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Changing Sexual Orientation: A Consumers' Report

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What motivates individuals to pursue conversion therapy and ex-gay groups? How do they perceive its harmfulness and helpfulness? In this study, 202 consumers of sexual orientation conversion interventions were interviewed to answer these questions. The results indicated that a majority failed to change sexual orientation, and many reported that they associated harm with conversion interventions. A minority reported feeling helped, although not necessarily with their original goal of changing sexual orientation. A developmental model that describes the various pathways of individuals who attempt to change their sexual orientation is presented.

Despite the declassification of homosexuality as a disorder by the American Psychiatric Association in 1973 and similar action by the American Psychological Association in 1975, some mental health clinicians continue to view a homosexual[1] orientation as a mental illness and provide psychotherapy to change it. In the early 1990s, the National Association for Research and Therapy of Homosexuality, a professional organization that claims a membership of hundreds of mental health providers, was formed with the intent of treating and *preventing* homosexuality. Additionally, Exodus International, a network of ex-gay Christian ministries that provides peer and religious counseling, was formed in 1976.[2] These interventions, known variably as reparative, ex-gay, or conversion[3] therapies, have generated controversy and opposition from mental health organizations. According to the American Psychiatric Association (1998),

> The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone reparative therapy relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing the effects of societal stigmatization discussed.

This position is consistent with theoretical and clinical arguments echoed in the writings of several clinicians (Drescher, 2001a; Haldeman, 1991, 1994; Isay, 1990, 1997) and recent guidelines from the Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force (2000) but lacks the support of a systematic base of empirical data. No large-scale study has been made with the specific goal of looking at the harmfulness of conversion therapies (Haldeman, 2002). The current investigation seeks to remedy that.

The goals of this preliminary study were to add to the body of empirical evidence on conversion therapies so that consumers can make an increasingly informed choice about engaging in conversion therapy and to identify how consumers perceive their failure to change or their success in changing. In addition, we examined ethical issues of conversion therapy.[4] This is the first in a series of studies that can help develop a more rigorous empirical under-

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[1] We use the adjective *homosexual* (instead of *lesbian* or *gay*) to describe both men and women when we refer to the views of conversion therapists or consumers of conversion therapy. We are aware of the American Psychological Association's recommendation that the words *lesbians* and *gay men* be used because of the historical association of the term *homosexual* with stigma and psychopathology and because the term is sometimes associated only with men. Nonetheless, on the basis of the conversion therapy literature and our own empirical research, we have found that conversion therapists and many clients of conversion therapy steadfastly reject the use of *lesbian* and *gay*. Therefore, to have used gay-affirmative words would have been inaccurate and unfaithful to their views. Our own use of the term *homosexual orientation* is as a neutral descriptor that neither stigmatizes nor affirms.

[2] At the time of this writing, Exodus International has 135 affiliated ministries in 17 countries.

[3] We use the terms *conversion therapies* or *conversion interventions* to refer, nonspecifically, to any professional or peer-group attempt to change a homosexual orientation.

[4] These results are presented in Schroeder and Shidlo (2001).

standing of conversion therapies. Therefore, the focus is on qualitative data that will help generate quantitative instruments to be developed and validated in future studies.

The Conversion Therapy Project

Because we know so little about the experiences of consumers of conversion therapies, we chose a mixed-method approach. Our methodological approach is inspired by Flanagan's (1954) article on the critical incident technique; Garnets, Hancock, Cochran, Goodchilds, and Peplau's (1991) report on psychotherapy with lesbians and gay men; and Pope and Vetter's (1992) work on ethical dilemmas encountered by psychologists. These investigators used qualitative methods to identify critical incidents that are of help in developing conceptual categories for future quantitative study.

It is necessary to briefly mention the limitations of the present study: *The data presented in this article do not provide information on the incidence and the prevalence of failure, success, harm, help, or ethical violations in conversion therapy.* The qualitative data obtained can serve to develop rigorous quantitative measures to be validated in future studies.

This exploratory study was based on the retrospective accounts of consumers. Their self-reports may not always accurately reflect therapist behavior or therapy effects. Rhodes, Hill, Thompson, and Elliott (1994), in a study of misunderstandings in psychotherapy, have written of the limitations of retrospective data from clients:

> Informants may . . . [engage] in narrative smoothing, that is, the process of changing a story when recalling events. Clients' retrospective reports that recollect misunderstanding events from the vantage point of distance may lose the detail of the event as clients make sense of the events over time. (p. 481)

Complementary research needed would include interviews with sexual orientation conversion therapists and analysis of psychotherapy sessions by independent third-party observers.

We conducted structured interviews between 1995 and 2000. Participants who met the following criteria were included: (a) six sessions in any form of conversion intervention and (b) pretreatment self-report ratings of 5 (*more homosexual than heterosexual*) to 7 (*exclusively homosexual*) on a modified 7-point Kinsey scale (Kinsey, Pomeroy, & Martin, 1948) assessing sexual desire, attraction, and feelings. The total number of interviews conducted was 216. Fourteen interviews were excluded from the final analysis because they did not meet the criteria for inclusion.

We defined sexual orientation conversion intervention as any therapy administered by a licensed psychologist, psychiatrist, social worker, family and marriage therapist, or counselor, as well as individual, couple, and group interventions administered by peer counselors and religious counselors, which the consumer viewed as being explicitly aimed at changing a homosexual orientation. The number of participants included in this study was 202. Twenty participants (10%) were women; 182 (90%) were men. Mean age was 40 years ($SD = 18.83$, range = 20–74 years). With regard to ethnicity, 174 (86%) participants were Caucasian, 11 (5%) Hispanic/Latino, 4 (2%) Asian American, 4 (2%) Jewish, and 1 (<1%) African American. One hundred and thirty-three participants (66%) considered themselves to be religious, and 49 (24%) nonreligious; 76 participants identified with a Protestant denomination, 19 as Catholic, 11 with the Church of Latter Day Saints, 9 as Jewish, 2 as Pagan, and 2 as Buddhist (percentages do not add up to 100% due to missing data).

Participants reported receiving psychotherapy from a total of 203 licensed mental health practitioners: 122 psychologists, 32 psychiatrists, 22 social workers, 11 marriage and family counselors, and 16 master's-level therapists. Many participants reported courses of therapy with different practitioners. A total of 105 nonlicensed counselors were reported. Of those, 43 were peer counselors, 58 were religious counselors, and 4 were unlicensed therapists.

Regarding numbers of clinical intervention types, we obtained the following figures: individual psychotherapy—type not specified (132); behavior therapy/cognitive–behavior therapy (27); psychoanalysis (25); aversive conditioning (18); clinical/religious individual (17); clinical group therapy (9); hypnosis (9); couples therapy (4); psychotropic (5); clinical/religious group therapy (4); and inpatient psychiatric (3). The numbers of nonclinical interventions were as follows: peer group (85); peer individual (81); Homosexuals Anonymous (9); Aesthetic Realism (2); peer couple counseling (1); and residential program (Exodus affiliate) (1).

Each participant underwent the following total number of interventions: 84 participants, one intervention; 87 participants, two interventions; and 31 participants, three interventions. The average number of counseling sessions was 118 ($SD = 135$, $Mdn = 72$). The average number of months spent in interventions was 26 ($SD = 29$, $Mdn = 17$). The average time between the end of the last intervention and the date of the interview was 12 years ($SD = 8$; the earliest treatment ended in 1951, and the most recent in 1999).

The reader may question the usefulness of a study that presents data that, on average, refer to interventions that took place 12 years ago. There are several reasons why these data remain timely. First, we did not find evidence of significant changes in treatment approaches. When we compared consumers' reports on interventions that occurred recently with those that took place several decades ago, we found no significant changes. Although these data are, of course, limited to consumers' perspectives on therapy and may not accurately reflect actual practice, corroborating evidence is provided by a review of the conversion therapy literature. We found remarkable consistency in the therapeutic approaches advocated by conversion therapists over the past few decades. One notable exception is that of aversion therapy, in which we noted a sharp decline of interest in the late 1970s, as evidenced by the number of published articles. In our own data, the most recent course of aversion therapy occurred in 1992 and was not identifiably different from earlier courses of aversion therapy that other participants went through in the 1960s.

Second, although to many psychologists the practice of conversion therapy may seem archaic and not consistent with the current practice of psychotherapy with lesbians and gay men, conversion therapists argue that their approach is the treatment of choice for persons with a homosexual orientation. It is striking that in spite of changes in social acceptance of lesbians and gay men, conversion therapists continue to argue that persons with a homosexual orientation are mentally ill and a threat to society (cf. Socarides, 1995). Leading conversion therapists have served as activists in courts across the country to keep laws that criminalize sex between persons of the same gender and have been vocal opponents of laws

that serve to extend protections against discrimination toward lesbians and gay men (Drescher, 2001b) .

Third, one of the striking results of the study is that clients of conversion therapies go through significant developmental changes—sometimes over as long as a decade or more—in their views and feelings about the process of attempting to change. Participants who failed to change told us that at some point in their journey, they would have regarded themselves as having been successes and that it was only with the benefit of the perspective of a long period of time that they came to terms with the fact that they had failed to change. *Therefore, a study that would limit itself to interviewing only clients who had recently completed conversion therapy may significantly distort the long-term effects of conversion therapies*.

Initially, our goal was to document negative effects of and harm done by conversion therapies (an area that has been identified as a priority topic for research [cf. American Psychiatric Association, 2000; Haldeman, 2002] but that has not been empirically studied). The original title of the project was "Homophobic Therapies: Documenting the Damage" (see Appendix A for the initial participant recruitment text). After the first 20 interviews, we discovered that some participants reported having been helped as well as harmed. Consequently, we broadened the inquiry and changed the project name to a more inclusive one: "Changing Sexual Orientation: Does Counseling Work?"(see Appendix B for modified recruitment text). Participants were recruited through advertising in gay and lesbian Web sites and E-mail lists (19%) and in newspaper advertisements in the gay and lesbian (24%) and the nongay (9%) press. Eight percent of participants heard about the study from friends, 4% from a story in the media, and 3% from our brochure (percentages do not add to 100 because many participants were not sure how they heard of the study; some individuals revealed during the interview that they had been referred by a conversion therapist, but unfortunately we did not keep record of this number). We developed a Web site and sent direct mailings to gay and ex-gay organizations and to a national professional association of conversion therapists. We established a toll-free phone number to facilitate anonymous interviews. At the start of each 90-min interview, participants were given an informed consent form; when the interview was conducted by telephone, verbal consent was obtained.

We had to deal with participants' curiosity about our own views on sexual orientation conversion therapies. We told them that we are openly gay psychologists and that our research was hosted by two gay organizations: the National Lesbian and Gay Health Association and the National Gay and Lesbian Task Force. At the end of each interview, we asked the respondents about their perception of bias in the structured interview or any information that they may have heard about our investigation. Responses fell into two categories: (a) no prior knowledge about the study or perception of bias and (b) preinterview perception of a "pro-gay" bias or concern that we may be affiliated with a religious organization or ex-gay group. Both groups reported that they felt the interview had allowed them to articulate their recollection of conversion therapy:

> [I was] very happy with the interview. I had no idea of your bias and felt you were very fair.

> I was hoping that . . . because I saw this was sponsored by the gay and lesbian center [*sic*], this would truly be an unbiased study. Before [the interview], I thought, well, maybe you were looking for something and not wanting to hear what I had to say. But I felt like it's been very unbiased, and you listened. I feel you said that I [the interviewer] want to make sure you got your feelings down right. So I feel real comfortable with it.

A semistructured protocol evolved through several iterations during the course of our study (for a discussion of the rationale of using iteration in research, see Rubin & Rubin, 1995). The protocol included the following areas of inquiry: (a) goals of treatment; (b) information provided by the therapist on mental health issues of lesbians and gay men and the planned intervention; (c) informed consent; (d) intervention type; (e) perceived help and harm; and (f) assessment of sexual orientation (sexual desire, sexual behavior, romantic-primary affectional relationships, and self-labeling).

Participants were asked to use three time frames to describe their sexual orientation: (a) before the first conversion intervention, (b) immediately after the intervention (and after the second and third interventions), and (c) at the time of the interview. To assess the stability of self-report on changes in sexual orientation, we administered follow-up interviews to participants who viewed themselves as being treatment "successes." Our decision not to conduct follow-up interviews with those who perceived that they had failed in treatment ("treatment failures") was based on the rationale that we did not expect to see a change between the first interview and the follow-up in the status of treatment failures. In other words, participants who viewed themselves as treatment failures were not expected, without any further intervention, to suddenly view themselves as treatment successes. This was supported by our findings that even with regard to treatments that occurred many years prior to the interview, no participant spontaneously changed his or her view of treatment from failure to success.

We briefly want to address the importance of integrating follow-up interviews into a study of self-perceived successes. One male participant who at the first interview described himself as a success changed considerably when we spoke with him at later follow-up interviews. He shifted from being heterosexually married and labeling himself as heterosexual on the first interview to viewing himself as a treatment failure and describing himself as gay and as having separated from his wife. Conversely, a participant who on the first interview described herself as a success but as struggling with same-sex desire denied difficulties managing her same-sex desire on the follow-up.

Qualitative analysis was conducted with the help of Nvivo software (Fraser, 1999). We read through each interview and identified and coded salient themes and stages reported by participants. For harm and help sections, we first created low-abstraction categories, and then, after completing the low-order coding of each questionnaire, created higher abstraction supracategories.

Developmental Model

On the basis of interviews with consumers of conversion therapy, we created a developmental model to describe the varied pathways of individuals who attempt to change their sexual orientation. This model evolved out of detailed questions that asked participants to identify critical experiences before, during, and after conversion therapy. The stages identified below are a synthesis of these individual signposts (see Figure 1).

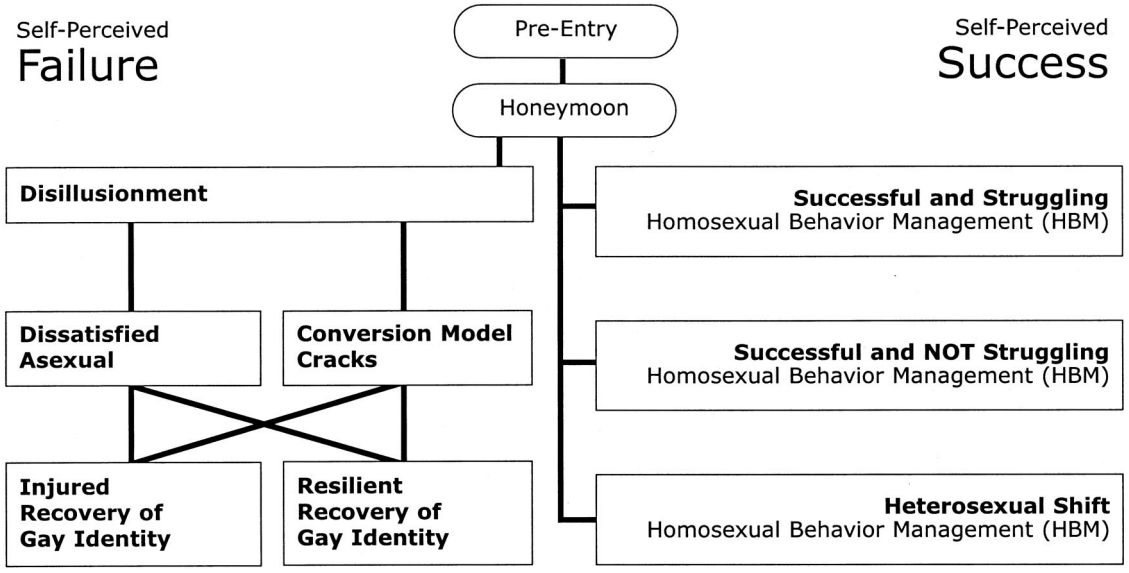

Figure 1. Developmental model: Pathways of conversion therapy.

The *preentry period* describes the participant's motivations for entering treatment. A significant motivational factor to change was the desire to belong to a community. Some participants reported they had been "out" as lesbians or gay men for many years but felt alienated from other lesbians and gay men; subsequently, they sought conversion therapy in an attempt to find a group to belong to. They experienced a failure to connect with other lesbians and gay men, voiced considerable disappointment in and contempt for gay persons and relationships, and overwhelmingly blamed their personal and interpersonal frustrations on being lesbian or gay. They viewed a homosexual orientation as an intrinsic obstacle to creating a sense of community. Conversion therapy offered a setting in which to affirm such beliefs.

Conversion interventions may offer a powerful social component as part of the treatment process. Some participants reported that it was easier for them to form a social connection with ex-gay persons than it had been to form such connections previously with lesbians and gay men who were out. Some individuals who were celibate or asexual for long periods of time reported that they were content to give up their sexuality for the sake of the sense of social belonging that they experienced in an ex-gay setting.

Unlike the group described above, there was a group of participants who had little or no exposure to the lesbian and gay communities prior to the conversion intervention. For this group, the motivation to seek conversion therapy was based on religious guilt, anticipated fear of social stigma and rejection by their church community, and fear of eternal damnation. Ex-gay groups and conversion therapy provided a forum that supported their religious beliefs and a sanctuary where they could be honest about their struggle. These groups created a new sense of belonging.

Some participants were motivated to pursue treatment with the hope of saving their heterosexual marriage and keeping their children. Others entered conversion therapy through force and coercion. For example, some students in religious universities were told that noncompliance with the mandated treatment would be followed by academic expulsion or the termination of financial aid. One participant reported the following:

> I am being forced to be in therapy [by a large religious university]. I sit there and agree with what he [the therapist] has to say to avoid confrontation. He is pushing me to marry a woman. My goal is basically just to graduate.

Finally, there was a group of conversion participants who entered therapy not for the purpose of conversion but rather to seek help for depression, anxiety, and feelings of guilt about a homosexual orientation. After disclosing their homosexual orientation, they were instructed by the clinician to undergo conversion therapy. The percentage of conversion interventions in which sexual orientation conversion was specifically asked for by the client was 74%. Thus, approximately a quarter of conversion interventions were initiated by the conversion therapist, not by the client.

We identified the next period as the *honeymoon period.* Many of our respondents reported feeling initially hopeful and positive. This is commonly what people often experience in the first phase of any form of psychotherapy: a sense of relief in telling their story, a sense of hope for change, and the adoption of a model that explains their difficulties and offers ways of changing (see Asay & Lambert, 1999; Hubble, Duncan, & Miller, 1999; Mays & Franks, 1985; Smith, Glass, & Miller, 1980). A powerful component common to conversion therapies is the cognitive framework that they provide that helps make sense of the history, identity, and struggles of individuals who feel unhappy with their homosexual orientation. Many participants, given their history of disappointing parents, lack of comfort with stereotypic gender traits, and difficulties with same-sex friendships, initially experienced the cognitive framework offered by the therapist as a good fit. Participants reported that when such explanations of same-sex desire were provided by the therapist, they experienced a strong sense of relief. This explanatory framework permitted a new understanding of the relationship between their homosexual orientation and what ailed

them. It explained away a homosexual orientation as *both the cause and consequence of negative life-events and psychological dysfunction*. Therefore, a history of negative life-events (e.g., "my dad was a salesman who was distant," "everybody made fun of me in school," "I felt like an outcast"), combined with a person's preexisting vulnerabilities and dysfunctions (e.g., poor self-esteem and addiction), were framed by the therapist—and later adopted by the patient—as both cause and consequence of a homosexual orientation.

Following the honeymoon period, a significant split in the developmental pathway occurred. One of two paths was followed: the path of *self-perceived failure* or of *self-perceived success.* Although 176 (87%) of our participants reported perceiving themselves as having failed conversion therapy, 26 (13%) participants perceived themselves as having been successful. We identified three categories of self-perceived successes: (a) *successful and struggling* (12 participants), (b) *successful and not struggling* (6 participants), and (c) *successful heterosexual shift* (8 participants). What all three groups had in common was the application of *homosexual behavior management* (HBM), a term we created to identify the range of cognitive and behavioral tools taught in conversion therapy to diminish and cope with same-sex desire and behavior and to increase heterosexual desire and behavior (for a detailed description of HBM, please see the *Consumers' Perspectives on the Helpfulness of Conversion Therapy* section).

Twelve of the 26 individuals who perceived themselves to be successes were categorized as being in the successful-and-struggling period. Participants experienced repeated incidences—what they termed "slips"—of homosexual behavior, including anonymous homosexual sex, masturbating to gay pornography, phone sex, cybersex, or disturbing same-sex fantasies.

Six of the 26 self-perceived successes were identified as being in the successful-and-not-struggling period. Five of the 6 participants in this group refused to put a self-label to their sexual identity, and 3 of the 6 were celibate. Nonetheless, they all felt that they had succeeded in the conversion therapy and were able to manage same-sex desire using HBM without experiencing distress or struggle. They accepted the active management of same-sex desire as part-and-parcel of being on the road to recovery as a heterosexual who has a *history* of homosexuality. In the interview, they appeared to be high-functioning individuals both socially and vocationally. A successful-and-not-struggling participant who reported being satisfied with conversion therapy said that "the goal is to maintain where I have been. My opinion is that change per se is not possible. This is a physical thing and I will always have to manage it."

Of the 26 participants who perceived themselves to be successful in the treatment, only 8 were in what we termed the *heterosexual shift period*. We operationalized this subgroup as follows: (a) rated 3 or less on a modified 7-point Kinsey scale of sexual desire, (b) self-labeled as heterosexual, (c) reported heterosexual sexual behavior, (d) denied homosexual sexual behavior, and (e) involved in a heterosexual intimate primary relationship. These participants appeared well-adjusted and content with living as heterosexuals. They viewed themselves as heterosexual and denied distress with regard to periodic experiences of same-sex desire. They reported satisfying heterosexual sex with their spouses. We obtained follow-up interviews with 6 of the 8 in this subgroup. Two participants refused follow-up interviews.

Participants in the heterosexual shift period who experienced same-sex desire described it as fleeting and manageable by using HBM cognitive reframing. Seven of the 8 participants in the heterosexual shift period provided ex-gay counseling. Four of the 7 had paid positions as ex-gay or conversion counselors. This finding needs further research. We failed to identify what other psychosocial variables distinguished this subgroup from all other subgroups in our sample. Thus, it is unclear why this small group reported a significantly different experience from other participants in managing and modifying their sexuality.

Subsequent to the honeymoon period, all those who perceived themselves to have failed experienced what we identified as the disillusionment period. This period is characterized by a significant conflict between cognitions, emotions, and behavior. Many of our respondents realized that in spite of their earnest efforts to use HBM, their sexual orientation had not changed. As the honeymoon period receded, increased frustration and discouragement developed; for many respondents, this started a process of blaming themselves for the therapy's failure, whereas other participants spoke of intense battles to keep same-sex desire away.

Subsequent to the disillusionment period, two subgroups were identified: the *dissatisfied asexual period* and the *conversion-model-cracks period*. In the dissatisfied asexual period, respondents shifted from disturbance about the lack of change to a state of numbness and dissociation, characterized by celibacy, compulsive work behaviors, anxiety, and depression. Some conversion therapists may view these kind of participants as successes, based on the fact that they no longer have sex with partners of the same gender. Similarly, some participants who reported having failed conversion therapy indicated that if they had been asked at this stage of their therapy, they would have presented themselves as successful. This kind of self-report, when limited to a single-point data collection that is obtained in the midst of the developmental journey, can skew conversion success data.

The other pathway-split from the disillusionment period is the conversion-model-cracks period. We believe this period to be the most troubling. These participants experienced a resurgence of ego-dystonic same-sex desire. This resurgence magnified their sense of being a treatment failure. They experienced a significant increase in guilt, depression, anxiety, confusion, and self-blame because of the rebounding of same-sex desire or behavior. Some participants in this group engaged in serious self-harmful behavior, including suicidal gestures, unprotected anal intercourse with untested partners, and heavy substance abuse.

The conversion-model-cracks period is often characterized by increased social withdrawal. Having left the initial closet of a homosexual orientation by opening up to a conversion therapist and supportive peers in the ex-gay community, the individual subsequently experiences a heightened sense of failure and shame and reenters a new closet. This closet consists of hiding from others the fact that the conversion therapy has indeed failed.

Many participants also reported that this period was associated with withholding from the conversion therapist information about continued same-sex desire and behavior and, at times, the fabrication of heterosexual feelings. Thus, some respondents reported that they told their therapists that they were "cured." It is likely that some conversion therapists may be left with a false perception of high success rates.

The path continues to branch out. We identified two groups of participants who resumed the development of being gay or lesbian. One group (155 individuals), in the *injured-recovery-of-gay-identity* period, experienced significant long-term damage from the conversion therapy, whereas another group (21 individuals), in the *resilient-recovery-of-gay-identity* period, demonstrated psychological hardiness.

When they terminated conversion therapy, participants in the injured-recovery-of-gay-identity period reported serious residual psychological damage and dysfunction. They blamed themselves for failing to change and reported feeling worse than they had before entering conversion therapy. This was a period of great disorientation and confusion, depression, substance abuse, and suicidal features; neither the cognitive nor the social framework provided by the conversion therapy worked, and there was not an alternative gay-affirmative framework to replace it. For decades, many experienced anger and grief at having lost time; they struggled with feelings of betrayal by mental health professionals.

The other period in which the development of a gay identity is resumed is the resilient-recovery-of-gay-identity period. These participants reported few or no long-term damaging effects and actually felt strengthened by their experience of having tried to change. Their failure at conversion therapy freed them to embrace their gay or lesbian identity without ambivalence or guilt. They appear to have been resilient individuals who maintained a strong sense of self-esteem prior to and during the process and did not blame themselves for having failed to change.

Consumers' Perspectives on the Harm of Conversion Therapy

Many consumers of conversion therapies reported to us that they were plagued by serious psychological and interpersonal problems during the therapy and after its termination:

> I felt dirty about [my homosexual orientation]. I felt like a cancer with a boil that someone is trying to lance out. I felt and still feel like a failure. . . . The counseling helped for a while but after that it reinforced the self-loathing and internalized homophobia. . . . It increased my self-loathing greatly.

How We Assessed Harm and the Limits of Our Data

We asked participants an open-ended question, separately for each of the three interventions that they reported on: "Do you feel that this counseling harmed you or had a negative effect on you?" This question attempted to assess the participant's *perception* of harm; it was not a quantitative measure of symptom deterioration. After participants' responses to the open-ended question, we followed up with a checklist of symptom areas (self-blame for not trying hard enough to change, self-esteem, depression, difficulties with intimacy, social isolation, loneliness, self-harmful behavior, suicidal thoughts, suicide attempts, feeling paranoid, self-monitoring behavior for "homosexual mannerisms," and alcohol and substance abuse) and asked them to tell us whether they noticed negative changes in these areas. This symptom checklist was developed in our pilot interviews.

We do not report here on the frequency of responses to these items because of two methodological limitations. First, because we emphasized breadth of inquiry and yet were constrained to keep the interview within a reasonable time limit (approximately 90 min), we used single items for each domain of functioning; this methodological decision came at the expense of sensitivity, reliability, and content and construct validity. Second, participants who felt harmed and unhappy about their therapy experience may have answered affirmatively to a deterioration in a particular area and attributed it to the conversion therapy because of a negative halo-effect or narrative smoothing (Rhodes et al., 1994) rather than having provided an accurate recollection of actual change in that particular area. Thus, instead of using the checklist as a quantitative measure of negative effects, we used these items as qualitative interview-prompts to help respondents explore areas of deterioration. Our results, therefore, focus on the meanings of harm attributed by clients, and the accuracy of these attributions remains to be determined by future process-and-outcome research.

Psychological Harm

Participants reported perceiving the conversion intervention as harmful in the following areas:

Depression, suicidal ideation and attempts. Many participants spoke of depressed feelings resulting from the conversion intervention. Some attributed the negative effect to the event of having being told by the therapist—and their believing—that they had *chosen* a homosexual orientation:

> I felt more depressed after I did the therapy. The negative aspect was that I really felt it was all up to me, a choice I had made, and because of that choice I was condemned to being in this pain forever. This need for unnatural affections.

Other participants said that they tried not to be homosexual, and when change failed to come or they experienced a resurgence of same-sex desire, they then became depressed. Some participants spoke of suicidal ideation and attempts:

> I wanted to die. I felt as though I would never change and be "cured." It harmed my self-esteem very much. I wanted to die. I felt as though it [the conversion therapy] took away who I was. . . . It took away my dignity.

One female participant described her experience of conversion therapy as an experience akin to being killed:

> I attempted suicide with pills. I just wanted to die. Part of it had to do with the feeling that I was dying already because of what the nun [conversion therapist] was doing to me. It felt like she was killing me, trying to rid me of my lesbian self.

In examining the data, we distinguished between participants who had a history of being suicidal before conversion therapy and those who did not. Twenty-five participants had a history of suicide attempts before conversion therapy, 23 during conversion therapy, and 11 after conversion therapy. We took the subgroup of participants who reported suicide attempts and looked at suicide attempts preintervention, during intervention, and postintervention to see if there was any suggestive pattern. We found that 11 participants had reported suicide attempts since the end of conversion interventions. Of these, only 3 had attempted prior to conversion therapy. Of the 11 participants, 3 had attempted during conversion therapy.

Self-esteem and internalized homophobia. Many participants linked the iatrogenic effects of conversion therapy on their self-esteem to the therapist's intervention of devaluing their homosexual orientation and providing defamatory and false information about gay and lesbian persons, and their lives, relationships, and communities (see Schroeder & Shidlo, 2001). This is consistent with the portrayal of lesbians and gay men in the conversion therapy literature (cf. Nicolosi, 1991, 1993, 2000; Socarides, 1978, 1995). It seems incontrovertible that an intervention that frames a homosexual orientation as undesirable, sick, and evil, *when applied to individuals who fail to change their homosexual orientation,* will have iatrogenic effects by virtue of exacerbating self-hatred, poor self-esteem, and internalized homophobia. One participant reported:

> I think it harmed me. . . . It reinforced all my own negative stereotypes about homosexuality and my being a failure and an inadequate human being.

Distorted perception of homosexual orientation. We found that some conversion therapists and patients appeared to attribute, without substantiation, many—sometimes all—negative traits and life events to a homosexual orientation. For many of our participants, homosexuality became a receptacle of all that was dysfunctional and undesirable. This created unrealistic demands that a change of sexual orientation would resolve unrelated personal and interpersonal problems.

Intrusive imagery and sexual dysfunction. A group of participants who underwent cognitive behavior therapies, especially those who had aversive conditioning, reported long-term harm as indicated by the intrusion of disturbing images formed in conversion therapy. Some male participants also complained of sexual impotence:

> In a sex act, I can imagine . . . my wife . . . and I find that disturbing, because it doesn't belong there. He [the psychologist] taught me to do that a long time ago. The first time I attempted to have anal intercourse with my lover, I couldn't because I would get flashbacks of my life. The same way when I was in the behavior mod program, when I was in the relationship with that guy, my therapist would have me envision [wife's name] there, versus the guy being there; I was to envision her, not him, while having sex with him. That was a mind bender. . . . I still have it with me sometimes. Not as bad as I used to, but I still get a flashback; either it takes away from the moment or destroys the moment. . . . When I'm involved in a sex act, sometimes I really have to try to push out thoughts in my mind that he planted, or I will not be able to achieve an erection or ejaculation.

Unanimously, participants reported that aversive conditioning had especially destructive effects. They experienced aversive conditioning as punitive and degrading, and they responded with fear and shame:

> It was a pretty humiliating experience. It was sitting in somebody's office and unzip your pants and strapped to electrodes. And [then] walk out to the waiting-room with burn marks in my arms—the size of quarters. Being in his presence [and] having to look at these pictures [pornographic images]. It was embarrassing.

Monitoring of gender-deviant mannerisms. Some respondents spoke about an increase in worrying that they appeared "gay-acting." This is not surprising, as a central component of some conversion therapies is to increase stereotypically gender-appropriate behavior. Some participants reported hypervigilance over displaying incongruous gender traits, resulting in an increase in paranoid-like worries and fears that they would not "pass" as being heterosexual.

Social and Interpersonal Harm

Many participants spoke of having experienced significant harm in their relationships and social functioning in the following areas:

Family of origin. Many respondents reported that conversion therapy significantly harmed relationships with their parents. These participants reported that they were instructed to blame their parents for their homosexual orientation and were taught to identify failures in parenting as causal to their sexual orientation. Participants spoke of anger, alienation, hatred, and other negative emotions toward their parents as results of the conversion therapy:

> I really wanted to believe . . . [my therapist about the cause of my homosexuality]. So for a while, it added to my hatred of my father. . . . During that period I broke off relationship with my father to get away from that influence.

Alienation, loneliness, and social isolation. Many participants complained of experiencing social isolation and loneliness as a consequence of conversion therapy. This occurred even in individuals who had many ex-gay or heterosexual social supports. Participants attributed their loneliness to hiding that they were still homosexual:

> [The conversion therapy] made me feel like a freak. Made me feel about it even worse than I did before [the conversion therapy]. Consequently, I couldn't reach out to anyone about it. . . . I had no one to talk to, and didn't feel I could be open with that therapist.

Interference with intimate relationships. This included loss of same-sex partners or missed opportunities to commit to long-term relationships with same-sex persons whom participants were in love with. Some therapists advised their clients to break off intimate relationships with same-sex partners. Long-lasting exacerbation of shame about sexual orientation interfered with lesbian and gay relationships after treatment failure:

> It changed my sexual life as well. . . . I feel that it has been a very slow process to having a normal sexual life as a gay male. Subconsciously or consciously I still view being gay as bad, or something you should be guilty about. . . . I think it made me less of a sexual homosexual.

Loss of social supports when entering and leaving the ex-gay community. Upon entering ex-gay support systems, many participants were instructed to distance themselves from lesbian and gay friends. A converse loss occurred when leaving the ex-gay community; many reported being rejected for abandoning the struggle against homosexuality.

Fear of being a child abuser. Some male participants reported that conversion therapy created in them a fear of becoming child abusers and subsequently interfered with their relationships with children:

> It really screwed me up, because these thoughts were put in my head that I was attracted to little boys, and I'm not. I was very angry at

> that. . . . I had very young nephews, I was afraid to be around them, afraid to play with them.

Delay of developmental tasks due to not coming out as gay or lesbian earlier. Many participants reported that the years invested in conversion therapy (over a decade for some) delayed opportunities to have intimate relationships and develop social skills. They complained of difficulties in distinguishing between intimacy, friendship, sex, and love:

> It delayed my being a gay man once again. It preserved the false notion that sexual orientation could be changed and added more years to my time in the closet. I lost a lot of my life as a result of this.

Spiritual Harm

The majority (66%) of our sample was religious. Many who considered themselves to be treatment failures reported experiencing a negative impact on their religiosity. We identified several negative outcomes in this group: (a) complete loss of faith, (b) sense of betrayal by religious leaders, (c) anger at clinicians who introduced punitive and shaming concepts of God, and (d) excommunication.

> I had this spiritual foundation that therapy fucked up. God became this very punishment. In church you get homophobia twice a year, in therapy it was every week. God was a punishing-homophobic figure, and I became an evil sinner every time.

Consumers' Perspectives on the Helpfulness of Conversion Therapy

Perceived helpfulness of conversion therapy can be categorized as help in (a) changing a homosexual orientation and (b) promoting psychological well-being and reducing symptomatology.

In our sample, a small percentage (13%) of participants reported that conversion therapy was helpful in changing their sexual orientation. Of this 13%, 4% experienced help in shifting heterosexual orientation, and the remaining 9% found help by using HBM techniques and were satisfied with being celibate or else accepted the struggle to manage same-sex desire.

HBM is a term we created to identify cognitive and behavioral tools used in conversion therapy in an attempt to diminish and cope with same-sex desire and behavior and to increase heterosexual desire. These tools include (a) the cognitive reframing of homosexual desire as a symptom of emotional distress in order to explain away such desire while lessening fear and guilt; (b) imagining getting AIDS or another aversive image when aroused by the same sex (covert sensitization); (c) abstaining from masturbation; (d) using opposite-sex sexual surrogates; (e) using another person for accountability (like an Alcoholics Anonymous sponsor); (f) forming relationships with heterosexual persons of the same sex; (g) playing team sports; (h) going to the gym; (i) immersing oneself in one's work; (j) reading the Bible; and (k) praying.

Of these HBM strategies, cognitive reframing appeared preeminent in the accounts of participants. This strategy appeared to enable participants to frame their homosexual orientation as a "receptacle" for negative life-events and undesirable personality traits. This cognitive framework provided hope that individuals' psychological and interpersonal suffering would be diminished through fighting their same-sex desire and behavior. Those who perceived themselves to be successes described almost universally that when they noticed same-sex desire, they embarked on cognitively challenging the meaning and importance of the arousal. They reported that this strategy gave them an increased sense of self-control.

How We Assessed Perceived Help in Other Areas

We asked participants an open-ended question, separately for each of the three interventions that they reported on: "Do you feel that this counseling was helpful or had a positive effect on you?" This question assessed the participant's perception of helpfulness; it was not a quantitative measure of symptom amelioration. After the participant's response to the open-ended question described above, we followed up with a checklist and asked them to tell us whether they noticed positive changes in these areas: (a) self-esteem; (b) if present, the diminishing of depression; (c) if present, the diminishing of self-harmful behavior; (d) if present, a decrease in thoughts and attempts of suicide; (e) improved intimacy; (f) improved social functioning; and (g) if present, decrease in alcohol and substance abuse.

Psychological Benefits

Participants reported a range of positive benefits, which included (a) relief from just talking; (b) increased sense of hope; (c) insight into relationship with parents; (d) general psychological insight; (e) coping strategies; and (f) improvement in self-esteem. Much to our surprise, for the subgroup of conversion failures who were in the resilient-recovery-of-gay-identity period, the therapy paradoxically solidified their gay or lesbian identity. It demonstrated to them that change was not possible and thus resulted in a sense of relief from the pressure to change.

Social Benefits

In addition to the psychological benefits discussed above, participants also reported social benefits from the conversion therapy. We identified two broad areas of perceived social benefit: (a) an increased sense of belonging and (b) an improvement in social relationships with friends and family.

Increased sense of belonging. Many participants who attended ex-gay groups and ministries experienced a positive and powerful sense of social inclusion and support. These were the first forums in which they could be open about their struggle with a homosexual orientation These were religious individuals who had spent a lifetime isolated in a battle against a homosexual orientation, tormented by feelings of sin and fears of being doomed to Hell. Ex-gay groups and ministries provided them, at least at first, with hope, openness, support, and fellowship. This experience normalized their previously shameful secret:

> It was tremendously freeing to come in and speak openly. That was extremely healing. That I could be open even to Christians and not be rejected or feel condemned. That was very freeing. Talking about my past and what had gone on, and hearing other people's stories, being allowed to talk through that, working through it, did a lot for my self-image, which impacted my sexuality.

Improvement in social relationships with friends and family and social skill building. Some participants reported an improvement in social skills in their relationships with friends and family:

> Being in that program, socially, was good for me. I was very shy, afraid to pick up the phone. It was helpful. It helped me grow.

> They [my family of origin] were very happy that I was in this program. I was still of a mindset that this was a sinful lifestyle. I was convinced I was doing the right thing, and they were very happy. There was a point we became very close, they sent E-mails saying it was wonderful we were communicating . . .

Spiritual Benefits

Some participants who were in a conversion intervention that had a religious component reported an improvement in their religious and spiritual life. This improvement was associated with a religious setting that provided acceptance of the individual while he or she was struggling with a homosexual orientation. In addition, many individuals found that praying, Bible study, and religious counseling were all helpful to their sense of well-being.

How Many Interventions Were Rated by Consumers as Helpful and Harmful?

For each treatment course, we determined whether participants reported perceived (a) harm only, (b) help only, (c) both harm and help, or (d) neither harm nor help. We summarized these numbers separately for self-perceived failures and self-perceived successes, with a breakdown for clinical versus nonclinical interventions. The classification into the categories of perceived help and harm was done by examining the participant's response to the open-ended questions ("Do you feel that this counseling harmed you or had a negative effect on you?" "Do you feel that this counseling was helpful or had a positive effect on you?"). We found that some participants answered in one way to the open-ended question but then, on further prompting with the symptom checklist, proceeded to answer in a contradictory way. Therefore, for those participants for whom we also had data from the symptom checklist, we used the presence of one (or more) positive response(s) as the indicator that determined the final classification of a treatment course into one of the four harm and help categories mentioned above.[5]

For self-perceived successes, out of 31 clinical treatment courses, 22 were described as helpful only, and 9 were described as both helpful and harmful. With regard to 15 nonclinical interventions, 10 were viewed as helpful only, and 5 as both helpful and harmful.

For self-perceived failures, out of 168 clinical treatments, 85 were viewed as harmful only, 9 as helpful only, 72 as both harmful and helpful, and 2 as neither harmful nor helpful. With regard to 90 nonclinical interventions, 32 were harmful only, 3 were helpful only, and 55 were both harmful and helpful.

In our study, many participants reported feeling that the same intervention was both helpful and harmful. Some participants appeared quite able to distinguish between these effects, whereas others could not. For example, a participant responded in the following way to the question "Did the therapy make you feel better about yourself?":

> Both yes and no. At times I felt better and other times worse. Better in the sense that I was trying to deal with these issues. Worse in the sense that it was reemphasizing my horrible nature as a human with the horrible decision I had [supposedly] made as child [to become homosexual].

In examining the reports of participants who reported both help and harm, we found that many reported feeling helped in the honeymoon period and harmed in later periods. Future research needs to provide detailed accounting of the active components of conversion therapies and to clarify their relationship to help and harm. This effort requires a rigorous operationalization of conversion therapies and measurement of in-session therapist behavior and patient response.

A related critical area that we did not conceptualize at the outset of the study but articulated only toward the end of the data collection is the issue of distinguishing between short-term and long-term negative effects. This was brought to our attention by one of our respondents, who made this distinction in response to the open-ended question about harm. Short-term harm can be defined as a decline in psychological and interpersonal functioning that occurred during and shortly after therapy (perhaps up to a year, using some arbitrary cutoff point). Long-term harm would be observed several years after termination of the intervention. These two effects need to be measured in a distinctive way in future research.

Summary and Implications

We found evidence that many consumers of failed sexual orientation therapies experienced them as harmful. Areas of perceived psychological harm included depression, suicidality, and self-esteem. In the case of aversive conditioning and covert sensitization, harm included intrusive flashback-like negative imagery that was associated with serious long-term sexual dysfunction. Areas of perceived social harm included impairment in intimate and nonintimate relationships. Some religious participants also reported experiencing spiritual harm as a result of religious therapy.

We found that some participants also reported feeling helped. For a minority (4%), conversion therapy provided help in shifting their sexual orientation. Others (9%) found help in HBM techniques and were content with being celibate or else accepted an ongoing struggle to contain their same-sex desire. Participants also reported other therapeutic benefits, including an increased sense of belonging, improved insight, improved self-esteem, improved communication skills, and relief from talking about sexuality for the first time. Surprisingly, some participants who failed to change reported that their failure had been a needed proof, which freed them to embrace their gay/lesbian identity with less guilt.

What do these results mean for the psychologist who is working with individuals who are considering sexual orientation conversion therapy? On the basis of our research, we offer the following suggestions:

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[5] Four interventions that were classified as "both harm and help" instead of "help only" had a positive response on the symptom checklist only on the following item: "Did it lead you to watch your behavior for 'homosexual' mannerisms?" Some may argue that this is a desirable result of conversion therapy and does not constitute true harm. On the basis of our clinical work with lesbians and gay men, we believe that monitoring of gender-deviant behavior is associated with shame and therefore view an increase in monitoring as possibly harmful. Nonetheless, classifying without the use of this item would have changed the results only negligibly.

1. If a clinician pursues conversion therapy, detailed informed consent is essential. Clients should be told that the American Psychological Association and other professional associations do not encourage change of sexual orientation. Clients should be informed that a homosexual orientation is not a disorder and given accurate information about lesbian and gay lives and relationships. Clients should be given accurate information about the efficacy of the proposed intervention and associated prognosis. They should not be told that high motivation and hard work in the treatment assures a change in sexual orientation. Our research suggests a likelihood of harmful side-effects of conversion therapy for those who fail to change. Alternative treatment options such as gay-affirmative therapy need discussion. Clinicians who are employed by religious universities may consider being especially attuned to possible conflict of interest if they provide conversion therapy to students who are mandated to change their sexual orientation at the threat of academic expulsion.

2. The clinician may find it helpful to educate the client about the possible developmental pathways that an attempt to change sexual orientation can lead to.

3. The clinician should educate the client on the various definitions of change that exist in conversion therapy. Clients' perceptions of change may be inconsistent with what the conversion therapist or program define as change or therapeutic success.

What does a psychologist do if a client reports that he or she has failed a conversion intervention? We suggest the following:

1. Be prepared for heightened mistrust of mental health providers. Clients who failed conversion therapy may feel unsafe about being truthful about homosexual desire and behavior. They may also be angry if they view prior therapy as having caused them harm and may fear additional injury.

2. Educate the client about the developmental pathways that conversion consumers go through; this may prove helpful to clients in processing their journey through conversion therapy.

3. Explore the positive and negative outcomes of the conversion therapy experience, being especially attuned to the likelihood of self-blame for failure. Because many conversion therapy clients report feeling both harmed and helped by conversion therapy, it is important that the therapist not focus exclusively on the harm incurred. Assist the client in establishing gay-affirmative support networks to facilitate a sense of belonging as a gay or lesbian person in society. It is also important to examine shame about having been through conversion therapy. Organizations that support ex-ex-gays may be a helpful support system for postconversion clients.

4. Be prepared to educate your client with accurate information about the lesbian and gay communities, lives, and relationships. Conversion clients may have been provided fraudulent and damaging information about gay and lesbian people in previous therapies.

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Appendix A

The following is the initial text used in participant recruitment, which was directed toward self-perceived treatment failures.

Homophobic Therapies: Documenting the Damage

Have you gone through counseling or therapy where you were encouraged to become heterosexual or ex-gay? The National Lesbian and Gay Health Association wants to hear from you. The organization is conducting research for a project entitled "Homophobic Therapies: Documenting the Damage." The NLGHA is conducting a survey of lesbians, gay men, and bisexuals who have been in counseling that tried to change their sexual orientation. They intend to use the results to inform the public about the often harmful effects of such therapies. Participation in the survey is confidential. Persons who are interested in responding can participate either through e-mail, by telephone, or in person. No record of your name, Internet address, or any other identifying information will be kept.

Appendix B

This is the modified participant recruitment text used, after the initial 20 interviews, to encourage both self-perceived successes and self-perceived treatment failures to participate in the study.

Changing Sexual Orientation: Does Counseling Work?

Can counseling or psychotherapy change gay men and lesbians into heterosexual persons? We want to know your experiences! If you have taken part in counseling or psychotherapy that has attempted to change your homosexuality, please give us a call. We are conducting a national study of individuals who have undergone such counseling. Did it work? Did it fail? We want to know how it affected you. For a confidential interview please call: Dr. Michael Schroeder or Dr. Ariel Shidlo at . . . Or, E-mail us at . . . Changing Sexual Orientation: Does Counseling Work? is sponsored by the National Lesbian and Gay Health Association and funded by the H. van Ameringen Foundation.

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