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The Treatment of Homosexuality: Some Historical, Contemporary, and Personal Perspectives

P. Scott Richards, PhD

The treatment of homosexuality has a long history in the psychiatric and psychological professions. Beginning with Sigmund Freud at the turn of the 20th century, many clinicians since then have attempted to help homosexual clients. Psychoanalysis, psychoanalytically-oriented psychotherapy, a wide variety of behavioral therapies, rational psychotherapy, exaggeration therapy, fixed-role therapy, and a variety of group psychotherapy approaches have all been used to help homosexual clients (e.g., Bancroft & Marks, 1968; Barlow & Agras, 1973; Berg & Allen, 1958; Birk, 1974; Conrad & Wincze, 1976; Eliasberg, 1954; Ellis, 1959; Feldman & MacCulloch, 1971; Freund, 1960; Gordon, 1930; Hatterer, 1970; Ince, 1973; Jacobi, 1969; London & Caprio, 1950; Maletzky & George, 1973; Mintz, 1966; Skene, 1973; Socarides, 1969; Stevenson & Wolpe, 1960; Truax & Tourney, 1971; van den Aardweg, 1972).

A variety of treatment goals for homosexual people have been pursued including: (1) decreasing the frequency and intensity of homosexual behaviors, thoughts, and feelings; (2) increasing the frequency and intensity of heterosexual behaviors, thoughts, and feelings; (3) reducing heterosexual anxiety; (4) improving heterosexual social skills; and, (5) exploring and altering cognitive and psychological aspects of homosexuality, such as self-perceptions, motivations, and gender-role identification (James, 1978). Reviews of the therapy outcome literature which have been published reveal that therapists have reported considerable success at helping
homosexual people achieve these goals (Adams & Sturgis, 1977; Clippinger, 1974; Hinrichsen & Katahn, 1975; James, 1978; Rogers, Roback, McKee, & Calhoun, 1976).

Though acknowledging the limitations of the database, Rogers et al. (1976) concluded that “Homosexuals can be successfully treated in group psychotherapy whether the treatment orientation is one of a change in sexual pattern of adjustment, or whether a reduction in concomitant problems is the primary goal” (pp. 23-24). Adams and Sturgis (1977) reported average success rates in decreasing homosexual urges and behaviors ranging from 18% to 78% and in increasing heterosexual urges and behaviors ranging from 8% to 71% for the behavior therapy studies they reviewed. They concluded that “Although the current status of sexual reorientation procedures as clinical techniques for modifying sexual preferences is not overwhelmingly positive, there are indications that, as the sophistication of the conceptualizations and treatment procedures increases, more significant results are achieved” (pp. 1185-1186). After reviewing a number of psychoanalytic, group, and behavioral studies, Clippinger (1974) concluded that “at least 40% of the homosexuals were cured, and an additional 10-30% of the homosexuals were improved” (p. 22).

For her doctoral dissertation at Brigham Young University, Elizabeth James (1978) completed perhaps the most comprehensive, rigorous review of the homosexuality-treatment literature that has been conducted to date. James meta-analyzed 101 outcome studies which had been published between the years 1930 to 1976. Based on her analysis, she drew a number of conclusions regarding the efficacy of various treatment approaches. Most importantly, she concluded that when the results of all research studies were combined, approximately 35 percent of the homosexual clients “recovered” and 27 percent “improved” (James, 1978). Based on this finding, she concluded that pessimistic attitudes about the prognosis for homosexuals changing their sexual orientation are not warranted. “Significant improvement and even complete recovery [from a homosexual orientation] are entirely possible.” (James, 1978, p. 183). James acknowledged that the “recovery” and “improvement” rates during therapy for bisexuals (81%) and long-
term therapy clients (69%) were higher than those reported for exclusively homosexual clients (42%) and short-term therapy clients (53%). Nevertheless, the recovery and improvement rates for even exclusively homosexual and short-term therapy clients were encouraging and “there is certainly room for the development of new treatments and combinations of techniques that will enhance the effectiveness of those procedures already in use” (James, 1978, p. 99).

James (1978) also concluded that there appeared to be little difference in the success rates reported by the behavioral therapies and the traditional verbal psychotherapy approaches. Both of these general therapeutic orientations have principles and techniques which are of value in treating homosexuality (James, 1978). She recommended that the homosexual client should be “viewed as a complex human being with intricately balanced and interwoven thoughts, feelings, and behaviors” and that a “multifaceted” treatment approach which considers the client’s total identity (behaviors, feelings, thoughts, and values) should be used (James, 1978, pp. 182-184).

Current Attitudes Regarding the Treatment of Homosexuality

Although therapists and researchers during the 1930’s through the mid-1970’s reported considerable success in helping homosexual clients reduce and change their homosexual tendencies, by the late 1970’s to early 1980’s the treatment of homosexuality and research evaluating its efficacy came to a virtual halt (Nicolosi, 1991). Why has such a decline in treatment and research occurred? Perhaps the major reason is that public and professional perceptions of homosexuality have changed. During the 1960’s, gay activists began to more openly and vigorously fight to legitimize the homosexual lifestyle (Bayer, 1981). Gay activists fought to ensure that homosexuals would be accorded all of the civil rights heterosexuals enjoy. As gay activists grew in power, they became more radical in their efforts to shape public and professional perceptions of homosexuality. Gay activists fought not only for public tolerance of homosexuality, but battled to get the public and
professionals to value and endorse homosexuality as a desirable alternative lifestyle (Bayer, 1981).

An important landmark in the gay activist battle to reshape public and professional perceptions of homosexuality came on December 14, 1973, when the Board of Trustees of the American Psychiatric Association (APA) voted to remove homosexuality as a abnormal diagnostic category from the APA’s Diagnostic and Statistical Manual (DSM). The decision to remove homosexuality from the DSM was made after APA leaders and members had endured several years of intense political pressure and disruptive lobbying efforts by militant gay activist groups (Bayer, 1981; Socarides, 1978, 1988). In discussing the APA decision, Socarides (1978), a leading researcher and theoretician on homosexuality, stated:

The removal of homosexuality from the DSM 2 was all the more remarkable when one considers that it involved the out-of-hand and peremptory disregard and dismissal not only of hundreds of psychiatric and psychoanalytic research papers and reports but also of a number of other serious studies by groups of psychologists, psychiatrists, and educators over the past seventy years. . . . It was a disheartening attack upon psychiatric research and a blow to many homosexuals who looked to psychiatry for more help, not less. (pp. 421-422).

Though Socarides and others have characterized the APA’s decision as politically motivated, “clinically untenable and scientifically fallacious,” it has not been reversed (Socarides, 1988, p. 51; Bayer, 1981; Nicolosi, 1991). In January, 1975, the governing body of the American Psychological Association voted to support the American Psychiatric Association’s decision, saying that it wished to oppose discrimination against homosexuals and encourage mental health professionals to “take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations” (Conger, 1975, p. 633).

The decision to remove homosexuality from the DSM had a chilling effect on the treatment of homosexuality and on treatment outcome research because it “became common knowledge that homosexuality was in fact not a problem” (Nicolosi, 1991, p. 10). Professionals who persisted in viewing and treating homosexuality
as an abnormal condition which can be changed came to be stigmatized as un-enlightened, prejudiced, homophobic, and even unethical (Bayer, 1981; Davison, 1976; Friedman, 1988; Marmor, 1980; Martin, 1982; May, 1977; Nicolosi, 1991; Silverstein, 1977; Socarides, 1988). Some gay activists now fight to convince professionals and the public that the only legitimate and healthy choice for people who experience homosexual attractions is to “come out of the closet” and become actively involved in the gay lifestyle and culture. These gay activists work to restrict people’s access to treatments which are designed to help them resist and overcome their homosexual tendencies by arguing that therapists who provide such treatment are unethical agents of a homophobic society (Browning, Reynolds, & Dworkin, 1991; Davison, 1976; Hancock & Cerbone, 1993; Marmor, 1980; Nicolosi, 1991; Joseph Nicolosi, personal communication, October 14, 1992; Silverstein, 1977; Welch, 1990).

**Gay Affirmative Therapy**

The changing of professional perceptions of homosexuality during the past couple of decades has led to the development of what is known in the psychiatric and psychology professions as the gay affirmative therapy approach (e.g., Fassinger, 1991; Browning et al., 1991; Shannon & Woods, 1991). Gay affirmative therapists make several major assumptions about homosexuality and therapy with homosexual clients (cf., Baron, 1991; Betz, 1991; Brown, 1991; Browning et al., 1991; Buhrke & Douce, 1991; Fassinger, 1991; Hancock & Cerbone, 1993; Martin, 1982; May, 1977; Morin, 1991; Shannon & Woods, 1991; Stein & Cohen, 1986):

1. Homosexuality is a legitimate, valuable, alternative lifestyle. There is nothing abnormal, immoral, or pathological about homosexuality. Cultures or religions which disapprove of the homosexual lifestyle are oppressive, homophobic, and heterosexist (i.e., they value heterosexuality as superior to and more natural than homosexuality). Efforts need to be made to change oppressive cultural and religious views of homosexuality.

2. Homosexuality is probably caused by genetic or pre-natal hormonal influences. Thus, people are born with their homosexual
orientation and, even if they want to, cannot change it. Research which has shown that people can change their sexual orientation is methodologically flawed and invalid. There is no convincing scientific evidence to support the idea that homosexuals can change their sexual preference or orientation.

3. The most desirable and psychologically healthy choice for people with homosexual attractions and feelings is to “come out of the closet.” In other words, homosexual people will be most happy and emotionally adjusted if they accept their “true” homosexual identity and becoming actively involved in the gay lifestyle and culture.

4. Psychotherapy with homosexual clients should focus on helping the clients (1) become more accepting and affirming of their homosexual feelings and identity, (2) negotiate and cope with the often difficult and lengthy “coming out” process, and (3) become more happy and fulfilled in their homosexual lifestyle.

5. Psychotherapists should not help homosexual clients attempt to change their sexual orientation, even if clients request help in doing so. Homosexual clients who wish to change their sexual orientation have internalized society’s negative, homophobic attitudes about homosexuality, and need help in recognizing this so that they can adopt more accepting, self-affirming attitudes toward themselves and their homosexual identity. Psychotherapists who attempt to help homosexual clients change their sexual orientation are maintaining the status quo of a prejudiced and oppressive society. Such therapists simply reinforce clients' internalized self-hate by perpetuating society’s negative, homophobic attitudes.

During the past decade, gay affirmative therapy has become the dominant therapy model within the psychiatric and psychological professions. Political and professional pressure is now being exerted to make gay affirmative therapy the only professionally acceptable therapeutic approach for homosexual clients (Hancock & Cerbone, 1993). Gay activists hope to influence the American Psychological Association to eventually adopt standards for therapy with gay and lesbian clients which will make it unethical for psychologists to help homosexual clients attempt to change their sexual orientation
Reparative Therapy for Male Homosexuality

In response to requests for assistance from “non-gay homosexuals,” that is, from people who do not value the gay lifestyle and culture and who desire assistance in controlling and changing their homosexual attractions and behavior, several therapeutic approaches collectively referred to as reparative therapies have been developed in recent years (Byrd, 1990, 1993; Consiglio, 1991, 1993; Dallas, 1991; Nicolosi, 1991). The reparative therapies are multi-faceted treatment approaches which are based upon the clinical and research knowledge regarding the etiology and treatment of homosexuality which accumulated during the 20th century (Byrd, 1990; Dallas, 1991; Nicolosi, 1991). Reparative therapies attempt to help non-gay homosexual people learn to resist and overcome their homosexual behaviors, thoughts, and feelings so that they can live more happily within the mainstream heterosexual culture which they value. Organizations such as Exodus International (Dallas, 1991) and Evergreen International (Matheson, 1993) supplement the efforts of reparative therapists by providing education and support groups for non-gay homosexual people and their families. Reparative therapists make several assumptions about homosexuality and therapy with homosexual clients (e.g., Byrd, 1990, 1993; Consiglio, 1991, 1993; Dallas, 1991; Nicolosi, 1991):

1. Homosexuality is not a desirable, normal, or moral lifestyle. Ultimately, one’s belief about whether or not homosexuality is desirable, normal, or moral is a value choice and cannot be resolved by scientific findings regarding etiology, prevalence, or treatment outcome. People of various cultures and religions have a right, therefore, to believe the homosexual lifestyle is not a valuable, alternative lifestyle just as gay activists have the right to believe otherwise.
2. Homosexuality is probably caused by multiple factors. Genetic and pre-natal hormonal influences may predispose or place people at greater risk for developing homosexual attractions. However, current research indicates that post-natal environmental influences must also be present in order for the homosexual attractions to be manifested (Byne, 1993; Byne & Parsons, 1993, Money, 1987). Some environmental and psychological factors that may play a causal role in the development of homosexuality include (1) cross-gender, effeminate behavior in childhood, (2) gender-identity deficits, (3) hostile, detached, or absent fathers (which leads to "defensive detachment" from the father and other males), and (4) overly close, controlling, or dominating mothers (Byrd, 1990; Nicolosi, 1991).

3. Regardless of the causes of homosexuality, while homosexual people may not initially have a choice about whether they experience same-sex attractions, they do have a choice about whether or not to behaviorally act on these attractions. Clinical and empirical evidence also provides support for the belief that homosexual people can reduce and often overcome their homosexual behaviors, thoughts, and feelings (Adams & Sturgis, 1977; Birk, 1974; Byrd, 1990; Byrd & Chamberlain, 1993; Clippinger, 1974; Hinrichsen & Katahn, 1975; James, 1978; Nicolosi, 1991; Rogers et al., 1976).

4. The most desirable, psychologically healthy, and moral choice for people with homosexual attractions is to resist acting sexually on their homosexual attractions and to make efforts to control, reduce, and overcome their homosexual behaviors, thoughts, and feelings. People with homosexual tendencies will be most happy and emotionally adjusted if they reject the gay lifestyle and culture, discover and affirm their true heterosexual identity, and remain within the mainstream heterosexual culture which they value. Despite the gay activist rhetoric, there is really little evidence to support the Gay Affirmative notion that the process of coming out and identifying with the gay lifestyle and culture leads to greater, long-term happiness, and adjustment for homosexual people (Nicolosi, 1991).
5. Psychotherapy with non-gay homosexual clients should focus on promoting clients' social and emotional well-being within the predominantly heterosexual culture. A premature focus on trying to help clients develop heterosexual interests, however, is not helpful and may be harmful (Byrd, 1990, 1993). Helping clients (1) reduce and gain control over their homosexual behavior, thoughts, and feelings, (2) set goals and achieve success in other areas of their lives (e.g., intellectual, physical, spiritual), and (3) gain insight into and work on psychological issues such as defensive detachment, loneliness and abandonment, gender-identity deficits, assertiveness, shame and guilt, and achieving non-erotic intimacy and support systems with men are all viewed as interventions that may be appropriate during the reparative therapy process.

6. Psychotherapists have the right to help non-gay homosexual people attempt to change their sexual orientation, if clients request help in doing so. Reparative therapists believe that in doing so they are affirming and protecting their clients' right to choose and define their own values, identity, and lifestyle. Reparative therapists believe that the non-gay homosexual person “has made a valid philosophical and existential choice. He is not a guilt-ridden, intimidated, fearful person. He is someone who, from the fullness of his own identity, seeks not to embrace—but to transcend—the homosexual condition” (Nicolosi, 1991, p. 6).

7. Reparative psychotherapists do not impose reparative therapy on homosexual clients. If clients indicate they have no desire to change their sexual orientation, reparative therapists respect their right to value and choose the gay lifestyle. Referral to a gay affirmative therapist would most likely be appropriate for homosexual clients who wish help in more fully accepting their homosexual feelings and identity, and in becoming more happy and fulfilled in their gay lifestyle.

During the past several years, a number of professionals have provided a theoretical and ethical defense of why reparative therapies are needed in contemporary society (e.g., Byrd, 1990, 1993; Consiglio, 1991, 1993; Dallas, 1991; Nicolosi, 1991). Theoretical rationales which articulate why reparative therapies are effective and clinical guidelines describing how to do reparative
therapy have also been provided (e.g., Byrd, 1990, 1993; Consiglio, 1991, 1993; Dallas, 1991; Nicolosi, 1991). There is also some clinical and antedotal evidence which supports the efficacy of these approaches (e.g., Byrd, 1993; Byrd & Chamberlain, 1993; Dallas, 1991; Nicolosi, 1991). There is a need, however, for well-designed therapy outcome studies to more thoroughly evaluate and document the effectiveness of these treatment approaches.

Reparative Therapy with Lesbians

To date, most reparative therapy and outcome research has been done with male homosexuals (James, 1978; Nicolosi, 1991). While some clinical work has recently been done with female homosexuals (e.g., Ahrens, 1991; Diamant, 1987; Siegel, 1988), we still know much less about the etiology and reparative treatment of female homosexuality. Adams and Sturgis (1977) reviewed 37 behavior therapy treatment studies and were surprised to find that only 4 out of 350 clients were females. James’s (1978) comprehensive meta-analysis of 101 treatment outcome studies revealed that only 26 out of 896 clients were females. The reasons for this are unknown although it may be due to (1) lower prevalence rates of lesbianism compared to male homosexuality, and, (2) lesbians may be less interested in seeking treatment than male homosexuals (James, 1978). Whatever the reasons may be, carefully done studies of female homosexuality and its reparative treatment are still greatly needed.

Personal Reflections and Conclusions

As a PhD student in counseling psychology at the University of Minnesota, I was thoroughly instructed in the gay affirmative therapy model by my professors and mentors. This indoctrination led me to rather uncritically believe that scientific research provides support for the major assumptions of the gay affirmative perspective. While in Minnesota, as well as a faculty member in Washington state after graduation, I also became well acquainted with several gay and lesbian classmates and colleagues. These valued associations and friendships helped break down some of my stereotypes and prejudices towards gay and lesbian people. I began
to see gay and lesbian people as complex individuals with feelings, hopes, and disappointments, rather than as one-dimensional caricatures.

As a result of these professional and personal experiences, I became "almost a gay affirmative therapist." While I felt that the gay affirmative approach posed some serious conflicts for my religious beliefs and values, I really did not know how else to behave ethically in my professional role. After all, the only therapy approach I had been trained in was the gay affirmative model, and I had been told that the homosexual condition is inborn and cannot be changed. I had no professional basis from which to make the claim to clients that I could help them reduce or overcome their unwanted homosexual tendencies. I avoided the conflict of having to implement the gay affirmative therapy model in my professional work, however, because until recently, I never had a client who presented sexual orientation concerns as a therapeutic issue.

During the past couple of years, as I have become more acquainted with the research literature on homosexuality, I have been rather surprised to discover that the current scientific evidence does not so clearly support the gay affirmative assumptions that homosexuality is simply inborn and cannot be changed. While biological influences may predispose, or make it more likely that a person will develop homosexual preferences, current evidence suggests that environmental, familial, and personal influences also contribute to the development of homosexual tendencies (Byne & Parsons, 1993; Byne, 1993). More importantly, while many people who experience homosexual attractions and thoughts may not have chosen to have such tendencies, they do have a choice about whether to behaviorally act on these feelings (Byrd & Chamberlain, 1993; Dallas, 1991; Nicolosi, 1991). Furthermore, while the therapy outcome research in this domain is not without methodological limitations, it does, nevertheless, provide considerable support for the notion that many people can control, reduce, and even overcome their homosexual thoughts, attractions, and behaviors (Adams & Sturgis, 1977; Birk, 1974; Byrd & Chamberlain, 1993; Clippinger, 1974; Hinrichsen & Katahn, 1975; James, 1978; Rogers et al., 1976). I have come to believe, therefore, that
the current widespread professional acceptance of the gay affirmative model is not due to solid research data which proves that this is the only viable therapy option for homosexual people, but is the result of powerful political and social gay activist forces that are at work in our society (Bayer, 1981; Byne, 1993; Nicolosi, 1991; Socarides, 1978, 1988).

I continue to value the friendships I have developed with my gay and lesbian classmates and colleagues. I believe I have developed, to some extent at least, a greater understanding of and compassion for the challenges they face and the pain they often experience. I believe homosexual people have the right to live their lives free from discrimination and violence. I believe the gospel makes it clear that expressions of hatred, persecution, or violence toward homosexual people are inappropriate and morally wrong. As Latter-day Saints, I believe our responsibility to homosexual people is to care about them, avoid judging them, and seek to help them in appropriate ways. However, this does not mean that we must give up or compromise our religious beliefs that homosexual behavior is morally wrong. Our very difficult challenge, in my opinion, is to condemn homosexual behavior while still providing caring, acceptance, and help to people with homosexual tendencies.

I now find myself unwilling to accept the notion that gay affirmative therapy is the only treatment option we should offer clients, just because this is currently the "politically correct" thing to do. I believe that Latter-day Saint (and other) therapists have a right to offer reparative therapy as a treatment option to those who request help in understanding, controlling, and/or overcoming their homosexual tendencies. In fact, if we do not inform such clients of this option, I believe we are letting them down. In saying this, I am not endorsing all "reorientation" or "sexual orientation conversion" therapeutic approaches which have been utilized over the years. For example, I agree with the gay activists that some of the reorientation approaches (particularly the surgical and the electrical and chemical aversion therapies) are dehumanizing and may be harmful (Hancock & Cerbone, 1993). I also believe that we need to further test the efficacy of the contemporary reparative therapy approaches with carefully conducted research. Although the gay activist position (Hancock & Cerbone, 1993)
that there is no valid evidence that people can change their sexual orientation seems clearly untenable to me in light of the therapy outcome research cited earlier, I do agree that this data base has methodological shortcomings and that more rigorously designed studies need to be done. Such research could help us better understand which reparative approaches are most effective and what types of changes people are most likely to experience during therapy.

I also do not believe that we should impose reparative therapy on homosexual clients who do not wish to change their sexual orientation. The American Psychological Association (APA) ethical standard 1.09 states that “In their work related activities, psychologists respect the rights of others to hold values, attitudes, and opinions that differ from their own” (APA, 1992, p. 1601). I believe that in order to avoid imposing reparative therapy upon those who do not want it, we should not only be trained in reparative therapy, but we should be well-informed about the gay affirmative therapy model and about the challenges and issues gay and lesbian people face. If we cannot empathize with their pain, how can we avoid inflicting more?

I also, of course, do not believe that gay affirmative therapists have the right to impose gay affirmative therapy on homosexual clients who wish to control and overcome their same-sex attractions. This would also be a violation of the APA ethical standard 1.09. I believe that ethical gay affirmative therapists will remain open-minded and become informed about reparative therapy approaches and the issues and challenges “non-gay homosexual” people face. Only by empathizing with non-gay homosexual people, and attempting to more fully understand why they have made the value choice to reject the gay or lesbian lifestyle, can gay affirmative therapists themselves avoid being oppressive, culturally insensitive, and unethical. Finally, as psychotherapists, I believe all of us need to be explicit with our clients about our values and about treatment options that are available so as to maximize their freedom of choice (Bergin, 1985, 1991). In so doing, we will show respect for our clients’ right to own and follow their own cultural or religious values, regardless of how divergent these beliefs and values may be from our own.
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References


