violations of the ethic of doing no harm” (p. 905), but, once again, the only authority for this was the anecdotal Haldeman (1991) paper and others of similar vintage.

If the criterion for valid therapy is taken from the results of sociological
surveys, then the standard must be open, universally agreed upon, and applied across all therapies in psychology. This has not been done; therefore, the playing field is not level.

**Principles for Therapy**

The National Association for Research and Therapy of Homosexuality (NARTH) agrees that usual professional standards should apply to therapies which try to change sexual orientation. Among those is the principle, “First, do no harm.” Therapy ought not to lead to significant, immediate, or avoidable harm. Thus, NARTH believes it would be highly unprofessional to approve therapies which create large amounts of immediate self-hatred, depression, and other self-destructive results. Similarly, NARTH does not endorse any aversive therapy, and to its knowledge none of its members use such therapy. NARTH also believes any known significant down-side to therapy should be a matter of prior informed client consent, and any long-term negative effects of therapy which might be revealed by future research should be forestalled during therapy as far as practical.

All therapies (apart from those which try to change sexual orientation) may, and sometimes do, lead inadvertently to later indirect harm beyond the time frame of therapy. There is no valid literature which shows that this is any greater for therapies offering orientation change than for other therapies. At the most, there are collected cases of accusations by the dissatisfied, similar to what one would find for
any therapy in any field. It surprises many even in the caring professions to
learn, for example, that there are many clients very disgruntled with standard
treatments for alcoholism.

It may be argued that given the intensely political nature of the subject, there
are surprisingly few accounts in the open published literature of harm resulting from
reparative therapies. If such therapies were universally harmful, one would expect,
in the current climate of opinion, a flood of reports giving numerically high harm
percentages.

The statement, “shown to be harmful,” is almost meaningless in the present
context. In the absence of detailed literature it is simply untrue in a quantitative
sense. If it means the therapies being discussed produce some harm, then all
therapies in the entire field of psychology are equally guilty – all will have caused
(usually inadvertently) damage at some time. We insist that a therapy with no
obvious universal ill effects and anecdotal good ones, and historically a
professionally supported case, is innocent until it is proven guilty.

Avoidance of Even Greater Harm

The prospect of not allowing therapy creates much worse harm. None of us
can accurately predict future swings in public opinion. It is quite conceivable that
refusal to offer reparative therapies to a client or class of clients, a large minority of
whom subsequently die of AIDS, will in future be the subject of extremely
damaging class action suits. Precedents are found for this in institutional inmates suing parent organizations many decades later for defective care. The APA or other professional organizations could quite plausibly be sued in the future by relatives of ego-dystonic homosexuals for not providing desired service or preventing risks of the gay lifestyle. For example, many who come for reparative therapy, come so for the fear of the physical results of remaining in the lifestyle. Statistically the risk of life-threatening disease in the gay community is greater than the risk for any activity for any comparable sized group. Death is a much greater harm than self-hatred, depression, and related traits. Someone who wishes to avoid the risk of death should be helped – it is a disgraceful dereliction of duty on the part of a therapist not to do so.

**Therapies and Harm**

The statement that says, “Efforts to change sexual orientation are shown to be harmful and can lead to greater self hatred, depression and other self-destructive results,” is a statement that does not specify which therapies. In view of the great variety of therapies actually used, this is impossible. It is attempting to say that all possible therapies now and in the future lead to harm.

Twenty-nine percent of therapists for all mental health conditions see client suicide (Anonymous, 1993). Therefore, therapy in general could be argued to lead to harm, which is a ludicrous conclusion. A better analysis would be that many were
prevented from committing suicide, and those that did commit suicide would mostly have done so with or without therapy.

Similarly, the recidivism rate of rapists after therapy, as given by Maletzky (1997) and Marques (1999), is 20%. This failure of therapy does not invalidate therapy for rape offenders (although they have not been obviously harmed by this failure).

Various professional organizations have position statements discussing disapproval reparative therapies, but no formal ban on such therapy has been put in force and would be met with extensive legal action if it were. Several discussions give the false impression that positions of professional organizations are more extreme than they actually are. Probably the most spectacular counseling/therapy failure in history, resulting in the death of tens of thousands, is probably that associated with safe-sex counseling. Rates of HIV infection have been resurgent in recent years, and in many countries they are as bad as before safe-sex counseling started. Although this may be associated with mental fatigue from overexposure to the safe-sex message, it is ludicrous to say that the counseling led to harm. Similarly, though less life-threatening, counseling to avoid teenage pregnancy has not avoided the emergence of a large group of sole mothers, often near or below the poverty line. No one would argue counseling in these areas should stop because it has not entirely fulfilled its ideal aim. Similarly, reorientation therapies, which have
been trying to avoid the greatest long-term harm imaginable to clients, cannot be fairly targeted as leading to harm.

**Suicidality**

Although Shidlo and Schroeder (2002) suggested that perhaps the most significant harm resulting from the therapies under discussion was suicidality, we now wish to show that an examination of their work demonstrates that long-term suicidality has not increased after therapy. On the contrary, it has significantly decreased.

From their account, we note the following numbers of persons they record were involved in suicide attempts before, during, and after therapy respectively were: 25, 23, and 11. From their demographic description, it can be inferred that the respective mean time periods involved were: 13 years, 2 years, and 10 years. (The pre-therapy figure of 13 years assumes an estimate of the establishment of a gay identity at a mean of 15 years). These are means only, and if distributions are highly skewed, adjustments could be needed. Taking into account the time periods involved, the expected suicide attempts (rounded down), assuming therapy had no effect, would be 29, 4, and 23; an equal rate per year in all three periods. A standard chi-square test examines whether the observed numbers, 25, 23, and 11, could be produced by random fluctuations of the expected numbers 29, 4, and 23. The probability of producing the observed distribution by chance is a negligible 8E-22.
The observed figures are not compatible with the hypothesis that they reflect a nil effect of therapy. What do they reflect?

Inspection shows that there is a relatively high number of attempted suicides during therapy (4 expected and 23 observed), and an unusually small number after therapy (23 expected and 11 observed). At first sight, this might seem to imply that therapy might be uniquely causing large numbers of suicides during its progress, but this is not so. Rather, it reflects the universal pattern seen in all psychotherapy. As demonstrated numerous times (Erlangsen, Zarit, Tu, & Conwell, 2006; Qin & Nordentoft, 2005; Qin, et al., 2006), when psychiatric patients are admitted to a hospital, attempted suicide rates rise to a very high level in the first week after admission, and there is a secondary peak the first week after discharge. However, the long-term effects are that the mean suicide rate is much less per unit of time than pre-admission, and decreases exponentially with age or even faster. This is usually interpreted as saying that treatment in hospitals has protected against suicide long-term, in spite of the short-term increased risk immediately post-admission and post-discharge. The same pattern is seen in Shidlo and Schroeder’s (2002) data for those in reorientation therapies. This says that the increase during therapy is nothing abnormal, and that like therapies for other conditions, the long-term suicidality is less than pre-therapy, and in this case, because the worst possible examples were chosen, at least halved. It follows that, if anything, the risk of suicidality is
decreased by therapies in their study. Although causal links for suicidality are related by ex-clients, the sum of the actual attempted suicides are less than they would have been without therapy.

A fuller check on this would involve better controls, using detailed suicidality rates in matched gay people who did not undergo any therapies of the type described by Shidlo and Schroeder (2002).

**Greater Homophobia**

It is suggested by critics that one outcome of reparative therapy is a negative attitude towards homosexuality. “Conversion therapies by their very existence exacerbate … homophobia” (Haldeman, 1994, p. 225). This is a vague criticism. It is not clear whether it refers to clients, the general public, professional bodies, or all of them.

Professional bodies have increasingly been producing statements critical of re-orientation therapies, which shows the effect on them has been nil. Nor has internalized homophobia increased in the gay community as a whole. It should be noted from Figure 1 that opinions among the gay and lesbian community about origins of same sex attractions have changed far faster than for the public at large. Almost all of them believe they were born that way and are not to be blamed. This means that the continuing availability of therapy, and a considerable growth in the size of NARTH over that time, has had negligible effect on the self-evaluation of the
gay community as a whole.

SSA: Belief in Genetics as a Source of SSA

Figure 1. Changes in how Same-Sex Attraction (SSA) individuals have viewed the origins of their trait with time. A few Opposite Sex Attraction (OSA) points are inserted for comparison (Cameron, 1988; Bell, 1976; Kryzan & Walsh, 1998; Otis & Skinner, 2004; Herek, 2002; Harris Poll 2000 cited in Schneider, 2006).

We show in the next few paragraphs that the public is certainly not affected. A clear trend in the last few decades, as shown in more detail in Figures 2 and 3 below, is for a greater belief in both the general public and the gay community that one is born that way. That indicates a growing belief in all communities that those with SSA are not to blame. The various therapies have had an unmeasurably small effect on general opinion, which has become much more positive.
Figure 2. Changes in opinions of the general population about origins of SSA with time (Robinson, 2006).
Figure 3. Changing opinions as to whether discrimination against people with SSA should be permitted (Robinson, 2006).

Figure 3 shows the increase of positive attitudes to those with SSA. However, if the statement about homophobia is intended to not apply to the general public, but that those who have elected therapy gain more negative attitudes to SSA, this would be a valid criticism only if attitudes unsupported by the objective evidence were always inculcated by therapy, and this were shown to be an inevitable side-effect of all therapy. NARTH believes that objective facts should be the basis of attitudes and opinions, and that nothing beyond this needs to be given to clients, but is usually irrelevant to therapy, which does not necessarily deal with such issues.
In summary, efforts to change sexual orientation have not been shown to be systematically harmful, nor to lead inevitably to psychological harm, and certainly in very many cases have psychological benefits beyond amelioration of SSA.
References


Throckmorton, W. (2002). Initial empirical and clinical findings concerning the


(3) Whereas the APA sates: There is no greater pathology in the homosexual population than the general population.

We find that the pathology, unique to homosexuals, is not monolithic, rather seen in several paradigms:

AIDS-risk:

The prevalence, consistency, and relapse of high Acquired Immunodeficiency Syndrome (AIDS) risk-behavior among homosexuals is much higher than among heterosexuals. Even more strains of Human Immunodeficiency Virus (HIV) are being detected; a new drug-resistant strain was found in a gay New York man in his mid-40s who had unprotected sex with multiple men (Lombardi, 2005).

The incidence of apparent heterosexual transmission of AIDS in the United States had been rather low during the twentieth century; approximately 10% of the total AIDS cases (Huether & McCance, 1996). Homosexual HIV/AIDS incidence was approximately 430 times greater than among heterosexuals (Odets, 1994a). Gays represented the highest rates of AIDS cases, for example in San Francisco, close to 96% of the city's AIDS cases represented gay men (Eskstrand & Coats, 1990).

Research data heavily confirmed epidemiologist's estimates. When one