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## Conversion Therapy Revisited: Parameters And Rationale For Ethical Care

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### Abstract:

**Observes that efforts are being made within certain professional counseling associations to oppose and prohibit attempts to modify homoerotic feelings and behavior on ethical grounds. Outlines several factors that can motivate the pursuit of conversion therapy and reviews data that suggest change is a viable treatment outcome. Proposes, based on an analysis of research data, an ethical framework within which conversion therapy can be legitimately practiced.**

The practice of conversion therapy involves psychological and/or pastoral intervention to promote change in the sexual orientation of homosexual men and women. Examining the history of the psychological and pastoral disciplines, it is only in the past few decades that the attempt to change unwanted homosexuality has been questioned.

During this time, efforts to marginalize practitioners of conversion therapy within their professions have grown increasingly strident. Opponents not satisfied with the results of collegial reproach are attempting to add a new, more potentially devastating weapon: ethical censure. Particularly precedent-setting in this effort is the intent to consider conversion therapy unethical, even when freely sought by clients. If successful, such efforts could logically lead to these counselors losing their memberships in professional associations and being investigated by state licensing authorities.



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The intent of this article is to first outline the ethical complaints that have been leveled against conversion therapy, and then to describe several considerations which mandate a reevaluation of such concerns. Matters pertaining to risks associated with homosexual behavior, the possibility of change, and related treatment issues will be examined. A case study, which highlights some of these considerations, will also be presented.

### The Ethical Case Against Conversion Therapy

There are a number of lines of reasoning that would ethically prohibit the treatment of dissatisfied homosexual persons who are seeking change.<sup>1</sup> These arguments essentially break down into two primary contentions. The first ethical objection is that efforts to change homosexual orientation are inappropriate given that homosexuality is no longer judged to be a mental disorder. Consequently, it should not be seen as undesirable. The second major contention is that conversion therapy reinforces prejudice and stigmatization of homosexuality. Some go as far as to indicate that given societal homophobia, no one seeks conversion therapy in a genuinely voluntary manner.

In support of these arguments, reference is made to the ethics codes of associated professional organizations, such as the American Association of Pastoral Counselors (AAPC) and the American Psychological Association (APA). The contentions are that practitioners of conversion therapy act in an unethical manner by 1) promoting discrimination, 2) lacking familiarity with current scientific research and professional developments, and 3) not acting to advance the welfare of the individual.

Practically, such a perspective supports Murphy's assertion that it is unethical for mental health workers to work with homosexual clients unless they have a positive view of homosexuality.

### The Case For Ethical Treatment Of Homosexual Orientation

#### Preconditions for Ethical Care

Practitioners of conversion therapy are beholden to these same ethical principles, although they may have a somewhat different understanding of how such principles are to be fulfilled in the context of the treatment of unwanted homosexuality. Conversion therapists should oppose social stigmatization and obstruction of the basic civil rights of homosexuals.

Moreover, it is clear that only clients who are dissatisfied with their sexual orientation and who freely and actively seek to change their orientation should be treated. Clients seeking to strengthen in one form or another their homosexuality should be referred to affirmatively oriented counselors, where the goal of counseling is acceptance of and adjustment to a gay or lesbian sexual identity. As will be discussed at length later, informed consent regarding treatment outcomes of conversion therapy also needs to be obtained.

These ethical considerations are, unfortunately, not likely to placate those who view conversion therapy as homophobic and implicitly unvolitional. The belief that individuals cannot freely choose to seek change in their homosexual orientation carries with it a remarkably low view of human agency.

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Of course, each situation must be evaluated on its own terms to determine if overt coercion might be part of the client's motivation for seeking treatment. However, it requires an extremely deterministic conception of human nature to deny there could be some individuals who freely and willingly seek conversion therapy out of deeply held moral and/or religious convictions.

Examples abound of individuals who defy societal expectations due to such beliefs (e.g., conscientious objectors of war, early civil rights leaders). Thus it is not hard to imagine that some individuals will request conversion therapy primarily in response to their moral and religious beliefs rather than due to the effects of social stigmatization.<sup>2</sup>

The issue as to whether or not conversion therapy is homophobic also needs to be addressed. A central problem is that research definitions of homophobia tend to mix prescriptive, moral and valuative statements with descriptive, emotional and behavioral items.<sup>3</sup> This suggests that homophobia often functions as a term of moral persuasion rather than scientific description. The general success of this construct in influencing cultural mores toward homosexuality can be expected to spawn further attempts along these lines.

Indeed, this can already be seen in the relatively new concept of biphobia, defined as a negative attitude toward bisexuality.<sup>4</sup> Unfortunately, here again the term is defined in such a way as to imply that all moral and religious disapproval of bisexual behavior is tantamount to phobia.

In light of these concerns, it is clear that the literature correlating high homophobia with adherence to traditional religious belief approaches the subject much too simplistically.<sup>5</sup> This has implications for evaluating the ethics of conversion therapy, in that research has indicated the primary factor distinguishing those who practice reorientation therapies from those who do not is their moral position regarding the acceptability of homosexuality.<sup>6</sup> It appears disingenuous to prejudge the ethics of conversion therapists on the basis of a definition of homophobia that begs the moral question.

Moreover, it is hard to overlook the irony in a strategy which denounces conversion therapy because homosexuality is not a psychiatric disorder, while simultaneously calling for efforts to educate these counselors to reduce their homophobia, a "disorder" that has never been included in the Diagnostic and Statistical Manual of Mental Disorders (DSM).<sup>7</sup>

### Factors in Seeking Change

The ethical viability of conversion therapy is dependent in part upon the establishment of reasonable considerations that lead some individuals to seek change. While the following list is not exhaustive, it describes several factors which often influence the pursuit of conversion-oriented treatment.

*Religious/Moral Conviction.* As alluded to above, deeply held religious and/or moral values are a potent source of motivation for behavioral change. It is likely that many individuals seeking change in their homosexual orientation do so in response to personal religious sentiment and moral belief.<sup>8</sup> Despite some contemporary revisionistic efforts,<sup>9</sup> the historic Judeo-Christian moral tradition has judged homosexual behavior as falling short of the biblical ideal for sexual conduct.<sup>10</sup> As we shall later see, the ethics codes of professional counseling organizations mandate respect for such values and beliefs, and given certain conditions, this respect should be demonstrated for clients seeking conversion-oriented treatment.

In addition to religious and moral motivations, other factors may also influence individuals to pursue counseling to change same-sex attraction. Health concerns are often cited, including fear of disease and premature death.

*Disease.* Homosexual men in particular are at significant risk of sexually transmitted disease, such as AIDS, as well as other medical conditions primarily associated with anal sex.<sup>11</sup> Epidemiological statistics suggest that the incidence of AIDS among 20 to 30-year-old homosexual men is roughly 430 times greater than for the heterosexual male population at large.<sup>12</sup> Safe-sex education in this population, even if complete compliance were possible, is far from removing risk as the physiological incompatibility involved in anal intercourse places severe stress on rectal tissue and any condom employed. Painful receptive anal sex has been found to be a lifetime problem in 61% of homosexual men compared to no occurrence in heterosexual men.<sup>13</sup>

Not surprisingly, another study discovered that among homosexual men who reported any anal intercourse in a three-month period, 18% had experienced at least one condom break or tear while doing so.<sup>14</sup> As receptive anal sex appears to occur developmentally later in the gay lifestyle than other sexual behaviors,<sup>15</sup> it follows that any change in orientation attained by a client with limited homosexual experiences could limit exposure to such health risks.

Recent studies also suggest that high-risk sexual behavior is increasing, particularly among younger gay men.<sup>16</sup> The fact that such sexual behavior is on the upswing in gay-tolerant cities such as San Francisco suggests that unsafe sexual practices cannot be completely interpreted as an effect of social homophobia. Another contributing factor may be that some gay men pursue high-risk sexual behavior (i.e., deliberately courting danger or engaging in unprotected anal intercourse) precisely because it enhances their sexual enjoyment.<sup>17</sup>

*Longevity.* Common sense and some research suggest that the above health concerns could reduce life expectancies among homosexuals. Epidemiologists have estimated that 30% of all twenty-year old homosexual males will be HIV-positive or dead of AIDS by the time they reach 30 years of age.<sup>18</sup> An examination of 6,737 obituaries revealed that homosexual persons had shorter lifespans than their heterosexual counterparts, and statistics indicated that the decline in longevity associated with the AIDS epidemic reduced this figure by 10%.<sup>19</sup> Gay men lived to their mid-40's and this figure declined to the early 40's or late 30's if AIDS intervened. Lesbian lifespans averaged less than 50 years of age. The most recent follow-up study on these statistics reported that the average age of death from AIDS among gay men has only increased by about two years.<sup>20</sup>

*Sexual Promiscuity.* The question of comparative sexual fidelity rates among homosexual and heterosexual populations has not been widely researched since homosexuality was declassified in the DSM. Prior to that time, promiscuity among gay men was largely taken for granted. While this area of research has fallen out of vogue since then, some recent studies continue to make the link between sexual promiscuity and homosexual orientation. One relatively recent study reported that male homosexuals averaged 42.8 lifetime sexual partners compared to 16.5 for heterosexual males.<sup>21</sup> Lesbians indicated 9.4 lifetime sexual partners compared with 4.6 for heterosexual females. Another study found that 63 men who

had sex with men exposed to infectious syphilis reported a total of 740 sex partners over a six month period, of whom 653 were met at anonymous venues such as bath houses, bars, or clubs.<sup>22</sup> Fifty of these 63 men had at least one anonymous partner. These tendencies may be even more pronounced among youth. In one sample of adolescent students, those who reported six or more sexual partners in the previous three months were 10.29 times more likely to also report being gay, lesbian, or bisexual.<sup>23</sup>

These differences may sometimes be masked by an apparent tendency, particularly among gay men, to define committed or primary relationships in emotional rather than sexual terms. Blumstein and Schwartz found that 79% of closed-couple male homosexuals reported at least one incident of non-monogamy in the previous year.<sup>24</sup> Comparison rates for lesbians, married heterosexuals, and cohabiting heterosexuals were 19%, 10%, and 23% respectively. Other studies have found comparable rates of nonmonogamy among committed male couples.<sup>25</sup>

Comparing data from 1980 and 1992, Bringle found consistent differences between homosexual and heterosexual men even after the onset of the AIDS epidemic.<sup>26</sup> Men in both groups were involved in less exclusive romantic relationships, had significantly more romantic relationships, and more often had partners who saw others on a romantic basis than their heterosexual counterparts. Moreover, homosexual men had less desire for sexual exclusivity and were significantly more accepting of additional sexual relationships by their partners than the heterosexual men.

Promiscuity may be an acceptable option for many in the gay lifestyle,<sup>27</sup> but it poses obvious health risks and serious emotional conflict among individuals with traditional moral and religious beliefs. Thus, it is not uncommon that such a combination of concerns is reported when an individual presents for conversion therapy.

*Suicide.* There has been some indication that homosexuals are at greater risk for suicide, although inconsistent data have been produced, especially when examining adolescents. In adolescent samples, sexual orientation has not always been linked to suicide, and suicide in gay, lesbian, and bisexual youth has not been conclusively linked to a history of abuse or harassment.<sup>28</sup> However, the best designed and controlled research in this area has recently reported a substantially increased risk of suicidal behavior for homosexual men and gay, lesbian, and bisexual youth in comparison to their heterosexual counterparts.<sup>29</sup> McBee and Rogers reviewed the pertinent literature and concluded that gays and lesbians are at increased risk for suicidal behavior while another recent analysis found homosexual and bisexual men to be 13.9 times more at risk for serious suicide attempt than heterosexual males.<sup>30</sup>

Of particular interest is a study by Remafedi, Farrow, and Deisher of 137 14- to 21-year old gay and bisexual males.<sup>31</sup> The authors discovered that those who attempted suicide tended to adopt a bisexual or homosexual identity at a younger age. Moreover, 75% of all first time suicide attempts followed self-labeling as gay or bisexual, indicating that the likelihood of attempting suicide decreases with advancing age at the time of self-labeling. The authors concluded that each year delay in self identification decreases the odds of suicide attempts more than 80%. Similar statistics have been reported in a recent study<sup>32</sup> and this trend could create significant liability problems for churches, counseling agencies, and schools that advocate early identification and affirmation of gay, lesbian, or bisexual identities among adolescents who later suicide.

*Victimization.* Research has suggested that gays and lesbians experience greater levels of victimization (i.e., sexual coercion) than their heterosexual counterparts, although this trend appears to apply more to youth, and further studies are needed, as in some of the literature it is uncertain if the perpetrator is same-sexed.<sup>33</sup> One large study of male homosexuals found 27.6% reported being sexually assaulted or having sex against their will.<sup>34</sup> One third indicated being forced into sexual activity against their will by men with whom they had previously had, or were currently having, consensual sexual activity. A national representative survey of 16,000 adults discovered that respondents who had lived with a same-sex intimate partner were significantly more likely than respondents who had married or lived with an opposite-sex partner to have been raped as minors and adults, physically assaulted as children by adult caretakers, and physically assaulted as adults by all types of perpetrators, including intimate partners.<sup>35</sup> Overall, violence was more prevalent among same-sex male couples than either same-sex female couples or heterosexual couples. In adolescents, Garofalo and his colleagues reported that gay, lesbian, and bisexual youth were more likely than their heterosexual peers to have been victimized.<sup>36</sup> Sexual contact against one's will was reported by 32.5% of gay, lesbian, and bisexual youth compared to 9.1% for heterosexual adolescents. A 26.9% to 7.4% contrast was found for the occurrence of sexual intercourse before age 13. However, it is not clear from this research whether this sexual contact came from an adult or a peer, placing an interpretive limitation on the findings.

While more research is clearly indicated, aspects of the subculture seem to support the notion of an increased risk of victimization, especially among gay men.

Fantasies of the sexually forceful man, the pleasure of "being taken," and the excitement of power-driven sex are very common in gay cultures and pornography. All these collective sexual fantasies normalize sexual abuse and rap of gay men by gay men, providing motivation, justification, and normalization for the assault. It is difficult to see how a climate of intolerance toward sexual aggression can be achieved when sexual aggression is one of the mainstays of collective sexual fantasies.<sup>37</sup>

Discussion of these factors would not be complete without some mention of the two divergent interpretive approaches found in the literature. The traditional perspective tends to locate the origins of the physical risk behaviors in psychological dynamics inherent to the homosexual adjustment. The more contemporary approach usually views such behavior as the result of internalized homophobia stemming from societal stigmatization.<sup>38</sup> As in most polarized debates, some combination of these perspectives is probably at play. Because such overarching assumptions are extremely difficult to research scientifically, it is quite likely that this debate will never be resolved via the scientific endeavor. Rather, any answer can be assumed to reflect the moral compass of the scientific community and its surrounding culture.<sup>39</sup>

Regardless of the origins of these risks and the limits on which they can be generalized to the homosexual population at large, many individuals who do seek conversion therapy appear to come from subpopulations for which these risks are a real motivation for change. The additional religious and/or moral concern typically gives added impetus to pursuing such treatment.

#### **The Possibility of Change**

Whatever motivations lead an individual to seek conversion therapy, an ethical case for this treatment cannot be made without indication that change in sexual orientation and behavior may be possible. This area of study remains highly controversial, but evidence exists on several fronts that significant change can

be achieved in many cases.

### Research on Change

Prior to and shortly after the declassification of homosexuality from the DSM in 1973, there were a great number of studies suggesting that change in sexual orientation can occur.<sup>40</sup> While this research was often not sophisticated in design and thus limited in its generalizability, it should not be dismissed lightly. Few if any bodies of clinical and scientific literature amassed over several decades have been as quickly discarded as this research has been since the mid-1970's. This hints rather strongly at the heavy involvement of sociopolitical influences in the process.

Throckmorton has reviewed this literature, as well as the few more recent studies, and concluded that there is support for the effectiveness of approaches seeking to modify patterns of homosexual arousal<sup>41</sup> For example, psychoanalytic approaches obtained change rates to exclusive heterosexuality ranging from 18% to 44%, with rates for shifts in orientation tending to be even higher. Clients with some prior heterosexual experience and motivation for change appear most likely to benefit from conversion therapy.

A recent study by Nicolosi, Byrd, and Potts surveyed 882 clients engaged in sexual reorientation therapy.<sup>42</sup> Of the 318 clients who rated themselves as having exclusively same-gender sexual orientation prior to treatment, post treatment results found 18% rating themselves as exclusively heterosexual and 17% almost entirely heterosexual. Only 13% reported remaining either exclusively or almost exclusively gay or lesbian following treatment. Self-report information on these individuals also revealed significant improvements in self-acceptance, emotional stability, depression, and spirituality.

A couple of recent studies specifically examined religiously-motivated attempts to change sexual orientation.<sup>43</sup> In one study, 248 individuals reported experiencing significantly more heterosexuality than they recalled experiencing at age 18. At a one-year follow-up, 140 of these subjects were reinterviewed and 60.8% of males and 71.1% of females reported behavioral success, defined as abstaining from homosexual contact. Success was associated with strong religious motivation and positive mental health. The authors also reported that therapy was not found to be a significant factor in participants' success. Additional analyses suggested that the benefits of conversion therapy may not be experienced until well into the therapy process. This is in keeping with the Nicolosi, Byrd and Potts study where the average length participants had received therapy was 3.4 years.<sup>44</sup>

In current non-polemic scientific quarters, the general consensus is that the origins of homosexuality are complex and include developmental and environmental influences.<sup>45</sup> These later influences appear robustly evidenced in the research on sibling and birth order patterns among homosexual men. Numerous studies have reported that homosexual men have later birth orders and a greater number of older brothers than heterosexual men.<sup>46</sup> While maternal immune reactions have been offered as one explanation of this finding, direct biological support for this theory appears to be lacking and psychosocial interpretations should not be ruled out. The birth order trend is also consistent with the involvement of developmental and familial experiences in the origins of sexual orientation.

These influences are commonly addressed in psychotherapy and pastoral care, and usually not believed to be strictly determinative of present personality and behavioral functioning. The potential for change in a homosexual orientation, therefore, should not be presumptively ruled out.

While it is inaccurate to state there is no scientific research that supports conversion therapy, it is true that recent contributions to this literature are quite sparse. The reasons for this paucity again highlight the impact of the social and political arena that surrounds this area of research. Modern studies that examine homosexual behavior from a non-affirming viewpoint or conversion therapy from a sympathetic position come almost exclusively from private organizations and practitioners. This is in large part due to the dominance of a morally and socially favorable perspective on homosexuality within secular universities and government agencies.

Thus these institutions, which are designed to fund and conduct research, are simply not going to sanction any study of homosexuality that can be construed as falling outside the affirmative position. An academician who chooses to research homosexuality in this climate would be committing vocational suicide by investigating hypotheses or publishing findings of a non-affirming nature. Moreover, even were such research to be conducted, attempting to publish it in the vast majority of highly regarded professional journals is a Herculean task. The publishing organizations and their affiliated manuscript reviewers are typically committed to an affirmative perspective and unlikely to be receptive to studies not in line with this. In light of these covert influences on the scientific endeavor, the suggestion that there is little contemporary research to support conversion therapy may be both accurate and misleading.

### Gender Identity Disorder (GID) Treatment

Relative to the possibility of change in adult homosexuality is the current treatment of GID. GID is commonly diagnosed in children and adolescents. According to the DSM-IV,<sup>47</sup> GID involves "a strong and persistent cross-gender identification" accompanied by the child's "persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex."

This diagnosis is increasingly controversial in part because a significant number of adult homosexual men and women report histories of early cross-gender behavior that would fall within the description of GID.<sup>48</sup> There is thus an inherent tension in the DSM regarding a childhood mental disorder that in many instances is a developmental precursor to a sexual orientation declassified for adults. In all likelihood, subsequent revisions of the DSM will remove the GID diagnosis in order to solve this problem, though this will be mostly due to social and political pressure as opposed to extensive empirical research on treatment efficacy.<sup>49</sup>

In fact, what limited research that exists on GID is consistent with both a developmental factor in the origin of homosexuality and the prospect of modification of sexual orientation. Zucker and colleagues recently reported data that suggest children referred for problems in their gender identity have a developmental lag in gender constancy acquisition.<sup>50</sup> In a 10-year review of the literature, Bradley and Zucker reported that GID sons perceived their relationships with their fathers as distant, negative, and conflicted.<sup>51</sup>

This mirrors the distant father-son relationship prevalently reported among homosexual men and is consistent with some developmental theories that propose a defensive detachment from rather than identification with the father as a significant causative factor. Treatment of GID children and adolescents involves working with these youth and often their parents as well.

Bradley and Zucker indicate that therapy can be effective in modifying cross-gender feelings.<sup>52</sup> Moreover, the type of treatment suggested, involving discouragement of cross-gender behavior and increasing opportunities to develop same-sex skills and friendships in theoretically consistent with the approach taken in the most professional forms of conversion treatments for adult homosexual men. Anecdotal reports indicate that even Gender Identity Disorder in adults can remit for over ten years, and suggest that the frequency of permanent remission may well be underestimated.<sup>53</sup> Clearly, these findings suggest the potential for change in at least some adult homosexuals who seek conversion therapy.

### **Pathways to Lesbianism**

While homosexual men often report having sensed homoerotic attraction early in adolescence, reports from homosexual women appear to describe a more fluid, flexible, and conscious process of self-identification as lesbians.<sup>54</sup> A significant subgroup of lesbians perceives their sexual orientation to be a choice among several options. In one study, 58% of sample of 90 women in lesbian couples reported they had chosen the orientation of their current sexual relationship.<sup>55</sup>

Highlighting the impact of religious values in this area, 33% of a comparison group of heterosexual couples and none of the lesbian couples cited family education and religion as reasons for their relationship choice. In general for these women, conscious evaluation of sexual preference was an important component in the process of identifying sexual orientation.

Another study by Diamond found that the majority of young lesbians in her sample continued to experience sexual attraction for men and demonstrated the capacity for subjective experiences of change in sexual attractions.<sup>56</sup> Almost 40% of participants reported changes in their sexual attractions over time that they did not attribute to changes in awareness.

Multiple pathways to lesbian self-identification may include practical necessity, political values, and opportunity structures. Conversely, it follows that religious conviction and moral belief can considerably impact attempts to reestablish heterosexual identification among these women.

Another finding worthy of mention in this regard is the frequency with which lesbian women report previous heterosexual marriages. One review of the literature reported a prevalence rate of between 25% to 50%.<sup>57</sup> A recent study of 6935 self-identified lesbians found that 77.3% had one or more lifetime male sexual partners and 70.5% had engaged in vaginal intercourse.<sup>58</sup> Overall, these data indicating fluidity and choice as important ingredients in lesbian self-identification should bolster the notion that change toward or return to heterosexual functioning is a real possibility if desired.

### **Other Developmental Influences**

As mentioned previously, presumed developmental influences in the origin of a homosexual orientation are often focuses of treatment in conversion therapy. The potential for change is based in part on the assumption that developmental wounds can exist and that, as emotional and spiritual realities, they can also be subject to modification. While only one factor in any causative pathway to same-sex attraction, two developmental experiences commonly cited in this regard area childhood abuse and conflicted parental relationships.

Several studies have reported significantly higher rates of childhood sexual abuse among homosexual as compared to heterosexual adults.<sup>59</sup> While the sample sizes tend to be small, the findings are remarkably consistent. For example, Bramblett and Darling found 54% of their sample of adult male survivors perceived themselves as heterosexual, 14% perceived themselves as gay and 32% perceived themselves to be bisexual.<sup>60</sup>

By contrast, in a non-abused control group 88% reported being heterosexual, 12% gay, and none self-identified as bisexual. The authors caution that it was unclear whether the large proportions of male survivors of child abuse were gay prior to their abuse or as a result of it. However, the mean age at the time the reported abuse occurred was 10 years with a range of 4 to 14 years, strikingly similar to the average age of first homosexual contact reported in a large sample of individuals pursuing conversion therapy.<sup>61</sup> Generally, this is not a period when self-identification of sexual orientation transpires.

It has been suggested that among men such statistics could also be accounted for by "prehomosexual" boys (whose orientation is assumed to have already been determined in utero) having greater interest in, or less aversion to, sexual interaction with other males. Given the fact that one is talking about children averaging 10 years or age, such reasoning seems to come dangerously close to blaming the victim.

Consistent with these findings on child sexual abuse, a study by Cameron and Cameron randomly sampled 5,182 adults and discovered that incestuous sexual relationships during childhood were disproportionately reported by homosexual respondents.<sup>62</sup> Thirty-five percent of homosexual male subjects in another study reported a sexual abuse history compared to 5% of a heterosexual comparison group.<sup>63</sup>

While lacking a comparison group, the largest study to specifically examine self-reported childhood sexual abuse among homosexual and bisexual men did report some prevalence rates unmatched in heterosexual samples.<sup>64</sup> Surveying 1,001 participants, the authors report that 93% experienced sexual contact with an older or more powerful partner during childhood or adolescence. Thirty-seven percent reported coercive sexual contact with an older or more powerful partner before age 19. The perpetrator was a man in 94% of these cases. Force was involved in 51% of these histories and 33% involved anal sex. A recent smaller study of 110 Latino gay and bisexual men found similar trends.<sup>65</sup> Half of the sample reported histories of childhood sexual abuse with an astounding average frequency of about 25 incidents of abuse before the age of 16.

Reviews of the literature on child sexual abuse also appear consistent with these trends.<sup>66</sup> Research has indicted higher rates of homosexuality and bisexuality among abused compared to non-abused adolescent and young adult males. Abused adolescent boys, particularly those victimized by males, were up to 7 times more likely to self-identify as gay or bisexual than peers who had not been abused. Women with sexual abuse histories are more likely to report homosexual experiences in adolescence or adulthood than non-abused women.

It should be noted that limitations in the research methodology place potential limits on the generalizability of these statistics. Nonetheless, the consistency of these findings, even when such data are not the primary focus of study, suggests that childhood abuse experiences could constitute an important developmental influence on sexual orientation for a significant portion of homosexual men and women.

Another developmental influence that is theoretically important to many practitioners of conversion therapy is the quality of the father-son relationship. Studies in this area have been rare since the 1970s. Reviews of this research report that an overwhelming majority of studies fail to find male homosexuals referring to their fathers in positive or affectionate terms.<sup>67</sup> Instead, they consistently report an antagonistic relationship. Phelan's more recent study compared 30 homosexual and 30 heterosexual men regarding memories of their fathers' behavior toward them.<sup>68</sup> Once again, findings indicated that the homosexual men recalled their fathers to have been significantly more rejecting and less loving and attentive than their heterosexual peers.

Such apparent developmental factors in adult homosexual men and women are considered to have treatment implications among conversion therapists, creating a genuine possibility for increasing opposite-sex attraction. Even Bern's recent developmental account of sexual orientation, while minimizing family influences and emphasizing peer-related factors, makes allowances for changes to occur in sexual orientation over the life span.<sup>69</sup> This theory is also instructive in that it reveals the underlying moral perspective regarding sexual behavior that must be present to avoid endorsement of conversion therapy when developmental influences are given prominence. Specifically, the moral equivalence of homosexual and heterosexual behavior is assumed, a decidedly non-scientific conclusion.<sup>70</sup>

Our understanding of the formation of homoerotic attraction is very far from complete. It is accurate to say that any data pertinent to causation are likely to be complex, variant and subject to divergent interpretations based on moral presuppositions.<sup>71</sup> The findings from the four areas mentioned above are no different. However, they at least give strong credence to the possibility of treatment success in conversion therapy. To deny this entirely is to disclose one's ideological blinders.

### The Question of Consistency

Given the specter of ethical censure for practitioners of conversion therapy, another line of inquiry needs to be pursued. Are professional associations that support censure willing to apply such standards to other comparable areas of concern for which clients seek pastoral and therapeutic care? One prime example of this is overweight persons who desire help with weight reduction.

The plight of such people parallels closely that of gays and lesbians described by advocates of censure. Notable similarities include: 1) being overweight is not a mental disorder, 2) the overweight face regular social stigmatization, 3) weight is considered to be strongly determined by genetic influence, and 4) the long term efficacy of weight loss and dieting programs is questionable at best and may in fact be harmful to many individuals.<sup>72</sup>

It is quite likely that the scientific support for the last two considerations is much more established in the case of being overweight than it is for homosexuality and conversion treatment. For example, adoption, twin and family studies suggest that genetic factors explain 30-90% of the variance in body mass index and only 10-52% for male homosexuality.<sup>73</sup> Considering the research noted earlier, it also seems unlikely that the health risks of obesity are significantly more than those associated with homosexual behavior. They may well be less.

Should associations like the AAPC adopt position statements that ethically censure or oppose conversion therapy, consistency would mandate a similar ethical stance toward pastoral and psychological efforts to promote weight loss. Offering psychodynamic or spiritual insights to explain the overweight condition or acquiescing to client requests for weight loss treatment would be grounds for censure. Only affirming counseling approaches to the client's current weight would be permissible. A lack of consistency in this regard would again implicate ideological and political motives (as opposed to scientific and humanitarian ones) behind any blanket ethical condemnation of conversion treatments.

One other area of contention in the debate over conversion therapy begs the question of consistency. Specifically, the high divorce rates among heterosexuals are often cited as proof of a double standard. The prevalence of divorce indicates heterosexuals fail regularly in their primary relationships, yet this is not attributed to their sexual orientation. Moreover, divorced persons are no longer discriminated against, even in the church; therefore the traditional judgment against homosexual behavior should also be dropped.<sup>74</sup> Certainly the divorce rate among heterosexuals is lamentable and deserves attention in its own right. However, these arguments miss the mark at the level of moral reasoning. Should heterosexuality be morally and/or religiously considered as society's ideal, then divorce rates only prove the difficulty of achieving the ideal and are not a justification for the moral equivalence of sexual expression. And while divorced persons are not as harshly judged as was once the case, for most people divorce is still a tragedy and a falling short of the hoed-for ideal of lifelong partnership. The notions of divorce-affirming counseling or homosexuality as a tragedy and a falling short of the heterosexual ideal are not likely to gain much resonance within the church or gay cultures, respectively. The moral inconsistency implicit in the analogy renders such arguments less than convincing.

### Case Example

The following case example highlights many of the aforementioned considerations pertaining to why clients may seek conversion therapy and how change may be possible in sexual orientation. The case is one of several known to this author. Mr. Jones (not his real name) is a 36-year old single man who is contemplating ordained ministry. He has two older brothers and a younger sister.

Mr. Jones stated that he and his brothers neither liked their father nor believed that he loved them or was proud of them. He described his father as being very tense and inept in social relationships. His father physically abused the oldest brother, but Mr. Jones was able to avoid such treatment. He recalls that his parents argued frequently and were eventually divorced when he was 16 years of age.

Mr. Jones stated that his first sexual experience was with a slightly older man. He felt extreme guilt about this incident. About this time he also began an "off again, on again" sexual relationship with a woman that lasted four years. However, he struggled with his same-sex attraction but did not act on it due to religious convictions until several years later.

At one point, Mr. Jones reported that he became "sexually obsessed" with two younger men. These sexual relationships ended when Mr. Jones began to suffer symptoms for chronic fatigue syndrome and mistook them for AIDS. Despite eventually testing negative for HIV, this experience helped Mr. Jones to decide to refrain from going any further into the gay subculture. This decision was further solidified when one of his friends died of AIDS a few years later. He has had some contact with a change-oriented religious ministry for individuals struggling with homosexual feelings and reports that this was a positive experience for him.

In keeping with his religious beliefs, Mr. Jones states that he views sexual expression outside of marriage to be sinful. He acknowledges that he still experiences "temptations" regarding homosexual involvement, but has been successfully chaste since the time of his AIDS scare. He reports that he has weekly meetings with other men from his church who hold each other accountable. Mr. Jones also indicated that when he is achieving regular emotional intimacy with other men he feels noticeably more secure in his masculine identity.

Psychological testing revealed that, apart from some general health concerns, and moderate interpersonal sensitivity, Mr. Jones was free from neurotic or characterological psychopathology. This is consistent with contentions that homosexuality need not be a mental disorder per se. It also indicates that a person who lives out convictions not to act on homosexual impulses and who seeks to change sexual orientation need not subsequently suffer from psychological distress.

While there is always a need for caution so as not to over-generalize from one case anecdote, Mr. Jones' history does highlight the importance of religious, moral and health related concerns in the decision to pursue modification of same-sex attraction and sexual behavior. Counseling which asserted that this deeply religious and thoughtful man should embrace and act on his homosexual feelings would appear likely to have promoted despair and fatalism.

### **An Alternative Ethical Framework For Conversion Therapy**

Given the aforementioned reasons people seek conversion treatment and the possibility of change in sexual orientation for a significant number of individuals, an ethical rationale can be constructed for such counseling.

The conversion therapist properly needs to consider the societal, familial, and religious prejudice, which may impinge upon a client's decision to seek treatment. After conducting such an examination and discussing with the client treatment options as well as possible outcomes, many clients will chose to pursue conversion therapy. Claims that this *ipso facto* implies homophobic coercion by the therapist and or internalized homophobia of the client contradict the assumption of human agency implied in the ethical mandate to obtain informed consent.<sup>75</sup> Thus ethical standards presume a degree of human autonomy and agency that cannot be considered suspended merely when clients are seeking to modify their sexual orientation.

The ethical principle regarding the need to respect people's dignity, rights, and self-worth also has to be considered. Ethical Principle D of the American Psychological Association's Ethics Code<sup>76</sup> and Principle I of the AAPC Ethics Code<sup>77</sup> focus on these concerns. The important feature to notice is that therapists are to be as aware of and sensitive to religious differences as they are with differences in sexual orientation.

Allowing individuals to pursue conversion therapy demonstrates ethical responsibility by respecting religious diversity. Prohibiting conversion treatment appears to restrict diversity and endorse discrimination against individuals who desire to modify homoerotic feelings and behavior. Yarhouse raises critical questions for all counselors in this regard.

If psychologists override the values of their clients, are they saying that psychologists can respect and be tolerant of religious diversity as long as clients do not make choices that actually reflect the normative teaching of their religious? Or does one way of understanding diversity (related to sexual orientation) take precedence over other expressions of diversity (religious or cultural diversity)?<sup>78</sup>

If only this latter approach exists in practice, a conclusion inherent in any ethical opposition to conversion therapy, then appeals to the banner of diversity or multiculturalism appear to disclose a viewpoint intolerant of certain ideological or moral dissent.

In addressing the ethical concern that homosexuality is no longer a mental disorder and thus should not be treated, two types of responses can be offered. First, homosexuality need not be considered a disorder for conversion treatment to be undertaken.<sup>79</sup> Professional mental health associations have never denied treatment to persons simply because they did not report a diagnosable mental disorder. In fact, the existence of V codes, including one for spiritual and religious concerns, implies that just the opposite is normative and not implicitly unethical.

A second response is to note there is a diagnostic condition in the DSM-IV that can be the proper object of change-oriented treatment without implying that homosexuality in general reflects mental disorder. The existence of this condition, Sexual Disorder-Not Otherwise Specified (code number 313.82) by its definition provides a rationale for a variety of services when issues concerning sexual orientation, behavior, and moral values are present.<sup>80</sup>

Finally, attention needs to be given to concerns that practitioners of change-oriented counseling are unethical in ignoring the latest scientific developments and literature regarding sexual orientation.<sup>81</sup> The recent research on sexual orientation and conversion therapy, suggesting complex origins and limited treatment efficacy, certainly needs to be acknowledged in any process of informed consent.

Others have additionally suggested that prospective conversion therapy clients should be informed that the change process may be difficult and lengthy.<sup>82</sup> However, these considerations also need to be tempered by an awareness of the research findings and implications presented in the present analysis.

A review of associated health risks and findings that suggest the potential for change in homoerotic feelings are equally important in enabling clients to make fully informed choices regarding conversion therapy. Moreover, as alluded to previously, the present climate within institutions most able to conduct research is generally not inclined to explore hypotheses that might support the theory and practice of conversion therapy.<sup>83</sup> Goodwill efforts in the true spirit of science will support and enable research funding of conversion treatment by its contemporary practitioners rather than preclude legitimate inquiry via ethical fiat.

Considering the potentially high stakes concerning disease, longevity, and religious disillusionment, a non-polemical scientific and pastoral perspective should encourage research efforts to determine specific criteria associated with treatment success in conversion therapy.

These considerations suggest that a valid ethical framework does exist within which conversion therapy can be practiced. Reorientation treatment affirms human freedom to choose the nature of one's therapy. It

implies diversity by respecting clients' religious and moral belief systems when such convictions motivate the attempt to change. In fact, the best criteria for clients to use in determining the type of therapy to pursue may well be the treatment approach most consistent with their values and goals.<sup>84</sup>

The choice of conversion therapy by no means has to imply a mental disorder among any gay or lesbian person as the treated condition can be classified using a V code. Even so, one diagnostic category is legitimately available. Conversion therapists can also show sensitivity to contemporary scientific information on sexual orientation while recognizing its limitations and incompleteness. They may also provide a broader informed consent in this regard by disclosing scientific data relative to the potentially adverse health related outcomes of homosexual behavior. Within this ethical understanding of reorientation treatment, it is quite reasonable to determine that conversion therapists can be operating to advance client welfare.

### Conclusions

Gay and lesbian persons deserve to be treated with the same respect and dignity afforded to anyone in the human community. In a counseling setting, this translates into being given the freedom to select the type of treatment and identify the treatment goals. Often this will result in the pursuit of a gay affirmative therapy process. However, for some it may also result in an attempt to modify same-sex attraction and behavior. It does nothing to further the civil rights of gays and lesbians to ethically prohibit conversion therapy. Rather, such an action punishes a subset of dissatisfied homosexual persons with religious, cultural, and/or health concerns by denying them access to a form of treatment that is far from being proven ineffective and harmful.

In light of the information put forth in this study, the question needs to be asked whether it is more ethical to completely prohibit conversion treatment and prevent some clients from outcomes which may be disappointing to them or to allow such therapy and enable some clients to live in harmony with their religious beliefs and avoid further exposure to serious health risks. The position of this author has been in support of the latter option.

Despite attempts to create "strawman" and "guilt by association" arguments suggesting conversion therapists exist at the fringe of their professions, many if not most of these practitioners are professional pastoral counselors and therapists who experience genuine compassion for the truly difficult struggles faced by gay and lesbian individuals. They have no desire to restrict any person's choice of pastoral and psychological treatment, but for various religious, ethical, and clinical reasons have chosen to work with clients who seek to modify same-sex attraction and behavior.<sup>85</sup>

The current controversy over conversion therapy reflects a sociopolitical struggle being played out in the arena of the social sciences. This must always be borne in mind when evaluating the relevant literature and research.<sup>86</sup> The intent of this article has been to underscore the fact that, despite rhetoric to the contrary, an ethically legitimate and scientifically sound rationale can be made for conversion treatment. When any professional pastoral or psychological association chooses to ignore the considerations presented in this analysis and opposes or prohibits conversion therapy, many people will rightly understand such action as a rather serious indictment of the association itself.

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<sup>2</sup> Timothy F. Murphy, "Redirecting Sexual Orientation; Techniques and Justifications," *Journal of Sex Research*, 1992, Vol. 29, pp. 501-523.

<sup>3</sup> William O'Donohue and Christine E. Caselles, "Homophobia: Conceptual, Definitional, and Value Issues," *Journal of Psychopathology and Behavioral Assessment*, 1993, Vol. 15, No. 3, pp. 177-195; Christopher H. Rosik, "'Outing' the Moral Dimension in the Research on Homosexuality," 1996, *Journal of Psychology and Christianity*, Vol. 15, No. 4, pp. 373-384.

<sup>4</sup> Michele J. Eliason, "The Prevalence and Nature of Biphobia in Heterosexual Undergraduate Students," *Archives of Sexual Behavior*, 1997, Vol. 26, No. 3., pp. 317-326; Laurie L. Guidry, "Clinical Intervention with Bisexuals; A Contextual Understanding," *Professional Psychology: Research and Practice*, 1999, Vol. 30, No. 1, pp. 22-26. Jonathan J. Mohr and Aaron B. Rochlen, "Measuring Attitudes Regarding Bisexuality in Lesbian, Gay Male, and Heterosexual Populations," *Journal of Counseling Psychology*, 1999, VI, No. 46, pp. 353-369.

<sup>5</sup> Just one example of this is found in Cathy S. Berkman and Gail Zinberg, "Homophobia and Heterosexism in Social Workers," *Social Work*, 1997, Vol. 42, No. 4., pp. 319-332. An important recent study by Aubyn S. Fulton, Richard L. Gorsuch, and Elizabeth A. Maynard ("Religious Orientation, Antihomosexual Sentiment, and Fundamentalism Among Christians," *Journal for the Scientific Study of Religion*, 1999, Vol. 38, No. 1, pp. 14-22) confirmed this problem. The authors conclude that, "The results of this study suggest that the relationship of tolerance to religious orientation is not a simple function of commitment to one's religion. Rather, the nature of the religious commitment must also be considered. Fundamentalists express negative sentiment toward homosexuals in excess of what would be consistent with their ideological beliefs. Intrinsic express a more nuanced negative sentiment, which is focused on the moral dimensions, but is less likely to be generalized to nonmoral dimensions, and does not necessarily lead them to restrict social contact. An implication of these results is that not all negative sentiment toward homosexuals by Christians should be interpreted as prejudice, while not all committed Christians are bound to express negative sentiment toward homosexuals" (p. 21).

<sup>6</sup> Karen M. Jordon and Robert H. Deluty, "Clinical Interventions by Psychologists with Lesbians and Gay Men," *Journal of Clinical Psychology*, 1995, Vol. 51, No. 3, pp. 448-456.

<sup>7</sup> It is interesting to note, in a chilling sort of way, that many gay activists now appear very willing to pathologize homophobia. For example, at the year 2000 annual meeting of the American Psychiatric Association, the Committee on Gay, Lesbian, and Bisexual Issues of the American Psychiatric Association was scheduled to present a workshop entitled, "Homophobia, is it a Mental Illness?" (see *American Journal*

of *Psychiatry*, 2000, Vol. 157, No. 2, p. 318). Gregory Herek has recently proposed that the term "sexual prejudice" be used in place of homophobia as it does not require value judgments that antigay attitudes are inherently irrational or evil ("The Psychology of Sexual Prejudice," *Current Directions in Psychological Science*, 2000, Vol. 9, No. 1, pp. 19-21). However, it is hard to see how the concept of sexual prejudice, by definition, will be able to avoid the same prescriptive moral implications regarding homosexual behavior that are found in the use of homophobia.

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<sup>9</sup> J. Harold Ellens, "Homosexuality in Biblical Perspective," *Pastoral Psychology*, 1997, Vol. 46, No. 1, pp. 35-53. Darryl Grant and Lawrence Epp, "The Gay Orientation: Does God Mind?," *Counseling and Values*, 1999, Vol. 43, pp. 28-33; Horace L. Griffin, "Revising Christian Ethical Discourse on Homosexuality; A Challenge for Pastoral Care in the 21<sup>st</sup> Century," *The Journal of Pastoral Care*, 1999, Vol. 53, No. 2, pp. 209-219; Daniel A. Helminiak, "Scripture, Sexual Ethics, and the Nature of Christianity," *Pastoral Psychology*, 1997, Vol. 47, No. 4, pp. 261-271.

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<sup>36</sup> Garofalo, *et al.*, *op. cit.*

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<sup>39</sup> Rosik, *op. cit.*

<sup>40</sup> H.E. Adams and E.T. Sturgis, "Status of Behavioral Reorientation Techniques in the Modification of Homosexuality; A Review," *Psychological Bulletin*, 1977, Vol. 84, pp. 1171-1188; J.A. Clippinger, "Homosexuality Can Be Cured," *Corrective and Social Psychiatry*, 1974, Vol. 20, pp. 15-28; E.C. James, *Treatment of Homosexuality; A Reanalysis and Synthesis of Outcome Studies*, 1978. Unpublished doctoral dissertation, Brigham Young University, Provo, Utah. It is worth noting in this regard that Robert Spitzer, M.D., widely considered to be the architect of the 1973 decision to remove homosexuality from the DSM, is currently in the process of interviewing 200 individuals who report at least five years of change from homosexual to heterosexual functioning. His initial statements about his research tend to support the claim that some individuals can change their sexual orientation through conversion therapy.

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<sup>42</sup> Nicolosi, Byrd and Potts, *op. cit.*

<sup>43</sup> Schaeffer, Hyde, *et al.*, *op. cit.*; Schaeffer, Nottebaum, *et al.*, *op. cit.*

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<sup>54</sup> Roy F. Boumeister, "Gender Differences in Erotic Plasticity; The Female Sex Drive as Socially Flexible and Responsive," *Psychological Bulletin*, 2000, Vol. 126, No. 3, pp. 347-374; Letitia Anne Peplau and Linda D. Garnets, "A New Paradigm for Understanding Women's Sexuality and Sexual Orientation," *Journal of Social Issues*, 2000, Vol. 56, No. 2, pp. 329-350; Rosemary C. Venigas and Terri D. Conley, "Biological Research on Women's Sexual Orientation; Evaluating the Scientific Evidence," *Journal of Social Issues*, 2000, Vol. 56, No.2, pp. 267-282; Vera Whisman, *Queer by Choice; Lesbians, Gay Men, and the Politics of Identity* (New York City, NY: Routledge, 1996).

<sup>55</sup> Susan Rosenbluth, "Is Sexual Orientation a Matter of Choice," *Psychology of Women Quarterly*, 1997, Vol. 21, pp. 595-610.

<sup>56</sup> Lisa M. Diamond, "Development of Sexual Orientation Among Adolescent and Young Adult Women" *Developmental Psychology*, 1998, Vol. 34, No. 5, pp.1985-1095.

<sup>57</sup> Karen L. Bridges and James M. Croteau, "Once-Married Lesbians; Facilitating Changing Life Patterns," *Journal of Counseling and Development*, 1994, Vol. 73, pp. 134-140.

<sup>58</sup> Allison L. Diamant, Mark A. Schuster, Kimberly McGuigan and Janet Lever, "Lesbians' Sexual History with Men," *Archives of Internal Medicine*, 1999, Vol. 159, pp. 2730-2736.

<sup>59</sup> Peter T. Dimock, "Adult Males Sexually Abused as Children," *Journal of Interpersonal Violence*, 1998, Vol. 3, No. 2, pp. 203-221; Robert L. Johnson and Diane K. Shrier, "Sexual Victimization of Boys; Experience as Adolescent Medicine Clinic," *Journal of Adolescent Health Care*, 1985, Vol. 6, No. 5, pp. 372-376; Robert L. Johnson and Diane K. Shrier, "Past Sexual Victimization by Females of Male Patients in an Adolescent Medicine Clinic Population," *American Journal of Psychiatry*, 1987, Vol. 144, No. 5, pp. 650-652.

<sup>60</sup> James R. Bramblett, Jr., and Carol A. Darling, "Sexual Contracts; Experiences, Thoughts, and Fantasies of Adult Male Survivors of Child Sexual Abuse," *Journal of Sex & Marital Therapy*, 1997, Vol. 23, No. 4, pp. 305-316.

<sup>61</sup> Nicolosi, Byrd and Potts, *op. cit.*

<sup>62</sup> Paul Cameron and Kirk Cameron, "Does Incest Cause Homosexuality," *Psychological Reports*, 1995, Vol. 76, pp. 611-621.

<sup>63</sup> Rosser, Metz, Bockting, and Buroker, *op. cit.*

<sup>64</sup> Lynda S. Doll, Dan Joy, Brad N. Bartholow, Janet S. Harrison, Gail Bolan, John M. Douglas, Linda E. Saltzman, Patricia M. Moss, and Wanda Delgado, "Self-Reported Childhood and Adolescent Sexual Abuse Among Adult Homosexual and Bisexual Men," *Child Abuse & Neglect*, 1992, Vol. 16, pp. 855-864.

<sup>65</sup> M. Rafael Diaz, Eduardo S. Morales, Edward Bein, Eugene Dilan, and Richard A. Rodriguez, "Predictors of Sexual Risk in Latino Gay/Bisexual Men; The Role of Demographic, Developmental, Social Cognitive, and Behavioral Variables," *Hispanic Journal of Behavioral Sciences*, 1999, Vol. 21, No. 4, pp. 480-501.

<sup>66</sup> Joseph H. Beitchman, Kenneth J. Zucker, Jane E. Hood, Granville A. DaCosta, and Donna Akman, "A Review of the Short-Term Effects of Child Sexual Abuse," *Child Abuse & Neglect*, 1991, Vol. 15, pp. 537-556; Joseph H. Beitchman, Kenneth J. Zucker, Jane E. Hood, Granville A. DaCosta, Donna Akman, and Erika Cassavia, "A Review of the Long-Term Effects of Child Sexual Abuse," *Child Abuse & Neglect*, 1992, Vol. 16, pp. 101-118; Clare E. Costentino, Heino F. L. Meyer-Bahlburg, Judith L. Alpert and Richard Gaines, "Cross-Gender Behavior and Gender Conflict in Sexually Abused Girls," *Journal of the American Academy of Child and Adolescent Psychiatry*, 1993, Vol. 32, No. 5, 940-947; Joanne L. Davis and Patricia A. Petretic-Jackson, "The Impact of Child Sexual Abuse on Adult Interpersonal Functioning: A Review and Synthesis of the Empirical Literature," *Aggression and Violent Behavior*, 2000, Vol. 5, No. 3, 291-328; William C. Holmes and Gail B. Slap, "Sexual Abuse of Boys; Definition, Prevalence, Correlates, Sequelae, and Management," *Journal of the American Medical Association*, 1998, Vol. 280, No. 21, pp. 1855-1862.

<sup>67</sup> Seymour Fisher and Roger P. Greenberg, *Freud Scientifically Reappraised; Testing the Theories and Therapy* (New York; Wiley, 1996); Marvin Siegelman, "Parental Backgrounds of Male Homosexuals and Heterosexuals," *Archives of Sexual Behavior*, 1974, Vol. 3, pp. 3-18; Marvin Siegelman, "Parental Backgrounds of Male Homosexuals and Heterosexuals; A Cross Sectional Replication," *Archives of Sexual Behavior*, 1981, Vol. 10, pp. 505-513.

<sup>68</sup> James S. Phelan, "Recollections of Their Fathers by Homosexual and Heterosexual Men," *Psychological Reports*, 1996, Vol. 79, pp. 1027-1034.

<sup>69</sup> Daryl J. Bern, "Exotic Becomes Erotic; A Developmental Theory of Sexual Orientation," *Psychological Review*, 1996, Vol. 103, No. 2, pp. 320-335.

<sup>70</sup> Bem's viewpoint is a good example of the constructivist perspective concerning sexual orientation. Constructivists consider the entire concept of sexual orientation to be the product of social and linguistic factors and consequently not a reference to some innate reality. Essentialists, on the other hand, regard sexual orientation as a fixed characteristic that is inherent, objective, transcultural, and transhistorical. Because constructivists hold sexual categories to be artifacts of social process, self-determination regarding the expression or even existence of a quality is emphasized. Given this commitment, it would appear logically consistent for constructivists to make allowances for conversion therapy, understood as a potential means for the individual seeking treatment to achieve their preferred sexual construction. The present inconsistency probably owes much to the assumption of many conversion therapists and clients that heterosexuality is to be morally preferred and serve as society's ideal, conclusions no doubt repugnant to the philosophical underpinnings of constructionism. For more on this topic, see Terry S. Stein, "Social Constructionism and Essentialism; Theoretical and Clinical Considerations," *Journal of Gay & Lesbian Psychotherapy*, 1998, Vol. 2, No. 4, pp. 29-50.

<sup>71</sup> Roik, *op. cit.*

<sup>72</sup> Frances M. Berg, "Health Risks Associated with Weight Loss and Obesity Treatment Programs," *Journal of Social Issues*, 1999, Vol. 55, No. 2, pp. 277-297; Kelly D. Brownell and Judith Rodin. "The dieting maelstrom; Is it possible and advisable to lose weight?," *American Psychologist*, 1994, Vol. 49, No. 9, pp.781-791.

<sup>73</sup> Bailey, Dunne, and Martin, *op. cit.*; Byne and Parsons, *op. cit.*; Michael J. Devlin, Susan Z. Yanovski and G. Terrace Wilson, "Obesity; What Mental Health Professionals Need to Know," *American Journal of Psychiatry*, 2000, Vol. 157, pp. 854-866; H.H.M. Maes, M.C. Neale, and L. J. Eaves, "Genetic and environmental factors in relative body weight and human adiposity," *Behavior Genetics*, 1997, Vol. 27, No. 4, pp. 325-351.

<sup>74</sup> Richard Dayringer, "Homosexuality Reconsidered," *The Journal of Pastoral Care*, 1996, Vol. 50, No. 1, pp. 57-71; Barry A. Schreier, "Of Shoes, and Ships, and Sealing Wax: The Faulty and Specious Assumptions of Sexual Reorientation Therapies," *Journal of Mental Health Counseling*, 1998, Vol. 20, pp. 305-314.

<sup>75</sup> Mark A. Yarhouse, "When Clients Seek Treatment for Same-Sex Attraction; Ethical Issues in the 'Right to Choose' Debate," *Psychotherapy*, 1998, Vol. 35, No. 2, p. 249.

<sup>76</sup> American Psychological Association, "Ethical Principles of Psychologists and Code of Conduct," *American Psychologist*, 1992, Vol. 47, No. 12, pp. 1597-1611. Principle D states, "Psychologists accord appropriate respect to the fundamental rights, dignity, and worth of all people. They respect the rights of individuals to privacy, confidentiality, self-determination and autonomy, mindful that legal and other obligations may lead to inconsistency and conflict with the exercise of these rights. Psychologists are aware of cultural, individual, and role differences, including those due to age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone unfair discriminatory practices" (my emphases).

<sup>77</sup> American Association of Pastoral Counselors, *Code of Ethics* (Fairfax, VA, AAPC, 1991). The beginning of the prologue to Principle I reads: "As members of the AAPC, we are committed to the various theologies, traditions, and values of our faith communities and to the dignity and worth of each individual. We are dedicated to advancing the welfare of those who seek our assistance and to the maintenance of high standards of professional conduct and competence."

<sup>78</sup> Yarhouse, *op. cit.*, p. 251. Similarly, prohibiting conversion treatment would appear to violate the AAPC ethic's code stipulation to "show sensitive regard for the moral, social and religious standards of clients and communities" (Principle III.C.) when those standards view homosexual behavior as immoral.

<sup>79</sup> Throckmorton, *op. cit.*, p. 296.

<sup>80</sup> *Ibid.*

<sup>81</sup> AAPC *Code of Ethics*, *op. cit.*, Principle 1: *APA Ethical Principles*, *op. cit.*

<sup>82</sup> Nicolosi, Byrd and Potts, *op. cit.*

<sup>83</sup> Rosik , *op. cit.*

<sup>84</sup> Nicolosi, Byrd and Potts, *op. cit.*

<sup>85</sup> Joseph Nicolosi, A Dean Byrd and Richard W. Potts, "Beliefs and Practices of Therapists Who Practice Sexual Reorientation Psychotherapy," *Psychological Reports*, 2000, Vol. 86, pp. 689-702.

<sup>86</sup> While generally true of any theoretical or research endeavor, it is almost axiomatic in the psychological disciplines that the pursuit of scientific knowledge is to a significant degree autobiographical in nature.

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