Change Effects in U.S. Men with Unwanted Same Sex Attraction after Therapy.

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Presented by

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DEDICATION

This dissertation is dedicated to those brave individuals who would like to get therapeutic help and try to change their unwanted same sex attraction. Being told to embrace a lifestyle/ sexuality because of other people's beliefs and values is unfair, unjust and discriminatory. Our country and our therapeutic profession are built upon respecting an individual's rights for self determination. Those brave souls who stand up and voice their desire to get therapeutic help for their unwanted same sex attraction deserve to be served.

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ABSTRACT

Thousands of people have claimed to change their same sex attraction to opposite sex attraction through sexual reorientation therapy. Published research is both positive and negative on this therapy approach. A convenience sample was gathered from individuals who had received assistance for their unwanted same sex attraction. Data collection was completed through an online survey. This study employed the descriptive research method as a means to collect data required to answer the research questions. The overall objective was to obtain data after the participants received therapy for their unwanted same sex attraction to:

1. Indicate if the participants' same sex attractions, thoughts and actions were diminished or changed to thoughts, feelings and behaviors towards the opposite sex.
2. Indicate if there were any helpful effects experienced due to therapy.
3. Indicate if there were any harmful effects experienced due to therapy.

According to the analysis of the data, two thirds of the participants diminished their same sex thoughts, feelings and behaviors as compared to before therapy commencement. Nearly everyone, 94%, experienced helpful effects from therapy and one third felt that they experienced harmful effects due to the assistance they received. This research will help inform interested individuals about this promising and controversial approach.

Chapter 1

Statement of Problem

Introduction to the Problem

Homosexuality has been talked about, acted out and documented since the days of ancient Greece and early biblical times. Homosexual acts have provoked strong opinions during any century or culture throughout history. Webster's dictionary defines homosexuality as an "erotic activity with another of the same sex" (Homosexuality, 2010). Why people become homosexual is not fully understood. Theories include, 1) People are simply born homosexual, 2) The environment can cause a person to acquire same sex attraction feelings, and 3) Internal psychological issues can be the cause. Recently, homosexuality has become a topic of great moral and political debate in the United States, as well as other countries. Forty years ago in the United States, homosexuality was seen as a mental disorder in the psychologist's eyes, frowned upon by society and hidden by most of those who experienced same sex attraction feelings. Today, there is stronger cultural and governmental support for people that have same sex attraction, feelings and behavior, both in the United States as well as other countries and cultures. More people that have same sex attraction are more open to express and proclaim their sexual desires and behaviors. They want the culture to accept and embrace them and laws to grant them the same rights and privileges as the heterosexual population.

There are also some people, both male and female, with same sex attraction, who desire to diminish their same sex attractions, thoughts, feelings and behaviors and desire to develop attractions for people of the opposite sex. Some also would like to stop their compulsive/ addictive sexual behavior (Nicolosi, Byrd & Potts, 2000). The American Psychological Association (APA) claims that this change is rarely achieved by psychotherapy or "reparative

therapy", and even if attempted, it can potentially cause psychological damage to the individual (APA Website, 2010). Even though the APA does not recommend that people try to change their same sex desires, fantasies and behaviors to opposite sex desires, fantasies and behaviors, thousands have claimed they have changed their homosexual attraction to heterosexual attraction and are satisfied with the result (Whitehead, N. & Whitehead, B., 2010).

Statement of the Problem

Can males who have same sex attraction change to have opposite sex attraction through psychotherapy? As mentioned above, the APA declares this is rarely possible, and in fact, can be harmful for those who attempt it. However, many people have claimed to have successfully changed their sexual attraction from homosexuality to heterosexuality through psychotherapy. Organizations (such as National Association for Research and Therapy of Homosexuality-NARTH, Courage, Exodus International) and studies (Nicolosi, Byrd & Potts, 2000; Spitzer, 2003; Karten, E., & Wade, J., 2010) report that this has happened.

Purpose

This is a descriptive and quantitative study which acquired its data through a review of previously conducted research and a survey of persons who received professional assistance to diminish their unwanted same sex attraction and enhance their opposite sex attraction through psychotherapy. The author decided to conduct this study because of the current position of the APA that people with same sex attraction should not try to change their sexuality and become heterosexual; as well as the process of reparative therapy being harmful if attempted (APA Task Force, 2009). This position contrasts with the fact that many mental health professionals believe such change has little risk of harm and that thousands of people have claimed to have done so and not only suffered no ill effects but also claimed to have benefitted from the process

(Whitehead, N. & Whitehead, B., 2010). It is intended that this study will benefit those individuals who desire and choose to attempt to change their sexual orientation from homosexuality to heterosexuality for whatever reason. This study also will potentially encourage individuals to seek professional care to resolve their unwanted homosexual orientation which right should be considered self-evident and inalienable.

Setting of the Problem

The people who participated in this study reside in the United States, are males between the ages of 18-65 who had received assistance for their unwanted same sex attraction. The therapists of the individuals who went through the reorientation therapy informed their clients of an on-line survey that they could participate in if they desired. The clients then went on the internet and filled out the survey. To ensure confidentiality, no names were written on the surveys. The computers used to e-mail and receive the completed surveys were equipped with firewalls, antivirus and antispyware security protection.

Scope of the Study

The scope of the study includes the convenience sample of people who received professional assistance for their unwanted same sex attraction. These people filled out the survey to indicate if their same sex attractions, thoughts and actions were diminished or changed to thoughts, feelings and behaviors towards the opposite sex after they received therapy. The scope also included the helpful and harmful therapeutic interventions and effects that the convenient sample experienced during therapy.

History and background of the problem

The intellectual history of the homosexual act has carried speculation, intrigue and disagreement. Since recorded history, there has been a debate among historians and researchers

about the popularity and acceptability of the same sex act. Historically, it was popular knowledge that the practice of homosexuality was not common, accepted or legal in most cultures excluding ancient Greece and Rome in the B.C. era. Even in these two cultures it was believed that only the upper class or aristocrats accepted and participated in this behavior (Fone, 2000). During the 20th century, however, in researching the topic in the different cultures around the world, many scholars discovered evidence in the form of poetry, art and writing that the homosexual act was indeed more common (Aldrich, 2006). Since there were not many historically accurate records remaining from any of the ancient cultures, excluding the religious texts- Hebrew Scriptures, Christian Scriptures, Koran, etc. - it is difficult to completely understand the popularity and acceptance of the homosexual act. Most historical material consisted of opinion and documents written by the upper class that could be interpreted in many ways. There was evidence of the existence of same sex love but evidence of the extent and acceptance in the different cultures was lacking. Some cultures had paintings, drawings and stories of homosexual love between men, which were generally written or painted by the upper classes or aristocrats of the societies (Spencer, 1995). However to imply that homosexual practice was widely accepted by the culture because of a few drawings and paintings is too broad a hypothesis and needs more conclusive evidence. The evidence that was known points to the existence of the homosexual acts, but the extent can only be speculated (Crompton, 2003).

In the 19th century, homosexuality was questioned by the first modern activist and theorist of homosexuality, Karl Heinrich Ulrichs, (1825-1895) of Germany. Ulrichs was a relentless campaigner against injustice to homosexuals and directed early sexologists to the subject of homosexuality. He published five booklets in 1864-1865 titled “Researches on the Riddle of Male-Male Love”. These booklets promoted a biological theory of homosexuality, the

so-called third sex theory, which he summed up in the Latin phrase meaning “the female psyche confined in a male body”. Ulrichs coined the term “Urning” for the male subject of this condition and called the female subject “Urningin”, “Uranierin”, “Urnin”, and “Urnigin” (the term "homosexual" was first coined by Karl Maria Kertbeny in 1869). Ulrichs, at a Congress of German Jurists in Munich on August 29, 1867, urged repeal of the anti-homosexual laws. His protests were ignored and silenced, but this was the first time that a self-acknowledged Urning/ homosexual spoke out publicly for his cause. Thus, Ulrichs was the first known modern theorist of homosexuality and the first known homosexual to "come out" publicly. Ulrichs’ campaign against the legal oppression of homosexuals was unsuccessful. The Prussian anti-homosexual law was extended to the unified Germany in 1872 (Mondimore, 1996).

Sigmund Freud

When the medical profession of psychology/ psychiatry began to become more prevalant in the 19th century, three individuals stood out: Sigmund Freud, Alfred Adler and Carl Jung. Probably the most well known psychologist was Sigmund Freud (1856-1939) who was considered the father of psychoanalysis. Freud’s opinion on homosexuality had a great influence on the culture during his time as well as in our current culture. In order to better understand Freud’s opinion of homosexuality, it’s important to first look at Freud’s view of sexuality. Freud saw reproduction through heterosexual intercourse as the ultimate aim of all sexuality. Freud believed the sexually mature individual’s choice was restricted to the opposite sex, and most extra-genital satisfactions were forbidden as perversions. Any sexual act that deviated from reproduction could not be called normal in his view. Freud described sexual actions outside of reproduction as “deviations” and “arrested development.” Freud believed that, from the standpoint of nature and species survival, people did not fulfill their role if they did not

participate in reproduction. From the standpoint of the individual's life experience, he did not say that alternate sexual behavior was a disorder. He explicitly said that, even if individuals call sexuality abnormal with regard to reproduction, it was not necessarily associated with any other abnormal functioning (Freud, S. 1905). The requirement, demonstrated in these prohibitions, that there shall be a single kind of sexual life for everyone, disregarded the dissimilarities, whether innate or acquired, in the sexual constitution of human beings; it cuts off a fair number of them from sexual enjoyment, and so becomes the source of serious injustice (Robinson, 2000).

Freud's writings can be interpreted as a belief that homosexuality stemmed from a biologically rooted bisexual predisposition and was the expression of a universal human trend. He believed all people go through a natural homoerotic stage of development and eventually achieved heterosexuality at maturity (Marmor, 1980). Freud believed that some people could get stuck and remain fixated at the homosexual stage because of a uncommon resolution of the Oedipal situation. The latter happened when the male became sexually attached to the mother; the male comes to view his father as a rival; the male develops a fear that his father will castrate him and the male eventually represses his sexual desire for the mother in the face of this castration anxiety. At this point in the process Freud believed the son could either identify with the father or mother and the male usually identified with the father. The male identification with the father could happen because of an innate predisposition in most males which led towards a masculine identification. Identifying with the father would reduce the possibility of the son being castrated. This identification with the father would also permit the son to interject the father's authority to aid in the repression of the sexual desire for the mother that the son must accomplish. The cases where the son identified with the mother happened because the son did

not repress his sexual desire for his mother and did not identify with his father. This usually happened because the son's contact with the father was minimal. Freud believed that homosexuality was caused through this uncommon resolution of the Oedipal situation. Freud also believed that this identification would increase in strength when the son's sexual urges were intensified by the changes at puberty. At puberty, having identified with the mother, the son was in a position to create vicariously the situation that he desired by having sexual intercourse with others similar to himself i.e. other young males. In short, by acting out his sexual desires on other males, the male homosexual was unconsciously acting out his wish that his mother (with whom he identifies) had sex with him (Freud, S. 1905). Freud's opinion of homosexuality can be looked at in many ways: male homosexuality is narcissistic self-love; male homosexual desire is a desire for sameness-for the replica of the self (a search for a young man with self-resemblance); male homosexual desire was an expression of panic over female sexuality; homosexual desire was a substitute for normative heterosexual desire; homosexual desire was a kind of repetition-compulsion through which some form of sexual trauma could be relived, re-experienced, but never resolved; male homosexuality was an attempt to escape women. (Freud, S. 1914) In terms of the genesis of female homosexuality, Freud believed a castration complex of the girl towards her father, led to resentment towards him and the mother became the love object in place of the father (Socarides, 1978).

In terms of treating homosexuality, Freud believed that people were not born with homosexuality but it was acquired at the developmental stages (the uncommon resolution of the Oedipal complex). If homosexuality was learned, then Freud believed that it certainly could be unlearned or cured. Freud felt that psychoanalysis could cure homosexuality, yet it was very difficult to do so. Freud wrote about a case of homosexuality in a woman in 1920

that to convert a fully developed homosexual into a heterosexual did not offer much more prospect of success than the reverse. Freud considered homosexuality to be a variation of the sexual function, produced by a certain arrest of sexual development (Bauer, 2005).

There was a debate among clinicians about the opinion of Freud, whether he viewed homosexuality as pathological or not. Some believed Freud thought homosexuality was an illness, others believed he didn't. Those who believed that Freud thought homosexuality was not an illness point to his famous 1935 letter to the mother of an American homosexual. In that letter, Freud stated that homosexuality was not an advantage and nothing to be ashamed of; it was no vice or degradation and it could not be classified as an illness. (Bauer, 2005). In Freud's interview from Die Zeit in 1903, he stated that he was convicted that homosexuals should not be treated as sick people, for a perverse orientation is far from being a sickness. (Spiers & Lynch, 1977). In fact, some critics argued that Freud believed homosexuality to be the opposite of a sickness. Some believed that Freud distinguished between inversion, his preferred term for homosexuality, and perversion. In section 3 of the "Three Essays on the Theory of Sexuality", Freud stated that if a perversion had the characteristics of exclusiveness and fixation then it would usually be justified to regard it as a pathological symptom (Freud, S. 1905). If Freud was describing a perversion as a pathological symptom then he could not be talking about homosexuality because Freud describes homosexuality as an inversion. Freud believed that neuroses were the "negative" of the perversions, by which homosexual urges become pathogenic only when repressed. The person who acted on his homosexual impulses was not neurotic, and those impulses became unhealthy when they were driven into the unconscious (Robinson, 2000).

Those who interpreted Freud's writing and believed he thought homosexuality was pathological, looked to the very same text in section 3 of Freud's "Three Essays on the Theory of

Sexuality". They believed that Freud thought homosexuality was a perverse orientation and that when homosexuality had the characteristics of exclusiveness and fixation it was a pathological symptom (Roughton, 2002). They also looked at the fact that Freud believed homosexuality was a variation of the sexual function, produced by a certain arrest of sexual development that could be restored to heterosexuality or the fullness of sexual development (Bauer, 2005). Others see Freud's theory of bisexuality as part of the process where homosexuality develops. Freud's theory of bisexuality gave birth to the idea of duality of the sexual instinct. Normal heterosexuality was dependent upon the individual repressing the homosexual component of the sexual instinct and the "passive-feminine" wishes deriving from the negative Oedipus complex. Freud believed excessive pressure of pre-genital libidinal components and failure of the defenses of repression and sublimation permit or threaten emergence into consciousness of homosexual impulses, which gave rise to conflict manifested in the appearance of symptoms. These symptoms included fear of being homosexual, dreams with manifest and "latent" homosexual content, conscious homosexual fantasies and impulses, "homosexual panic," disturbances in heterosexual functioning, and "passive-submissive" responses to other males. Individuals in whom such symptoms appeared were frequently referred to as "latent homosexuals" (Bieber, 1962).

Alfred Adler

Alfred Adler (1870-1937) was part of the psychoanalytic movement with Freud. Adler's revolutionary observations triggered a life of research dedicated to understanding people and a corpus of ideas that he called Individual Psychology. Adler thought that homosexuality was a sexual deviation, along with sadism, masochism and fetishism. Adler thought that a sexual deviation was the expression of a psychological distance between a man and a woman because of

a lowered self esteem. He believed that homosexuals (men and women) were compensating to relieve a perceived inferiority of the domineering opposite sex. The deviation usually occurred in people that were usually oversensitive, over-ambitious and defiant. Adler believed that homosexuals felt that they were not accountable or they were free from responsibility for their behavior. The homosexual had a hostile attitude towards society, did not seek a peaceful adjustment, had little communal spirit or goodwill towards others where a weak bond of unity could be tied. The homosexual had not developed into a partner of society and failed to become a fellow man (Chandler, 1995). Adler thought that homosexuality was an avoidance of one of the goals of marriage. The love in a marriage of heterosexuals results in the procreation of the human race. Getting married and having children resulted in expanding the human race and contributing to society (Adler, 1978).

Adler believed that homosexuality stemmed from an inadequate foundational upbringing, faulty preparation for their usual sexual role and an incorrect interpretation of their physical deficiencies. Homosexuality signified the exclusion of the other sex and was justly considered countercultural. Homosexuality was an expression of great discouragement and hopeless pessimism where one was satisfied with life in a small circle, far from the other sex. Any aggravation or stressors in life or the experience of insecurities of interpersonal relationships can increase the number of homosexuals and made homosexuality a mass phenomenon. In times when women become more prominent in life, Adler believed that men will distance themselves and feel safe to resort to homosexuality. Adler referred to homosexuality as a neurosis based on fears of failure with the opposite sex and a denial of social responsibility because of feelings of inferiority. Adler considered homosexuality as one of the most difficult cases to change, needing

an experienced psychotherapist, many sessions and much personal work by the individual. Success for the individual could not be guaranteed (Adler, 1978).

There was evidence that Adler felt a different way about homosexuality. In 1917 Adler admitted that the knowledge of homosexuality at that time was incomplete, that more information could be discovered about homosexuality. Adler believed that homosexuality was ambiguous and could only be understood in reference to the time in history and the individual. Times and culture changed so people now believe that Adler would also change his view and not consider homosexuality neurotic in today's world. The critics of Adler's neurotic description of homosexuality also looked to his concept of the mature phase of belonging and predicted that Adler would approve when a homosexual "came out" and declared their sexuality and claimed their rightful place in the human community. Adler stated in 1926 that reliable sources believed non-compulsive homosexuality to be almost a normal manifestation in the life of every individual (Fairfield & Kopp, 1993).

Carl Jung

Another influential individual of psychology was Carl Jung (1875-1961), the founder of analytical psychology. He viewed the issue of homosexuality with a more open mind compared to Adler. To examine homosexuality from a Jungian perspective, it is helpful to have a basic understanding of Jung's concept of the collective unconscious and archetypes. Jung built on Freud's concept of the unconscious by dividing it into two distinct parts. The individual component he called the "personal unconscious" and the more universal aspect he called the "collective unconscious". Jung saw the collective unconscious as universal and common to all people as well as being composed of archetypes- socially constructed models that cultures create to provide guidance for their people. Archetypes were symbolic types of characters or

personalities that populate one's collective unconscious and could potentially guide behaviors as people identify with them (Jung, C. G. 1913).

Jung did not think that homosexuality should be viewed as criminal and those that practiced the behavior should not be penalized (this probably because psychiatrists of his day were trying to protect deviants accused of undesirable behavior by society). He also believed that homosexual actions do not decrease the value of the individual as a member of society. Jung also thought homosexuality was best understood when put in a historical and cultural context. Jung believed that one's homosexual nature should be distinguished from other parts of their personality. Jung thought that an individual's homosexuality had its own meaning particular to that individual and that psychological growth was dependent on recognizing that meaning (DeVoll, & Blazina, Fall 2002). Despite this, Jung believed that homosexuality was a result of psychological immaturity as well as abnormal and disturbed. With this view, Jung, like Freud, believed that psychological maturity was reached when heterosexuality was reached (Jung, C. G. 1913). Jung's theory is similar to that of Paul's beautiful truth about love in 1 Corinthians 13:11"When I was a child, I talked like a child, I thought like a child, I reasoned like a child. When I became a man, I put the ways of childhood behind me."

Jung believed that there could be a few causes of homosexuality in the individual. One possible cause was that homosexuality was a result of a feminine relationship, primarily an unresolved dependence on the mother, for men as well as women. He thought that homosexuals were acting outside of themselves and projecting themselves on to others of the same sex. Jung explained that same sex attraction to females could either be caused by an incomplete or unsatisfying relationship with the mother or by a psychological response when women assumed traditionally masculine gender roles in society. Another possible cause of homosexuality

resulted by an individual acting out an incomplete detachment from the original archetype of the Hermaphrodite, the unbroken state of non-differentiation or wholeness. In this case, homosexuality was a response to acting out a one sided sexuality, exclusively allied with the feminine and not including the masculine (Jung, C. G. 1917-43). Finally, there were some who believed that Jung thought homosexuality could be determined by biological factors when he mentioned the possibility of a constitutional homosexuality in his writings in "The psychological aspects of the Kore" (Hopcke, 1988). Jung did not pay a great deal of attention to the issue of homosexuality; sexuality would be only one of many other building blocks to be used in constructing the various individual and symbolic lines of the ''truth of the psyche''. Jung spent little time or attention on the issue of homosexuality and as a result the literature concerning his views on the topic remains limited at best (Lingiardi, 2001).

Alfred Kinsey

Alfred Kinsey (1894-1956) was a zoologist who gained fame for his research on human sexual behavior. He did a prestigious study about homosexuality in 1948. Kinsey's study supported the concept that homosexuality was not an illness. Homosexual behavior was viewed as an inherent capacity of all human beings. As a result of conditioning and social pressure, the sexual potential became channeled in the direction of accepted social behavior. Sporadic homosexual behavior in the general population prior to maturity was found to be the rule rather than the exception. Kinsey's report showed that about four percent of adult white males were exclusively homosexual after adolescence and that about 10% of the total male population was exclusively homosexual for at least three years. Another finding was that at least 37% of the total male population had some overt homosexual experience (Kinsey, A. 1948). In preadolescent boys Kinsey found an incidence of 48% homosexual genital stimulation. Since

preadolescent heterosexual stimulation occurred in 40% of his sample, homosexuality in some form exceeded heterosexuality during the preadolescent period. Because of Kinsey's report, many psychologists and psychiatrists felt that homosexuality should not be regarded as a crime against nature. Kinsey believed that homosexuality should not be regarded as a disease and thought that only a small number of those involved in homosexual behavior were ever disturbed by their experiences and that personality disturbances associated with homosexuality came from the expectation of adverse social reactions (Bieber, 1962). Critics of Kinsey's findings argued his survey was distorted because it oversampled prison inmates, especially those convicted as being sex offenders, as well as surveying gay affirming organizations (Jones, Yarhouse 2000). A more recent report on sexual behavior found that two percent of men and less than one percent of women were homosexual and an additional 0.8% of men and 0.5% of women identified themselves as bi-sexual (Jones, Yarhouse 2000). Other reports gave results that ranged from 1 to 20% of the population being homosexual. In the United States, according to exit polling on the 2008 Presidential elections, 4% of the people who voted self-identified themselves as gay, lesbian, or bi-sexual, the same percentage as in 2004 (Advocate on line).

Evelyn Hooker

In 1953, Dr. Evelyn Hooker began a research study that helped change the psychological assumptions and practice for counseling gay men. Hooker did a study on a group of 30 homosexual men and 30 heterosexual men with similarities in age, I.Q., and education. The investigation consisted of a battery of projective techniques, attitude scales, and intensive life history interviews. Hooker's hypothesis was that homosexuality was not necessarily a symptom of pathology. The report was based on analysis of the test materials by different, independent judges who did not know whether the record was that of a homosexual or a heterosexual. The

general outcome of the study was that the judges could not identify whether the results were from a homosexual or a heterosexual subject. Hooker's conclusion was that homosexuality may be a deviation in sexual pattern which is within the normal range psychologically (Hooker, E., 1957). The findings challenged the widespread belief that homosexuality was a psychological sickness by demonstrating that experienced clinicians using psychological tests could not differentiate the nonclinical homosexually oriented group from the nonclinical heterosexually oriented group. The study concluded that gay men were not more likely to exhibit mental illness than heterosexual men (Pope, M. 2005). Critics of the study pointed out that the people with same sex attraction in the study were carefully chosen on the basis of good adjustment and function in the community. People who were in therapy and any who showed evidence of disturbance in the preliminary screening were eliminated (Bieber, 1962).

Homosexual Life, Protest and Laws in the 20th Century United States

In the United States, a homosexuality subculture began to emerge in the first half of the 20th century. The largest and best-known homosexual communities were in New York, Los Angeles and San Francisco. During times of economic hardship (the great depression) people migrated to large cities to find work. Once there, they were often forced to live outside traditional family structures, many in same sex settings such as military and industrial barracks. Those with homosexual inclinations found the freedom to express themselves in these environments without ever-present familial and religious disapproval. Another factor in the development of coastal gay life was the ban on gays in the military. During World War I and II any known homosexual men were not admitted for service and if anyone was caught in a homosexual act they were then sent to military prison and dishonorably discharged. They

usually ended up in port cities and stayed because they could not go home due to the disgrace (Aldrich, 2006).

In 1953, President Eisenhower extended the ban on military service to all government employment when he signed executive order 10450, in a time when police entrapment, harassment in gay bars and interference with the mail was common in the postwar period (Hegarty, 2003). In the 1950's, the first known homosexual political organization in the U.S. was the Mattachine Society, founded in Los Angeles to combat the discrimination that homosexuals were suffering (Spencer, 1995).

On June 28th, 1969 in Greenwich Village, New York, the famous "Stonewall" incident took place. The Stonewall Inn, a known gay bar, was raided by police on an alleged infringement of its liquor license. The Stonewall customers, joined by other gay men from the streets fought back for two days. This riot sparked a new movement that demanded respect and equal rights from society for people practicing homosexuality. It was at this time that the new term "coming out" was coined and the word "gay" was preferred to the term homosexual. A year later in 1970 the first march for gay's rights took place when between 10,000 and 20,000 people marched from Greenwich Village to Central Park in New York. The same day in Los Angeles, California, 1,200 people marched down Hollywood Blvd to promote gay rights. This would start the annual tradition of gay rights marches in the United States (Spencer, 1995).

With the new perception of homosexuality changing, sodomy laws in the United States started to be repealed in the 1970's and currently only 14 of the 50 states still have laws that forbid the act of sodomy. The military policy of prohibition of homosexual persons changed in 1993 when President Clinton, faced with strong opposition from military leaders, introduced the "Don't Ask, Don't Tell" (DADT) policy. This policy prevented military authorities of asking the

sexual orientation of the individual but prohibited public statements of sexual orientation to the military. In 1996, the Defense of Marriage Act (DOMA) defined marriage solely as a union between couples of the opposite sex for all federal purposes was passed. In 2003, the right to marry was granted to same-sex couples in Massachusetts and by 2010 four other states followed (New Hampshire, Iowa, Vermont and Connecticut) and the nation's capital, Washington D.C. In 2011, New York legalized marriage for same sex couples. Same-sex civil unions and domestic partnerships have been in existence in a quarter of the states in America since 2000 (Newsweek, 2010).

The DSM

The American Psychiatric Association developed its Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952 in which homosexuality was listed among the sociopathic personality disturbances. With the United States going through a moral uprising in the 1960's with the civil rights movement for women, and African Americans, and issues against the Vietnam War, it was a perfect and opportune time for the gay community to organize and promote their cause. Along with demonstrations for equal rights and fair treatment, gay rights activists also protested against the medical establishment to change an unfair "disorder" label given to their sexual behavior. Gay rights activists first attended the annual American Psychiatric Association (APA) convention in San Francisco in 1970. In San Francisco the activists demanded that psychiatry support homosexuality and not condemn it as an illness. These efforts at the 1970 APA convention resulted in the gay rights activists being able to conduct their own panel at the 1971 APA convention in Washington, D.C. Several outbursts and demonstrations again occurred at the 1971 convention in which the gay activists demanded homosexuality be removed from the DSM as a disorder (Morgan & Nerison 1993). In 1972 the

Gay activist Alliance staged a demonstration at the annual meeting of the Association of the Advancement of Behavior at the Hilton Hotel in New York. This led to an invitation to make a presentation before the American Psychiatric Association Nomenclature Committee (Silverstein, 1991). In 1973 the APA committee voted to remove homosexuality as a disorder from the DSM II. Some people believed that social science research changed the minds of the committee members, especially the research done by Dr. Hooker in 1953. In 1992, The American Psychological Association summarized: "This revolutionary study provided empirical evidence that normal homosexuals existed, and supported the radical idea then emerging that homosexuality is within the normal range of human behavior." (Pope, M. 2005) Others believed that the APA committee was pressured by the gay organizations to remove homosexuality from the DSM II. In a March 12, 1973 letter, Abram Kardiner, a Colombian psychoanalyst, stated that gay organizations pressured the APA regarding homosexuality and also said that “this is one facet of a title wave of egalitarianism and divisiveness that is sweeping the country” (Silverstein, 1991). Kardiner also said that supporting the claims that homosexuality was healthy or normal was to deny the social significance of homosexuality which alienates the family and destroys its function as the last place in society where affectivity can be cultivated (Silverstein, 1991).

In 1987, M. Rosenberg stated that the understanding of homosexuality was overturned in a two-year period by committees of the APA responding to specific political manipulation and intimidation. This was such a violation of the standards of science as to call for some form of redress. The accepted solution was submission of the issue to the entire membership of the APA (Morgan & Nerison, 1993). Soon after, the American Psychological Association's Board of Social and Ethical Responsibility for Psychology and the Board of Directors issued this statement:

"The American Psychological Association supports the action taken on December, 1973 by the American Psychiatric Association removing homosexuality from the Association's official list of mental disorders. The American Psychological Association therefore adopts the following resolution: Homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; Further, The American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations" (Morgan & Nerison, 1993).

When the APA removed homosexuality from the sociopathic list from DSM II it then classified homosexuality as a sexual orientation disturbance. This new diagnosis was to be applied to gay men and women who were disturbed, in conflict or wanted to change their sexual orientation (Karten & Wade, 2010). In 1980, the DSM-III replaced the classification of sexual orientation disturbance with ego-dystonic homosexuality which referred to someone who was homosexually aroused and considered this arousal a persistent source of distress and who wished to become heterosexual. In this way homosexuality was not considered abnormal unless the individual treated it as such. The DSM-III also included the diagnosis of gender identity disorder of childhood (GIDC) which critics thought as a kind of "backdoor maneuver" to replace homosexuality, which was deleted from the DSM-II in 1973. Some thought that the GIDC was used as a diagnosis for gay and lesbian adolescents who were viewed as in need of treatment. (Zucker, Spitzer, 2005) The DSM-III-R and current DSM-IV-TR eliminated the classification of ego-dystonic homosexuality and GIDC with "Sexual Disorder Not Otherwise Specified" and "Identity Problem" which applied to an individual who was unsatisfied with his homosexual feelings (American Psychiatric Association, 2001). In short, homosexuality was viewed as a disorder for over 20 years by the American Psychiatric Association. The American Psychiatric Association changed their view of homosexuality, viewing homosexuality as healthy and only a problem if the individual with same sex attraction believes it's a problem.

Pertinent Questions

The following pertinent questions give focus to the study:

1. To what extent does a convenience sample of former and current clients of SOCE (Sexual Orientation Change Efforts) report changes in same sex and opposite sex thoughts, feelings and/or behaviors after receiving reparative therapy?
2. What does a convenience sample of former and current clients of SOCE report to have found helpful about their experiences of reparative therapy?
3. What does a convenience sample of former and current clients of SOCE report to have found harmful about their experiences of reparative therapy?

Hypotheses

The following hypotheses give focus to the study:

1. The convenience sample of former and current clients of sexual orientation change efforts (SOCE) can diminish or eliminate their same sex thoughts, feelings and behaviors and acquire a heterosexual orientation by increasing and having thoughts, feelings and behaviors for the opposite sex through psychotherapy (reparative therapy).
2. The convenience sample of former and current clients of SOCE will find reorientation counseling helpful in increasing their self esteem, self acceptance and overall positive self outlook.
3. The convenience sample of former and current clients of SOCE will find the therapeutic intervention of therapeutic touch to cause harm to themselves.

Importance of the Study

This study is significant because it could show that people have the possibility to change their same sex attraction to opposite sex attraction. This could be a benefit to homosexual individuals who wanted to get married to a person of the opposite sex and have their own biological children with their spouse. This could also benefit individuals who were homosexual and currently married to someone of the opposite sex and wanted to have stronger sexual feelings and desires for their spouse. This study could also reduce the fear of harm in individuals who wanted to change their sexual orientation.

Limitations

The Limitations of the study were that most of the subjects in the survey were from a white, Christian, religious background. The people who filled out the survey were from a convenience sample, not a random sample. The limitations included a bias in that the researcher conducted the interview questions. The study also is based on a self assessment of the clients involved in the survey. The results may not be generalized to the total population.

Operational Definitions

1. Reparative or Reorientation Therapy: any help from a mental health professional or an ex-gay ministry for the purpose of changing sexual attraction.
2. Homosexuality: exclusive erotic, sexual activity, feelings or attractions to another of the same sex
3. Heterosexuality: exclusive erotic, sexual activity, feelings or attractions to another of the opposite sex
4. SOCE: sexual orientation change efforts.
5. Lust: uncontrolled or illicit sexual desire or appetite.

6. Immoral: violating moral principles; not conforming to the patterns of conduct usually accepted or established as consistent with principles of personal and social ethics.
7. Idolaters: a worshiper of idols or images that are not God.
8. Sacraments: a visible sign of an inward grace, especially one of the solemn Christian rites considered to have been instituted by Jesus Christ to symbolize or confer grace.

Summary

It has been questioned whether same sex attraction can be changed to opposite sex attraction as well as if it's safe to try. Same-gender sexual behavior has been present through most of the cultures in history, though only a few cultures found it to be an acceptable form of sexual expression. The fathers of psychology, Freud, Adler, Jung looked at homosexuality mainly as an illness that happened when an individual's psychic sexual development was repressed; unhealthy attachments to the mother developed or even an unhealthy resolution of the Oedipus complex. Because all three saw it as an illness, all three believed that it could be cured or restored to heterosexuality. Since the late 20th Century, there has been a movement to culturally accept and normalize homosexual behavior. The APA has changed their original view of homosexuality being an illness or disorder, to currently believing that homosexuality is normal and healthy. Current legislation has taken place in several states to normalize marriage between people of the same sex. The study in this dissertation was important because it may determine if the reparative therapy process is safe, and hence give people the option and possibility to change their sexual attraction from homosexual to heterosexual . A study of people who described their sexual orientation as homosexual and who received psychological reparative therapy gaves some answers and insight about the question whether it is possible for a person to change their sexual orientation from homosexuality to heterosexuality.

Chapter 2

Literature Review of Therapies

Introduction

This is a descriptive and quantitative study which acquired its data from research and the survey conducted with people who have gone through counseling for same sex attraction, to determine if it was possible for individuals to change their sexual attraction from homosexuality to heterosexuality through psychotherapy. There was a disagreement among scholars about the acceptance of homosexual behavior throughout history in past societies. The fathers of psychology, Freud, Adler, Jung looked at homosexuality mainly as an illness that happens when an individual's psychic sexual development is repressed, an unhealthy attachment to the mother develops or even an unhealthy resolution of the Oedipus complex is achieved. Because homosexuality was seen as an illness, it was believed that it could be cured or restored to heterosexuality through psychological treatment. Up until the end of the 20th century, homosexuality was viewed as a disorder by science, originally being listed as a disorder in the DSM I. Starting in 1973, the APA changed their view of homosexuality, and now sees it as a normal and healthy way to express an individual's sexuality (APA Task Force, 2009).

Overview of the topic

Homosexuality has been understood by the medical profession to be an illness since the time of Freud. Therefore, people with this condition have been treated in an attempt to change or cure the illness. There have been many interventions that have been used to reduce, change and eliminate the same sex attraction that individuals present with. Interventions from the early to mid 20th century have differed quite dramatically from the interventions of the late 20th to early 21 century. A few of the common treatment methods used in early to mid 19th century included

psychoanalysis, cognitive/ behavior and classical conditioning approaches as well as some extreme types of aversion therapies, namely electrical shock and vomiting methods (Adams & Sturgis, 1977). These two extreme methods were very popular and effective in treating people with same sex attraction through the mid 20th century. When views of homosexuality changed from ideas that it was an illness to views that it was a healthy way to express one's sexuality, treating homosexuality became less popular as did these extreme methods. The most popular method from the late 20th century to attempt to help individuals change their same sex attraction was reparative or conversion therapy, which included elements from psychoanalysis, cognitive/ behavior and classical conditioning approaches (Nicolosi, 1991). The APA did not encourage therapists' using reparative therapy or any approach to attempt to reduce or change the same sex attraction in individuals because the APA felt it could be harmful and ineffective. The APA also considered the studies to reduce and eliminate the same sex attraction on individuals to be invalid because the studies did not contain a control group to compare the results to (APA Task Force, 2009).

Pertinent studies and literature related to the topic

Homosexuality had been looked at as a treatable disorder since the time of Freud, well before the establishment of the DSM in 1952, which listed homosexuality as a treatable illness. Because of this view, many studies were done with the goal to cure the client from this orientation and strengthening their opposite sex attraction. Many such studies were done before homosexuality was removed from the DSM II in 1973 . During this time there were grants available to help fund research and studies to discover more information and better counseling interventions for homosexuality. Aftger 1973, because homosexuality was no longer considered an illness by the APA, it did not need to be cured, and did not receive funding grants to be

researched. Additionally, due to political aspects, people interested in researching homosexuality ran the risk of getting backlash from his or her peers in the psychological community who treated such research as primitive and outmoded. Research on sexual conversion therapy did not considerably diminish because there was not a need for it or because it was found to be ineffective. Research diminished because homosexuality was no longer classified as a disorder.

Studies on homosexuality when considered an illness

There were many studies done on people with homosexuality when the APA considered it as a treatable illness. The studies are old and outdated, especially in their methods. Difficulties in generalizing findings of many older studies were the failure to specify goals of therapy, the degree of the homosexual's prior heterosexual experience, the patient's age, clinical diagnosis, IQ, sex of the therapist and theoretical treatment approach. Also, the determination of therapeutic progress was based on subjective judgments by the therapist or self-reports of the patients. In general, these behavior therapy studies were similar in many ways with some minor differences. In most of the studies, the researchers used aversion therapy (shock , nausea, vomiting, etc.) to discourage unwanted homosexual thoughts and behavior while positively reinforcing heterosexual thoughts/and behaviors. The studies used objective measures to determine the treatment results which included penile erection, heart rate, pulse volume, and electrodermal responses (Adams & Sturgis, 1977).

B.H. Fookes did an uncontrolled group study in 1960 that used aversive techniques to treat homosexuality in males. The homosexuals participated in classical conditioning that employed nude male slides as the unconditioned stimuli and electrical shock as the conditioned stimulus. As treatment progressed, increasing numbers of female slides were shown that were not paired with shock and were used to elicit sensations of anxiety relief to be associated with

positive experiences. With a 38-month follow-up, Fookes achieved a 60% success rate with homosexual clients (Adams & Sturgis, 1977).

In 1960 K. Freund did an uncontrolled group study using chemical aversion techniques to modify homosexual preference in 67 clients. Freund injected the homosexual clients with emetine, apomorphine, and caffeine eapomorphine combinations to induce nausea. Afterwards the males were shown slides of dressed and nude males. After the first treatment the patient was exposed to slides of nude and semi-dressed females seven hours after they were injected with testosterone propionate, a chemical that increases sexual arousal. Freund's conditioned reflex therapy techniques were designed to diminish the positive valence of the male sex objects and to enhance the positive valence of the more acceptable female sex objects. With a three to five year follow-up, no improvement was observed in 60% of the cases. There was short-term improvement, specifically decreased homosexual arousal, in 40% of the cases. There was long-term success of three to five years in 25% of the total cases (Adams & Sturgis, 1977).

In 1963 J. G. Thorpe, E. Schmidt, and D. Castell did an uncontrolled case study that combined masturbation training with heterosexual stimuli and electrical aversion in response to homosexual stimuli in the treatment of a 35- year-old male homosexual. The client increased heterosexual and decreased homosexual arousal after aversion was instituted. An eight-month follow-up indicated the client had maintained the treatment goals of changed sexual arousal (Adams & Sturgis, 1977).

In 1965, M. P. Feldman & M. J. MacCullough did an uncontrolled group study that used an anticipatory avoidance treatment procedure to alter homosexual preference. Forty-three homosexuals were treated in the study that used electrical aversion to reduce homosexual arousal. Slides of the same sex stimulus were viewed by the client as long as they were

attractive to the individual. A shock was applied to the individual if the individual looked at the slide longer than 8 seconds. A variable schedule of reinforcement was used to delay extinction. A slide of a member of the opposite sex was shown to the client after the homosexual slide and shock were removed to enhance the valence of the opposite-sex stimuli. Of the 36 patients completing the treatment, 25, or 58% were significantly improved (Adams & Sturgis, 1977).

In 1966, Elizabeth Mintz published a study conducted on 10 homosexual males and found that over two or more years, all of the men reported improved general adjustment to heterosexualism, three men reported satisfactory heterosexual adjustment and three men hoped to achieve it eventually. She used a combination of individual and group therapy, even including heterosexual men and women in the group. Mintz described four areas of observation/ treatment in the therapy of the males: (1) dissolution of surface defenses; (2) development of a stronger sense of personal identity; (3) the emergence of hitherto unconscious anxiety and (4) corrective emotional experience (Mintz,1966).

In 1968 S. M. Levin, I. S. Hirsch, G. Shugar, and R. Kapche did an uncontrolled case study that combined systematic desensitization and avoidance conditioning procedures in the treatment of a 20-year-old secondary (previous heterosexual interest or experience) homosexual. An 18-month follow-up after the study showed that his homosexual urges were minimal, his homosexual behavior was nonexistent, and the client functioned well in an intimate heterosexual relationship. There was also an increase in heterosexual interest and decreased heterosexual anxiety (Adams & Sturgis, 1977).

J. Bancroft used aversive techniques with 10 males to decrease homosexual arousal in his 1969 uncontrolled group study. Bancroft employed electric shock upon males with penile arousal in response to homosexual fantasies and slides. Aversion relief procedures were

employed to facilitate penile arousal to female stimuli. Five of the patients showed a reduction of homosexual interest and four demonstrated reductions in homosexual behavior following treatment. This reduction was accompanied by increases in heterosexual interest and behavior in seven and four individuals, respectively. One third of the cases showed significant and lasting improvements at the 1-year follow-up, and one half exhibited a diminished interest in homosexual activity (Adams & Sturgis, 1977).

In 1969, N. McConaghy used two forms of aversive therapy (apomorphine aversion and aversion relief) with 30 subjects in the controlled group study. In the first group McConaghy attempted to classically condition homosexual arousal with sensations of nausea by injecting 15 subjects with apomorphine. They were then shown slides of nude males and were instructed to attempt to respond sexually to the slides. The second group of 15 people experienced the pairing of slides, words, phrases, and homosexual fantasies with the administration of electrical shock. At irregular intervals in both cases, slides of females, not accompanied by shock, were projected on the screen to enhance heterosexual arousal through aversion relief procedures. Apomorphine treatment decreased homosexual desire in 60% of the cases and increased heterosexual desire in *60%* of the other subjects. In the shock aversion treatment, 47% showed a decrease in homosexual arousal and behavior, and 53% experienced an increase in heterosexual arousal and behavior (Adams & Sturgis, 1977).

In 1970, J Bancroft (1970) compared aversive and desensitization procedures in the treatment of homosexuality in his controlled group study. He studied two groups, one group received electrical shock contingent upon penile response to slides of male stimuli. The other group was desensitized to a hierarchy of heterosexual situations that were individually constructed with the patient. Bancroft found that both groups showed significant decreases in

homosexual behavior. The desensitization group showed increased heterosexual behavior, more stable long-term attitude changes and more significant changes in heterosexual attitudes. The Aversion group produced effective short-term changes in attitudes (Adams & Sturgis, 1977).

In 1970 J. J. Gray did an uncontrolled case study that used imaginable and in vivo systematic desensitization along with fantasy training with a 22-year-old homosexual subject with no heterosexual interest or experience. The client became involved in an enjoyable heterosexual relationship without using homosexual ideation after 19 therapy sessions had been conducted. At the termination of therapy, the client reported a substantial decrease in homosexual ideation accompanied by an increase in heterosexual fantasy and behavior. There was no follow up after the study (Adams & Sturgis, 1977).

J. LoPiccolo did an uncontrolled case study in 1971 that used systematic desensitization for female stimuli in the treatment of a 21-year-old male primary homosexual client. Desensitization was conducted in imagination and in vivo desensitization in the therapy sessions. After four sessions, the client had begun dating a female and behaved in a heterosexual manner congruent with that described in the desensitization sessions. Also, the client engaged in enjoyable heterosexual intercourse, which was followed by a termination of homosexual ideation and urges. A 14-month follow-up with the client revealed maintenance of therapy gains (Adams & Sturgis, 1977).

M. J. MacCullough, C. J. Birtles, and M. P. Feldman did an uncontrolled case study in 1971 that used aversive therapy in anticipatory avoidance conditioning. Dependent measures included heart rate, self-reported arousal, and latency of the arousal response. Data on two subjects showed decreased homosexual arousal and behavior following treatment on both clients. The third subject demonstrated no change. One of the individuals maintained gains at the 24-

month follow-up, while the second individual relapsed after 46 weeks. The client who maintained treatment progress displayed an increase in heterosexual arousal and the frequency and enjoyment of dating experiences (Adams & Sturgis, 1977).

L. Birk, W. Huddleston, E. Miller, and B. Cohler did a controlled group study in 1971 which compared the effectiveness of an aversive treatment procedure with that of a placebo feedback procedure to alter sexual orientation in 16 males. Of the 16 males, only five in the aversive condition demonstrated change. Two of the individuals in the treatment group demonstrated decreased homosexual arousal and behavior accompanied by increases in heterosexual behavior (Adams & Sturgis, 1977).

R. Hallam and S. Rachman did an uncontrolled case study in 1972 with three homosexual clients. Dependent variables included an autonomic response (pulse volume and galvanic skin response) to deviant and non-deviant fantasy and verbal response to a mood scale. Delayed classical conditioning was used to pair electrical shock with deviant fantasies in an attempt to neutralize the valence of the fantasy. Follow-up (12 and 3 months, respectively) revealed a significant reduction of homosexual ideation and behavior for one client and a decrease in homosexual activity with an increase in heterosexual activity for a second client. Aversion therapy had minimal effect on the other client (Adams & Sturgis, 1977).

C. E. Colson did a Controlled Single-Case Study in 1972 that used olfactory aversion methods to reduce homosexual behavior in a 24-year-old secondary homosexual male. Classical conditioning was used to decrease the valence of homosexual fantasy by pairing the male's fantasy with noxious odors. The results showed a termination of the homosexual behavior with decreased in the frequency of homosexual urges. There was no change in the heterosexual arousal (Adams & Sturgis, 1977).

R. W. Hanson and V. J. Adesso did a Controlled Single-Case Study in 1972 that used systematic desensitization, electrical aversion, masturbation training, and hetero-social skills practice to modify homosexual behavior in a 23-year-old male. The client monitored heterosexual anxiety, sexual history, orientation, and level of assertiveness, sexual urges and behavior. Aversion techniques and imagery and in-vivo desensitization were used in therapy. A 6- month follow-up showed an increase in heterosexual experience with an increase in positive attitudes toward heterosexual activities. Homosexual ideation significantly decreased and homosexual behavior stopped (Adams & Sturgis, 1977).

In 1973, N. McConaghy and R. F. Barr employed classical, avoidance, and backward conditioning in a comparative controlled group study of aversive techniques involving 46 patients. Similar results were demonstrated among the three treatment methods. At a 1-year follow-up, 50% of the patients reported a decrease in homosexual feelings, 50% experienced an increase in heterosexual feelings, 25% reported an increase in the frequency of heterosexual intercourse and a cessation of homosexual relations (Adams & Sturgis, 1977).

E. J. Callahan and H. Leitenberg did a controlled case study in 1973 that employed electrical aversion and covert sensitization in a classical conditioning test to eliminate deviant fantasy. Two primary and one secondary homosexual clients were tested. The dependent variables were penile circumference changes in response to slide presentations, self-monitored sexual urges, fantasies, and behaviors. Covert sensitization was most effective in reducing homosexual urges while there was no difference in effectiveness between contingent shock and covert sensitization in reducing physiological arousal. At an 18-month follow-up, the clients showed increases in heterosexual urges and behaviors and decreases in homosexual ideations and behaviors and one individual showed an increase in coital activity (Adams & Sturgis, 1977).

S. H. Herman, D. H. Barlow, and W. S. Agras did a Controlled Single-Case Study in 1974 that exposed explicit heterosexual visual stimuli to illicit heterosexual arousal. Changes in penile response to nude slides and self-monitored sexual urges and behaviors were dependent variables. All four clients increased heterosexual urges, two clients increased heterosexual behavior, and one increased coital activity. Two clients decreased homosexual arousal and behavior. The results indicated that prolonged exposure to visual stimuli may increase heterosexual response, but the increase had little effect upon homosexual response (Adams & Sturgis, 1977).

L. P. Rehm and R. H. Rozensky did a controlled case study in 1974 that employed self-management techniques, systematic desensitization, covert sensitization, aversion relief, orgasmic reconditioning, and assertiveness training in a multidimensional therapy study for a 21-year-old male secondary homosexual. Heterosexual activity increased with desensitization, orgasmic conditioning, and assertiveness training. Homosexual behaviors decreased with desensitization to females and covert sensitization to males. A 40- week follow-up indicated the stability of treatment results (Adams & Sturgis, 1977).

D. A. Sandford, R. D. Tustin, and P. N. Priest did a controlled case study in 1975 that gave electric shock to arousal in response to male slides and reinforced penile arousal in response to female slides, in trying to alter the sexual arousal of two homosexual males. Both subjects demonstrated an increased frequency of heterosexual urges with a decreased frequency of homosexual urges and behaviors. No follow-up data were provided (Adams & Sturgis, 1977).

In 1975 N. McConaghy examined both aversive and positive conditioning paradigms for the treatment of homosexuality in his controlled group study. Thirty-one clients received either aversive therapy with faradic shock and homosexual slides or were assigned to a positive

classical conditioning situation in which slides of heterosexual stimuli were paired with slides of nude males and later with slides of heterosexual relations. Measures of penile response served as the primary dependent variable. At a one year follow-up, about half of the clients reported an increase in heterosexual activity and feeling, which was accompanied by a decrease in homosexual activity and feeling. At the termination of treatment, there was more increased arousal among the individuals undergoing aversive therapy than among those experiencing positive conditioning. McConaghy hypothesized that the reported increase in heterosexual arousal resulted from a placebo effect rather than actual conditioning (Adams & Sturgis, 1977).

W. Freeman and R. G. Mayer used a classical conditioning test, and paired heterosexual slides with homosexual slides and masturbation activities with males in their 1975 uncontrolled group study. Homosexual arousal was eliminated by pairing the homosexual stimuli with electric shock. The test was arranged so that the person moved from homosexuality through a bisexual state and finally to heterosexuality. Seven of the nine subjects maintained an exclusively heterosexual orientation for 18 months after treatment, and all did so for a year. All six primary homosexuals achieved a heterosexual orientation for a year, and four of the six maintained the preference at an 18-month follow-up (Adams & Sturgis, 1977).

The results of all of these studies showed that 49% of the individuals experienced at least some decrease in their same sex attraction or some increase in their heterosexual attraction up to a five year follow-up period. The people studied were almost exclusively a male subject population, and female subjects were hardly represented. Most of the studies utilized self-reports of questionnaires, adjective checklists, and semantic differential techniques. Measures of penile erection (volumetric and circumferential), heart rate, pulse volume, and electrodermal response were used. Behavioral techniques of self-monitoring and charting of sexual fantasies, urges, and

behaviors were used. Most of the studies used self-monitoring to assess pretreatment and post-treatment patterns of behavior. There was a small difference in success between the uncontrolled group studies (47%) and the controlled group studies (50%). The frequency of homosexual behaviors and urges showed a larger decrease in the uncontrolled studies, and homosexual arousal, dating behavior, and frequency of coital activity showed larger increases. The studies showed mostly short-term results, or results under five years. No long-term effects were measured after five years.

In 1956 Albert Ellis completed his study involving 40 individuals who he treated for their same sex attraction from 1951 through 1955. His study was made up of 28 males and 12 females who were seen from 5 to 220 sessions of active psychoanalytic psychotherapy because of severe homosexual problems. The results of his study found that 36 percent of the male patients were little or not at all improved; 25 percent distinctly improved; and 39 percent were considerably improved in terms of achieving satisfactory sex-love relations with members of the opposite sex. The results of the female patients showed that 33 percent were distinctly improved and 66 percent were considerably improved. Ellis summary was that the majority of homosexuals who were seriously concerned about their condition and willing to work to improve it might, in the course of active psychoanalytically-oriented psychotherapy, be distinctly helped to achieve a more satisfactory heterosexual orientation (Ellis, 1956).

In 1962 the Society of Medical Psychoanalysts, who were comprised of eight medical psychoanalysts, led by Dr. Irvin Bieber, and one clinical psychologist, did a study of 106 male homosexuals that were in psychoanalytic treatment from 1952 to 1960 for many issues including homosexuality. The Society of Medical Psychoanalysts surveyed 77 of the members of their society who were counseling men who were homosexual. Of the 106 males being counseled

(almost all consisting of white, middle class) 76 of the males were exclusively homosexual and 30 of the males were bi-sexual at the beginning of treatment. The group also studied 100 heterosexual males in psychoanalytic treatment in order to compare common aspects of psychopathology in both groups. The measurement of a client being homosexual or heterosexual was based on their attraction to the same sex or opposite sex. A client who was bisexual was attracted to both sexes. At the end of treatment, 14 of the initially exclusive 76 homosexual men became exclusively heterosexual (19%) and 15 of the initially 30 bi-sexual men became exclusively heterosexual (50%). The study found that the more hours of therapy the men received the greater the likelihood of them shifting to a heterosexual adaptation. Of the patients who received between 150-349 hours of therapy, 9 (23%) became heterosexual. Of the men who received more than 350 hours of therapy, 18 (47%) became heterosexual. Of the 28 men who remained in therapy less than 150 hours, only 2 of the 28 (7%) shifted their sexuality to heterosexual. The key motivating factor that influenced a change in sexuality was the determination and desire of the patient. Of the 29 patients who changed to heterosexuality, 23 of them wanted to change from the onset of treatment. Another significant factor that was common to men transitioning from homosexuality to heterosexuality was the perception that their mothers envied men, giving the possible impression that heterosexual masculinity was of value. Clients who started psychoanalysis at the age of 35 or younger had more success in transitioning to heterosexuality than the clients who started after the age of 35. The expression of an effeminate voice or mannerisms acquired during childhood persisted more frequently in those clients who remained exclusively homosexual after the study. The Society of Medical Psychoanalysts also concluded through their study that the genesis of homosexuality was a combination of fears and inhibitions towards heterosexuality that develops as a pathologic alternative. The study's data

supported the assertion that homosexuality was a pathological condition. Overt homosexuality stemmed from the relationship the child had with the parents, particularly a close binding mother defined as over-protective women who made their children weak and feminine. Another factor was a father who was detached and hostile towards the son (Bieber et al., 1962).

Dr. Lawrence J. Hatterer treated over 200 homosexual men with a variety of supportive, directive and psychoanalytic therapeutic techniques in the 1950's and 1960's. He saw the males from one month to 15 years; from three to 375 hours; and from age 16 to age 65. Some of the patients he followed up on were from two to 15 years after therapy. Of these men, 49 of them recovered to heterosexuality, 19 had partially recovered to heterosexuality and 76 remained homosexual. Hatterer used a scale from zero to six to classify people in terms of their sexuality. Zero (0) meant the person was exclusively heterosexual, no erotic arousals or psychic responses to individuals of their own sex. Six (6) meant the person was exclusively homosexual, only erotic arousals or psychic responses to individuals of their own sex. The individuals, who rated between one and five, fall in-between homo and heterosexual with three being midway or bi-sexual. One of the methods that Hatterer found successful for his patients was to allow them to listen to the tape of their session the following week, two to three times before the next session. This helped in breaking a cyclical pattern of impulsive and compulsive homosexual fantasy and activity and it could help identify specific trigger mechanisms that induced homosexual practice. Hatterer edited many sessions of important therapeutic content onto tapes summarizing important points and information that the client found most beneficial for the clients use. Hatterer believed that numerous factors would elicit a man to experience homosexual feelings, attractions, fantasies and practices. Hatterer called these the trigger mechanisms. Trigger mechanisms were made up of elements including: environmental stimuli such as homosexual

friends, social places, media, attitudes that devalue maleness, biological drive, sexual preoccupation including fantasizing of past homosexual contacts, pornographic viewing, gazing at same sex genitalia, searching for maleness such as size of body- including genitals, masculinity, aggressiveness, sexual virility, rejection and failure with parents, siblings and authority, competition and comparison with others of the same sex in physical terms including height, weight, aggressiveness, sexual performance; and phobic reaction to women that were aggressive, hostile, overprotecting and emasculating. Hatterer believed that in therapy the most effective way a patient could experience change was to learn what specific historical, environmental and interpersonal dynamics trigger their stimulation and perpetuation of their homosexuality, along with an investigation of their family relationships or distorted identifications they might have (Hatterer, 1970).

Pro- Reparative Therapies.

After the APA removed homosexuality from the list of disorders from the DSM II in 1973, there was a dramatic reduction in studies to treat homosexuality. Since homosexuality was widely accepted and no longer an illness and was now considered a healthy way to express one's sexuality, there was no reason to try to cure someone of their same sex attraction. Yet, there remained those therapists who continued to treat individuals who wanted to be freed from their same sex attraction. Over the last 60 years there were a handful of therapists who had a great impact on treating people who had same sex attraction. One of these therapists was Dr. Irvin Bieber, who believed homosexuality was an illness. Bieber believed that homosexuality was caused by environmental factors. Bieber believed that between the third and sixth year of life is where the initial stage of heterosexual responsiveness occurred. In the male, a sexual response to the mother and the competitive feelings towards the father occur at this time, generally known as

the “Oedipus Complex” and mentioned previously. A mother who is pleased and accepting of her son’s masculinity encourages and reinforces a masculine identification in the boy. The father who relates to his son and is supportive of his son’s assertiveness also could reinforce and foster a masculine identification in the boy. This type of parental behavior could develop heterosexuality. The mother could have a negative effect on her son’s heterosexual development by being seductive, over-closely intimate, having a demasculinizing or feminizing attitude, interfering with the father-son and peer relationships and interfering with the development of independence. Mothers who were detached, hostile, controlling and dominating usually carried these characteristics. Detached fathers had a negative effect on their son’s heterosexuality in that they spent little time with their sons so the need for a male model for identification was not realized. The failure of the father to protect his son against destructive maternal influences as well as paternal hostility could contribute to homosexuality. Bieber felt that a boy whose mother is dominate and minimizing towards her husband who is a hostile detached father will become homosexual or have homosexual problems. Boys who exhibited excessive fear of physical injury, excessive dependency, avoided fighting, and avoided peer groups, tended to have same sex attraction. Sibling relationships also contributed to the person’s sexual attraction. The relationship with other siblings did not have as big an impact as the relationship with the parents, but they could affect the child’s sexual attraction development. Having a good sibling relationship with an older brother could make up for a poor relationship with a parent which could reinforce a heterosexual attraction. A traumatic disturbed sibling relationship could push the youth closer towards a homosexual attraction (Bieber et al., 1962).

As far as treating people with same sex attraction, Bieber believed that the most critical aspect for successful therapy was for the homosexual to be motivated to change their same sex

attraction. Bieber, who was a psychoanalyst, found that homosexuals may achieve significant therapeutic goals without necessarily changing their sexual orientation. A change in sexual orientation was not decided by the therapist; it may not even be the primary criterion for improvement. The goal was to resolve as much of a patient's psychopathology as could be accomplished. When irrational beliefs and idea systems that distort interpersonal relationships are clarified and corrected, significant changes in various areas of personality and behavior occur. Bieber believed that therapists should not extinguish homosexual behavior but should address themselves to improving the quality of interpersonal relationships for the client with same sex attraction (Bieber et al., 1962). Bieber's philosophy was similar to what Paul said in Romans 12:2 "Do not conform to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good, pleasing and perfect will."

Another person with a great influence in treating people with same sex attraction was Dr. Charles W. Socarides who had counseled people with same sex attraction since the 1960's. Socarides developed a comprehensive psychoanalytic approach to both male and female homosexuality. Socarides believed Freud, that homosexuality consisted of neurotic conflicts involving the anal and genital stages of sexual development and the oedipal phase. Socarides believed that there were three different homosexual symptoms. One was the oedipal form which is due to the failure to resolve the Oedipus complex and to castration fears which lead to a negative Oedipal position. The other two were called the pre-oedipal form Type I and Type II which oedipal conflicts were dominate and imposed on pre-oedipal anxiety. The pursued homosexual partners in both of these pre-oedipal types represented the client's own self in relation to an active, phallic mother. In the Type II homosexual, splitting processes of the ego,

object and superego were common. The oedipal conflict contained the pre-oedipal danger which was why Socarides recommended the psychoanalysis treatment. He believed that both the pre-oedipal and oedipal anxieties could be alleviated through the exploration of infantile memories, developmental arrests and traumatic states. This resulted in the re-integration and growth of the client. Other treatments for the damage of the pre-oedipal included education, retraining, support interventions and modifications in the handling of transference, resistance and regression. Socarides believed that the success or failure of psychoanalysis of homosexuality lay in the exploration of the unconscious libidinal phase of the negative oedipal complex, the reactive aggression with which it was associated and the effect of the ego and superego structures during the pre-oedipal phase of development (Socarides, 1978).

Socarides also stressed the degree of transference that could be established in the psychoanalysis. Ideally an active rapport could take place in the form of father transference where the positive element dominated. It was crucial to discover the negative elements of the father transference so that the patient may discover and explore the deeper mother transference and pre-oedipal material. Socarides believed that to achieve therapeutic success with the homosexual client a relaxation in resistance was needed. This was best accomplished by the client working through the concept that they were attempting to acquire masculinity (male) or femininity (female) through identification with the sexual partner and their sexual organs. In the male homosexual, the client must see that there once was a strong attachment with his first heterosexual object, his mother. The client must re-experience and understand his frustrations and fixations and give up his attachment to his mother and transfer his sexual interests to other women. All developmental phases needed to be investigated especially the client's identification with his father through the transference experienced in the psychoanalytic sessions with the

therapist. Socarides believed that it was wise not to encourage or prohibit homosexual activity in therapy with most homosexuals. Only until the client's unconscious motivation and fantasy was understood and analyzed could the client then decide on what was the best action for them. Sexual re-education could be necessary throughout the psychoanalysis. Socarides believed that the best way to do this re-education was to uncover and decrease inhibiting anxieties and the sources of infantile guilt. Socarides encountered a common resistance that homosexual clients have is the belief that their homosexuality was biological or a normal form of sexuality and a fear of the removal of homosexual pleasure would result in the client experiencing no pleasure at all (Socarides, 1978).

Socarides had treated psychoanalytically 44 male and female homosexual clients since the 1960's in long term therapy that averaged 3.5 years ranging from three to five sessions per week. Out of the 44 clients, 20 of them (45%) developed full heterosexual functioning and were able to develop love feelings for their heterosexual partners. A key factor in the success was that all of these clients were strongly motivated for therapy (Socarides, 1978).

Another person to have a significant impact on treating people with same sex attraction was Dr. Joseph Nicolosi. Nicolosi believed that homosexuality was a developmental problem that often resulted from early problems between the father and son. The failure of this relationship could result in the boy not being able to internalize a male gender identity. This could lead to an alienation from the father as well as male peers which could lead to an eroticization of maleness. Reparative therapy was the name Nicolosi uses for his psychotherapeutic approach to counseling males with same sex attraction. Reparative therapy placed more emphasis and responsibility on the client to take charge in therapy and the therapist as a passive, directive mentor. Nicolosi saw the male client needing to make assertive and

decisive decisions during therapy to uncover his masculinity. Masculine identity tasks need to be completed in therapy or the male will remain feminine (Nicolosi, 1991).

One of the critical factors Nicolosi believed for the success of reparative therapy was for the client to have a strong self acceptance and a sincere desire for wholeness. The acceptance of homosexuality as being a temporary part of himself and looking at the same-sex urge as a drive for male intimacy. People with same sex attraction needed to first experience and feel their natural gender; males needed to feel masculine. When this happened, the same sex attractions, fantasies, preoccupations would usually diminish. When the natural masculine gender feelings were not experienced, the same sex attractions and behavior would probably increase. Another important step in the change process was for the person with same sex attraction to identify the strengths and weaknesses in their masculinity and realize this was what attracted them to other men. The weaknesses in the homosexual's own masculinity would tell him what characteristics he sought in other men and why he is sexually attracted to them. When the person with same sex attraction grew in these areas of masculinity, a deep change in their personal identification happened which diminished their homosexual attractions and behaviors. Nicolosi suggested that the homosexual develop close, non sexual, mutual relationships with people of the same sex so that other males would less likely remain objects of sexual fantasy and they would experience themselves as a whole person. An element of competition in these male relationships could help the male discover and grow his own masculine strength (Nicolosi, 1991).

Making peace with the father was another important step Nicolosi emphasized for the male with same sex attraction. If there had been a bad relationship with the father, a resolution was needed. The homosexual male needed to forgive and accept his father for who he is. The homosexual male needed to realize that the father didn't hold the key to transform the

homosexual's masculinity, the client did. The client would discover his own defensive detachment from his father caused the damage in his masculinity. The client needed to end this defensive attitude, first with his father and then with all men. Other factors that could help the change process from same sex attraction to heterosexual attraction were a strong motivation, positive sense of self, high tolerance for stress and frustration, being less sexually active, strong family relationships, traditional values, patience with themselves and acceptance with the ongoing homosexual struggle (Nicolosi, 1991).

One of the critical aspects of psychotherapy was transference. Nicolosi found that negative or ambivalent feelings the client had with the therapist could represent frustrations the client had with his father. These painful, negative transferences were an opportunity for growth for the client if he was willing to go back to explore and work through these feelings with the therapist in order to re-gain his own masculinity. After experiencing significant progress, sometimes the client could resist moving forward because of lack of trust. Unwilling to give up homosexual pleasures or the dream of the perfect male soul-mate could be the root of the mistrust. The therapist had to be aware of his own counter-transference issues and make sure they didn't interfere with the therapy. Some common therapist counter-transference issues included his own success or cure rate for the client, the therapist's own hostile negative defensiveness and the therapist's ego needs of admiration from the client (Nicolosi, 1991).

Nicolosi believed that either individual or group therapy could be successful in treatment and usually a combination of both was best. A female therapist could help a male homosexual client in a general way, teaching him about self esteem, identification, feelings expression and trust. She can act as a bridge to support a transfer the client to the male therapist. Only a male therapist could stimulate the re-experience of conflicting feelings with males that was needed to

find masculine identity. Nicolosi found that men in their 20's to early 30's were the best candidates for change. Young males were more difficult because their sexual drive was at its peak and older males usually had many homosexual encounters which were deeply ingrained in their sexual patterns and were difficult to change (Nicolosi, 1991).

In 2000 Dr. Nicolosi did a study, along with Dr. Dean Byrd of the University of Utah and Dr. Richard Potts of the Utah Valley Regional Medical Center. The study surveyed 882 people (689 were men and 193 were women), with 29.9 years the average age of the participants upon entering therapy and the average duration in therapy being 3.4 years. Of the participants, 726 of them stated they received conversion therapy from a professional therapist or pastoral counselor. Over two thirds of the participants (67%) viewed themselves as almost exclusively homosexual or exclusively homosexual before they received conversion therapy. After receiving therapy, 34.3 % of the participants perceived themselves as exclusively or almost exclusively heterosexual. Of the 318 participants who viewed themselves as exclusively homosexual in their orientation before the therapy, 56 or 17.6% of them reported that they viewed themselves as exclusively heterosexual after the conversion therapy, 53 or 16.7% saw themselves as almost exclusively heterosexual and 35 or 11.1% saw themselves as more heterosexual than homosexual. The participants surveyed also reported a decrease in their frequency of their homosexual behavior after therapy. The study also measured the results of conversion therapy which included: increased self esteem and self acceptance, decrease in guilt and shame, increased intimacy with spouse, reduced homosexual thoughts and feelings, increased feelings of masculinity in men and increased feelings of femininity in women. Some of the mechanisms of change that helped the participants change was the support they received in group therapy, individual counseling, having a desire to change, being accountable for their behavior to others,

developing non-sexual relationships with same sex peers and their personal spirituality or faith (Nicolosi, Byrd & Potts, 2000).

Schaeffer and his colleagues did a survey of 184 men and 64 women in 2000 who were attempting to change sexual orientation with the assistance of the Exodus International ministry. The study found that Exodus participants were more heterosexually oriented at the time of the study than they remembered at age 18. The reasons for the changes reported were associated with religious motivation and positive mental health. (Schaeffer et al. 2000) In a follow-up study of 140 of the original participants, Schaeffer found that nearly 61% of the male and 71% of the female participants had abstained from any sexual same-sex contact in the past year. Of those 140 participants, 65% were in the process of changing sexual orientation, with 29% indicating that they had already changed sexual orientation in the last year. Of the remaining 8 participants, 2 indicated that they were no longer attempting reorientation, and 6 were unsure concerning continuation (Schaeffer et al.2000).

Psychologists Mark Yarhouse and Stanton Jones conducted a study on people with same sex attraction in 2007 that addressed two issues: whether it's possible to change sexual orientation and whether trying to do so is harmful. Yarhouse and Jones did the study over a four year period, starting with 98 subjects and ending with 73. Results of the study showed 11 of the 73 remaining subjects (15 %) had self-reported their same-sex attractions were significantly reduced and considered themselves converted to heterosexual attraction. The study showed 17 of the people (23%) still experienced some same-sex attraction but were not currently engaging in overt sexual activity. Twenty one subjects (29%) had not felt much of a change in their same sex attraction, but were still committed to the idea of conversion. An additional 11 people (15%) reported no-response, indicating that they didn’t feel a change in their same sex attraction and

hadn't given up on the idea of conversion. Three people (four percent) of the sample gave up on conversion but did not identify themselves as gay and another six people (eight percent) had given up on conversion and embraced a homosexual identity. The study findings showed that the average participant was not harmed in trying to change their sexual orientation. However, the study could not conclude that every participant was not harmed in their attempt to change their sexual orientation (Jones, Yarhouse, 2007).

Dr. Elan Karten and Dr. Jay Wade conducted a study based on self reported data in 2010 on 119 men who identified themselves as having homosexual attractions. The primary purpose of the study was to examine whether certain psychological and social characteristics were related to reports of change in sexual and psychological functioning in men who were involved in SOCE. The study revealed that the men decreased their homosexual feelings and behaviors, increased their heterosexual feelings and behaviors and had a positive change in their psychological functioning. The study's findings suggested that some men who were dissatisfied with their same-sex attraction felt disconnected from other men and felt they benefited from developing non-sexual affectionate relationships with other men. Married men who sought help with their sexual orientation were more likely than single men to feel they made changes in their functioning. The study also showed the most effective and helpful interventions to be a men's weekend/retreat and a mentoring relationship with another man (Karten & Wade, 2010).

Con- Reparative Therapies.

Most psychologists and psychiatrists believed that it was healthy to express one's same sex attraction and that attempting to change a person's same sex attraction could be harmful and rarely be successful (APA, 2007). One individual who believed that attempting to change a person's same sex attraction would be harmful is Richard Isay. Isay believed from his

experience of counseling men with same sex attraction that any attempt to change a man's homosexuality would inevitably be injurious to the homosexual man's self esteem. Isay stated that he has counseled approximately 40 men in psychoanalysis or analytically oriented therapy. Isay saw a connection between men with same sex attraction who had a low self esteem who also had a negative image of their sexuality and a need to avoid contact with other homosexual men. Isay had seen homosexual men improve their self esteem in therapy when their early problematic relationship with their mothers was analyzed and their homosexual contacts increased. Homo-sociability (non-sexual social relationships) further increased their acceptance of their sexuality and increased their self esteem. Isay believed that any guidance that a homosexual man received to abandon interaction with other homosexual men, whether it be sexual or non sexual, could lead to a lower self esteem and negative self regard (Isay, 1986).

Dr. S. Schwartzberg and Dr. L.G. Rosenberg also believed that attempting to change a person's same sex attraction could be harmful. Schwartzberg and Rosenberg believed that the fundamentals of psychotherapy (empathy, support, commitment and non-judgmentalism) were the key to success in counseling gay and bisexual men. Some of the errors that therapists made that could damage gay and bisexual men included: not asking about same sex fantasies or sexual experiences, applying heterosexual monogamous values on a homosexual relationship and discarding research that included multiple same sex partners; avoiding these errors could lead to a successfully happy and longevity relationship. Not exploring transference and counter-transference attractions in the therapeutic relationship and therapist misreading expressions of self doubt or self condemnation as the client not wanting to be gay or bisexual were also damaging errors that could affect homosexual and bisexual men (Schwartzberg & Rosenberg, 1998).

Dr. A. Lee Beckstead conducted a study in 2001 on the perspectives and opinions of 20 individuals (2 women, 18 men) who went through reorientation therapy. Beckstead believed that the results of the study showed the danger of reorientation therapy in that change may be possible which could lead an individual into a "failure" mind set. Hopes of experiencing heterosexual attractions and eliminating homosexual attractions may turn into harmful disappointments. In addition, all 20 participants described their "conversion" as a long-term process that was often painful. These long-term hopes for a change, along with continued relapse experiences, may be misunderstood as a weakness of the individual rather than the ineffectiveness of the reorientation therapy. This could result in the individual experiencing self-loathing, lowered self-esteem, and hopelessness. The individuals surveyed also reported a benefit from reparative/conversion therapy. Beckstead reported that the participants experienced a sense of peace and contentment as a result of the reorientation therapy. The participants did not indicate a change in sexual orientation but a change in self-acceptance, self-identity, focus, and behavioral patterns. No substantial or generalized heterosexual arousal was reported, and participants were not able to modify their tendency to be attracted erotically to their same sex. The participants self-identified as heterosexual because they decreased their homosexual behaviors. Their self-concepts seemed to develop into more acceptable ones, congruent with their values and needs. Beckstead believed that a change in how to define sexual identity seemed to occur in the participants rather than a change in sexual orientation. The participants in the study may have reoriented toward asexuality such as an absence of fantasies for either sex, rather than toward heterosexuality. Beckstead believed there were positive aspects of the conversion therapy that included providing normalization, support, reframing, workable solutions, empowerment, working within clients' religious values and relational needs,

enhancing self-esteem, self-acceptance, and self-control; increasing gender identity congruence and utilizing support groups to decrease the individual's sense of isolation. Beckstead believed reorientation therapy needed to improve in regards to being clear about therapeutic goals and outcome possibilities and the limitations of sexual reorientation theories and interventions. Reorientation therapists also explored the effects of homophobia and heterosexism internalized by and acted upon their same-sex attracted clients, and looked at the clients' rigid ways of defining self, gender, spirituality, homosexuality, heterosexuality, and relationships. Beckstead believed that there was a questionable reliability and self-presentational biases of surveys based on self-report. Unbiased and objective data, such as psycho-physiological data from sexual arousal assessments, was needed to corroborate self-report findings to understand what type of change was possible in sexual reorientation. Participants in the study expressed satisfaction with their experiences in conversion therapy and indicated that lesbian, gay, bisexual, transgender (LGBT) -affirmative therapy would not have been helpful for them. Therefore, Beckstead believed a broader perspective open to more labels of sexual orientation that was flexible and unbiased enough to help clients explore all options available would be most effective. Although it was important to recognize the legitimacy of the choices and self-defined successes made by participants in this study, Beckstead's did not endorse reparative therapy (Beckstead, 2001).

Dr. Ariel Shidlo and Dr. Michael Schroeder of New York City conducted a study on the effects of conversion therapy in 2002. Originally, the goal of the study was to document the negative effects of and harm done by conversion therapies (the original title of the study was "Homophobic Therapies: Documenting the Damage"). Shidlo and Schroeder soon discovered that some participants reported having been helped as well as harmed. The project was then

changed to the current title. “Changing Sexual Orientation: Does Counseling Work?” The new goals of the study were to add to the evidence on conversion therapies so that consumers could make an increasingly informed choice about engaging in conversion therapy and to identify how consumers perceived their failure to change or their success in changing. The examination of the ethical issues of conversion therapy was also explored. Shidlo and Schroeder conducted structured interviews between 1995 and 2000 for 202 people that felt they were more or exclusively homosexual at the start of their re-orientation therapy. The study found that 176 (87%) of the participants believed that they failed the conversion therapy, or their sexual orientation had not changed. The study also found that 26 (13%) of the participants believed the conversion therapy was a success. Four percent were successful in changing their sexual orientation and nine percent were happy with being celibate with their same sex desire. The study identified two groups of participants who failed the conversion therapy. One group of 155 individuals experienced significant long-term damage from the conversion therapy including depression, suicidality and lowered self-esteem. Another group of 21 individuals demonstrated psychological hardiness and felt strengthened by their experience of the conversion therapy. The participants reported feeling an increase in their sense of belonging, insight and self-esteem. Shidlo and Schroeder recommended that the clinicians provide detailed informed consents to clients about the possible benefits and drawbacks of the re-orientation therapy. If the results of the re-orientation therapy disappointed the client, the clinician needed to educate the client about the developmental pathways that conversion clients go through; explore the positive and negative outcomes of the conversion therapy experience, and educate the client with accurate information about the lesbian and gay communities, lives, and relationships (Shidlo & Schroeder, 2002).

Douglas C. Haldeman, PhD, believed that there was a potential for harm for those who tried some form of conversion therapy. Common problems presented by patients following an unsuccessful therapeutic attempt to change sexual orientation included poor self-esteem, depression, guilt, social withdrawal, religious and spiritual concerns, and sexual dysfunction. Haldeman believed that conversion therapies relied on the therapeutic relationship, specifically the transference between the client and therapist, to create a change in sexual orientation (because of an arrest in the psychosexual development of the individual due to an inadequate identification of the same sex parent). The client was expected to identify and bond with the male therapist and enjoy the therapist's approval when the client was able to develop heterosexual relationships. However, if the process fails, there was potential for harm. Haldeman after twenty years of his clinical work with individuals who had undergone some form of conversion therapy came to the conclusion that conversion therapy could be harmful. He also stated that not all individuals were harmed by conversion therapy as well as not all conversion therapies were harmful. It was not uncommon for some to report that a failed attempt at conversion therapy had an indirectly beneficial effect of releasing the denial surrounding their sexual orientation. Halderman also believed that mental health professions should not try to stop the use of conversion therapies (Haldeman, 2001).

Lee Beckstead and Susan L. Morrow did a study on 50 individuals who practiced the Mormon religion and had been through conversion counseling to change their sexual orientation. They studied the participants' motivations for seeking conversion therapy, their perceived benefits and harms of the therapy and the factors that promoted self-acceptance and consolidation of a positive self-identity. The study was also designed to understand the Mormon clients' experiences before, during, and after the conversion therapy and to develop an approach

to resolve religious conflicts with same-sex attractions. In the study, 42 individuals (4 women, 38 men) chose to be interviewed. Of these, 20 (2 women, 18 men) reported only positive outcomes (proponents) and 22 (2 women, 20 men) reported primarily negative outcomes (opponents). Other sources used for the study included participants' journals, focus-group discussions, participant verifications, and Beckstead's field notes and self-reflective journal. The proponent's average age was 40 and they spent an average of four years in conversion therapy. The opponent's average age was 35 and they spent an average of one and a half years in conversion therapy. All participants felt a need to change their sexuality because being heterosexual was the only way to avoid self-hatred, isolation, confusion, rejection, and suicide (Beckstead & Morrow, 2004).

The participants underwent some form of professional therapy that used conversion therapy principles and religious interventions that believed the cause of homosexuality was that people sexualized emotional same-sex needs that resulted from gender inferiority, unhealthy parental relationships, abuse, or a combination of the three. Treatment focused on strengthening traditional gender roles, developing nonsexual same-sex relationships and relying on God. Several opponent participants described experiencing other approaches that were ineffective, including aversion treatments (electroshock or chemicals); behavioral management treatments (orgasmic reconditioning and rubber bands snapped on the wrist); cognitive-behavioral therapy treatments (recording thoughts and behaviors, changing self-talk, and distracting or reframing sexual feelings); visual imagery treatments; hypnosis; medicinal or hormonal treatments; marriage counseling; rapid eye movement; obsessive-compulsive disorder treatments; and chiropractic treatments. Both proponent and opponent participants in the study found positive benefits in their conversion therapy experiences which included: hope, answers, and relief; found

a place to belong and fit in; enhanced same-sex relationships; sexuality became congruent with values; enhanced gender identity and self-exploration. Both proponent and opponent participants in the study felt harmed in their conversion therapy in that they felt the feelings of suicidality (Beckstead & Morrow, 2004).

Opponent participants felt harmed in many other areas including, 1) false hopes and disappointments, 2) increased self-hatred, 3) decreased self-esteem, 4) increased denial and emotional distress, 5) dehumanization and being untrue to self, 6) increased depression and suicidality, 7) lost loves and friendships, 8) wasted time and resources, 9) a slowing down of the "coming-out" process, 10) decreased capacity for same-sex intimacy, 11) damaged parental relationships, and 12) lost faith and spirituality. Almost all of the opponents and a few of the proponent participants expressed disappointment with conversion theories, techniques, and ideology. All participants from both samples reported not experiencing a substantial increase of generalized opposite-sex attraction. Yet, several from both samples talked about experiencing new sexual feelings. Several proponent participants reported an increase in attraction only to their spouse that heterosexual arousal was not as important as the emotional intimacy they felt with their spouses and many felt a significant decrease of same-sex attractions. The study showed that positive aspects were reported by the participants in the reparative therapy and the components in reparative therapy were found in most effective therapies including religious validation, reframing, congruent solutions, behavioral strategies, and group work. Beckstead and Morrow denounced the practice of conversion therapy, its underlying theories and ideology because the benefits gained by participants in conversion therapies could be gained through alternate therapies and the potential exists for conversion therapy to cause significant harms,

therefore, it was unnecessary and unethical to continue offering such treatments (Beckstead & Morrow, 2004).

Religious Organizations

There were many religious based organizations that supported and helped people who wanted to eliminate their unwanted same sex attraction. Religion based therapy believed that there were moral standards that needed to be followed because they had been revealed by God. Some of these moral standards could be found in the Bible. In the Hebrew scripture, or Old Testament in the Bible, a story of homosexuality occurred in the book of Genesis, written around the 15th century B.C. In the story of Sodom and Gomorrah, found in Genesis chapter 19, the entire city was destroyed by God because of inhospitality among the citizens and other sinful activity, including the sexual act of homosexuality. There were many other citings in the Hebrew Scriptures that condemned the homosexual act. The book of Deuteronomy 23: 17-18, prohibited male sodomy and female prostitution. Leviticus 18:22 prohibited the lying of male with another male (sodomy) and called it an "abomination". A more accurate interpretation for abomination in Leviticus 18:22 was "being led astray" (Goldberg, 2009). First Kings 14:24 also prohibited male homosexual activity. Leviticus 20:13 prescribed the death penalty to any man who committed the homosexual act. Other researchers interpreted the homosexual act and the above scriptural references as meaning male prostitution and not sex between two males. Some historians believed that the Hebrew Scriptures contained stories celebrating homosexual love. The story of King David and Jonathan's (son of King Saul) friendship, found in 1 Samuel 18, where David recalled Jonathan's love as "wonderful and passing the love of women", was interpreted as an example of homosexual love between two men. The strong devotion that Ruth had for her mother-in-law Naomi in the book of Ruth 1:16 is interpreted to mean that the two

women were possible homosexual lovers (Spencer, 1995). Most theologians disagreed with these interpretations of homosexual love or behavior (Goldbe rg, 2009).

In the New Testament portion of the Bible there are references made about the subject of homosexuality. Roman 1: 26-27 reads: "Because of this, God gave them over to shameful lusts. Even their women exchanged natural relations for unnatural ones. In the same way the men also abandoned natural relations with women and were inflamed with lust for one another. Men committed indecent acts with other men, and received in themselves the due penalty for their perversion." Paul also talked about homosexual sex in 1 Corinthians 6:9-10 "Do you not know that the wicked will not inherit the kingdom of God? Do not be deceived: Neither the sexually immoral nor idolaters nor adulterers nor male prostitutes nor homosexual offenders nor thieves nor the greedy nor drunkards nor slanderers nor swindlers will inherit the kingdom of God." The book of Jude in verse seven warned those who indulged in the sexual actions of Sodom and Gomorrah would "suffer the punishment of eternal fire." Other early Christian writings also described sodomy as unacceptable Christian behavior (The Didache - written approximately 70 A.D.), The Letter of Barnabas (74), Justin Martyr (151), Clement of Rome (190), Tertullian (220), Cyprian (253), Arnobius (305), Eusebius (319), John Chrysostom (391) and Augustine (400)). (DeYoung, 2000) The early Christian leaders (St. Clement of Alexandria, St. John Chrysostom, St. Eusebius of Caesrea, St. Gregory of Nyssa, St. Ambrose and St. Jerome) approved sexual relations only in marriage (Spencer, 1995). St. Augustine, probably the largest influence on the early Christian Church, also believed that the sexual act should only be expressed between a man and a woman in a marriage when open to life. In his Confessions, Augustine wrote of sodomy as a vicious deed contrary to nature which should be avoided by every city, custom and nation and established by law (Augustine & Chadwick, H. 1992).

Augustine was greatly influenced by Plato and in his writings once said that Plato was the first Christian philosopher before Christ because of Plato's strong beliefs on the value of virtue and his similar views on sex as Christianity (DeYoung, 2000).

Religious based programs believed the power of God could change the homosexual behavior that people with same sex attraction experience. Examples of these religious based organizations include JONAH (Jews Offering New Alternatives for Healing), Exodus and Courage. JONAH sought to reunify families through psychological and spiritual counseling, peer support, and self-empowerment, to heal the wounds surrounding homosexuality and to provide hope. JONAH was launched in 1998 with its outreach extending to five continents and more than a dozen countries which provided services to thousands of individuals. JONAH believes that homosexuality is a learned behavior that anyone could choose to eliminate if motivated and supported in that process. JONAH used multiple healing strategies when treating men with homosexual attractions. These include: Biblio-therapy (utilization of books, reading materials, tapes, video cassettes); Experiential Healing Weekends (discussions, psychodrama, journaling, and individual "drills"); Healing of the Family System; Individual Psychotherapy; Jewish Spiritual Development ; Masculinity Development and Empowerment; Mentoring, Networking, Support Groups; Overcoming Shame and Narcissism; and Receiving Healthy Touch and Affection (Jonah, 2010).

Exodus is the largest Christian referral and information network in the world dealing with homosexual issues. Established in 1976, Exodus is a nonprofit, interdenominational Christian organization promoting the message of: Freedom from homosexuality through the power of Jesus Christ. Exodus' process of being freed of unwanted same sex attraction begins with the individual's motivation and self-determination to change based upon a personal relationship with

Jesus Christ. Exodus believes that reparative therapy, a holistic, counseling approach to addressing unwanted same-sex attraction, can be a beneficial tool. Exodus does not conduct clinical treatment, but provides referrals to independent professionals as well as other resources including spiritual mentorship and support to those wanting to reconcile their faith-based beliefs with their sexual behavior (Exodus, 2010).

Courage, an apostolate of the Roman Catholic Church, ministers to those with same-sex attractions and Encourage ministers to family and friends of people with same sex attraction. Courage was founded in 1980 in New York by a Roman Catholic priest, has grown to more than 110 Chapters and contact people world-wide and helps thousands of men and women find peace through fellowship, prayer, and the Sacraments. Courage doesn't offer traditional counseling to its individuals per se, but it does have five goals for the individuals it serves. The goals include living a chaste life; prayer and reception of the sacraments; fellowshipping with others who have same sex attraction and being a good example to others (Courage, 2010).

Spitzer Study

One of the most controversial studies done on conversion therapy was done in 2001 by Dr. Robert L. Spitzer. His was a study about people who had same sex attraction which questioned if they could change through therapy and become attracted to people of the opposite sex. He played a key role in the decision to remove homosexuality as a disorder from the DSM II in 1973. His findings in his study in 2001 revealed that it was possible that individuals with same sex attraction could change and become attracted to members of the opposite sex. Dr. Spitzer's study not only measured the individuals change in behavior but also measured their change in feelings, fantasies and attractions which made the study unique among other studies (Throckmorton, 2004). Dr. Spitzer selected 200 volunteers (143 males, 57 females) who had

been through reparative therapy for their same sex attraction at least five years before being surveyed. The mean age of the male and female participants was in their early to mid 40's. Of those married, 76% were men and 47% were women at the time of the interview, while 21% of the males and 18% of the females were married before the therapy began. Almost all the participants were Caucasian (95%) and most of them had completed college (76%). Participants that were surveyed mainly lived in the United States with most of them being Christians (90%). The vast majority (93%) of the participants reported that religion was "extremely" or "very" important in their lives. Dr. Spitzer interviewed the individuals to measure where their attraction was a year before their therapy started (sex attraction, fantasy, yearning, and overt homosexual behavior) and then five years after the therapy was finished (Spitzer, 2003).

Spitzer believed that the study indicated some gay men and lesbians, following reparative therapy, made major changes from a predominantly homosexual orientation to a predominantly heterosexual orientation. The majority of the people surveyed reported a change from a predominantly or exclusively homosexual orientation before therapy (males, 46%; females, 42%), to a predominantly or exclusively heterosexual orientation when surveyed (males, 11%; females, 37%). The female participants reported significantly more change than did the male participants. Either the male and female participants actually changed their predominantly homosexual orientation to a predominantly heterosexual orientation or they lied about having changed their sexual orientation, or both. Dr. Spitzer believed the participants' self-reports as credible and that possibly only a few participants elaborated or lied for the following reasons:

1. Only a small amount of the participants experienced a complete change in sexual attraction.
2. The participants used change strategies that were commonly effective in psychotherapy.

3. The gender differences found in the study were consistent with the literature suggesting greater female plasticity in sexual orientation.

The survey also addressed the question of whether or not therapy for same sex attraction was harmful. The participants reported that they were "markedly" or "extremely" depressed before the therapy (males 43%, females 47%), but rarely depressed afterwards (males 1%, females 4%). Other results of therapy, besides from change in sexual orientation, were feeling more masculine (males) or more feminine (females) (87%) and developing intimate nonsexual relations with the same sex (93%). The study concluded that there was evidence that change in sexual orientation following some form of reparative therapy does occur in some homosexual men and women. He also believed that the results of his study questioned the current conventional view that desire for therapy to change sexual orientation is always succumbing to societal pressure and irrational internalized homophobia. Dr. Spitzer believed that some individuals wanted to change their sexual orientation because of a rational, self-directed goal. Also his study suggested that the mental health professionals should stop moving in the direction of banning therapy that has as a goal to change a person's sexual orientation. Dr. Spitzer further recommended that a study be done on volunteer individuals who were evaluated before starting reparative therapy and after several years of therapy was completed to better measure how often significant change in sexual orientation was reported (Spitzer, 2003).

Spitzer's study was published in the October 2003 issue of the Archives of Sexual Behavior and many psychologists and psychiatrists gave their opinions of the study which was captured in articles titled "Peer Commentaries on Spitzer", also written in the October 2003 issue of the Archives of Sexual Behavior. John Bancroft, M.D., believed Dr. Spitzer's sincerity in carrying out his study. He also pointed out some limitations. The sample consisted of men and

women who principally sought treatment because of their religious beliefs and who were presenting themselves as evidence that such change was both possible and desirable for others. Bancroft also felt it was difficult to discern from the study what the "reparative therapy" had involved. Bancroft believed Spitzer's findings were consistent with the idea that some people do change their sexual orientation in some respects during the course of their lives, but believed the study's findings did not justify the existence of "reparative therapy" (Peer Commentaries on Spitzer, 2003).

Dr. A. Lee Beckstead felt that the self-reports of the clients in Dr. Spitzer's study were not reliable. Beckstead felt another limitation of Spitzer's study was his selective reporting of clients' experiences which failed to describe the experiences of those individuals for whom reparative therapy did not work. Beckstead's biggest concern was that Spitzer's description of his data was misleading. He believed that "policy makers, religious leaders, families, and individuals in conflict may believe that all homosexual or bisexual individuals could (and, therefore, should) be heterosexual if they just tried hard enough." Beckstead felt that the study was important in that it demonstrated that a subset of same-sex attracted individuals could adapt successfully to live in a heterosexual relationship (Peer Commentaries on Spitzer, 2003).

Milton L. Wainberg, M.D., and 13 other doctors and researchers, at the Department of Psychiatry, in the New York State Psychiatric Institute, addressed many scientific problems of Spitzer's study. Wainberg cited methodological limitations of his study, including involvement of an unblinded research interviewer and the potential fallibility of participants' self-reports. He also criticized Spitzer's recruitment of a sample only interested in demonstrating change of sexuality, potentially creating a bias; not establishing a control group, leaving the study unable to demonstrate or determine that the reparative intervention was responsible for any reported

changes; lack of operational definitions of "homosexuality," "heterosexuality," or "bisexuality," and the use of a telephone interview with an invalidated instrument. Other criticisms included that the survey could have put the study's clients in danger of experiencing any unnecessary physical and mental suffering violating the Nuremburg Code. Finally, Wainburg believed the study implied that "change" in sexual orientation was possible, without indicating how likely it was for a given individual to achieve any degree of "change". Wainberg believed that this suggested that most or all homosexuals could "change" their orientation if sufficiently motivated and served only to reinforce the false notion that homosexuality was a choice. Thus, Wainburg concluded the report created an unsupported impression, that reparative interventions were effective ,which is unethical (Peer Commentaries on Spitzer, 2003).

Other psychiatrists and psychologists had more favorable reviews for Spitzer's survey. Dr. Dean Byrd viewed Spitzer's study as essentially reopening the debate over whether or not homosexuality was changeable. Spitzer provided evidence that some homosexual men and women were able to change self-identity and their features of sexual orientation, including fantasies, desires and attractions. Thus, his research made an important contribution to the growing amount of other studies on people's ability to change. Byrd pointed out that Spitzer's sample size was larger than those of prior studies. Spitzer considered the affective components of the homosexual experience and was very specific and detailed in his assessment as compared to other studies. Spitzer demonstrated clearly how the subjects were evaluated by using a structured interview. Spitzer only surveyed people who reported at least 5 years of sustained change from a homosexual to a heterosexual orientation. Virtually all bias in the interview coding was eliminated by excellent inter-rater scores. The entire set of the surveys data was available to other researchers. Spitzer had been and continues to be, supportive of gay

affirmative therapy and gay rights which showed that he was interested in finding the scientific truth about the issue and was not biased about demonstrating homosexuality being mutable. Byrd suggested that the suppression of data and discouragement of further scientific research on homosexuality should not be tolerated and was far from complete. Byrd believed that it is ethical and within the range of science to encourage the study of change in homosexuality. He cited a former president of the American Psychological Association (APA), Robert Perloff, in 2001 when he said about reorientation therapy with homosexuals: "It is considered unethical-That's all wrong. First, the data are not fully in yet. Second, if the client wants a change, listen to the client. Third, you're barring research" (Peer Commentaries on Spitzer, 2003).

Dr. Jerome C. Wakefield believed that Spitzer's study puts questions about sexual orientation change into the scientific domain and opens them to further scientific examination. He viewed Spitzer's subjects self reports as credible because many males reported post-therapy continuing significant same-sex masturbatory fantasies (45%) and significant same-sex attraction (50%) as well as standard cognitive, psychodynamic, and behavioral therapy techniques that have face validity as the causes of sexual orientation changes. Wakefield believed that the study showed that reorientation therapy was sometimes ethically allowable, contrary to recent professional association edicts. The study showed that the subjects' symptoms of depression, bothered by homosexual feelings declined dramatically from pre to post therapy. Wakefield stated it was unethical to ignore evidence of reduction of suffering in some highly motivated, deeply conflicted patients when considering treatment options, especially given the lack of any proven alternative. Wakefield agreed with the study that recent APA statements declaring reorientation therapy unethical, were potentially oppressive to some clients and should be revised. Wakefield was impressed that Spitzer went beyond reporting changes in the subjects'

orientation self-labeling, symptoms, and behavior; but also reporting their experiential variables (e.g., fantasies during masturbation and intercourse, attraction, lustful looking) that were generally more valid indicators of sexual orientation, which changed substantially, although not as much as self-labeling, symptoms, and behavior (Peer Commentaries on Spitzer, 2003).

Dr. Mark A. Yarhouse stated the key to understanding Spitzer's study was to understand that Spitzer examined whether anyone had ever experienced a change of sexual orientation, not how likely it was that someone will experience change of orientation. Spitzer's study suggested that there have been people who have changed their sexual orientation. Spitzer's study was not a treatment efficacy study and it should not be criticized for failing to provide evidence for that which it was never designed. Yarhouse stated that more research was needed to discover which variables were better predictors of the likelihood of change in one's sexual orientation and researchers interested in the scientific study of sexuality should to try to answer such complicated questions (Peer Commentaries on Spitzer, 2003).

Spitzer replied to the 26 peer review of his study in October of 2003. Spitzer stated the primary research question should have been "Contrary to conventional wisdom, do some ex-gays describe changes in attraction, fantasy, and desire that are consistent with true changes in sexual orientation?" instead of "Can some gays change their sexual orientation". Spitzer believed that the critics of his study who questioned the credibility of his subjects' self-reports of change should be equally critical of the studies done by Beckstead and of Shidlo and Schroeder for accepting their subject's self-reports of no change in sexual orientation. Another criticism to Spitzer's study was that the recruitment strategy and study design were biased towards positive findings. Spitzer responded in that the studies done by both Beckstead's (2001) and of Shidlo and Schroeder's (2002) were the same as his; they listened to former homosexuals who believed

that reorientation therapy worked as they answered questions about their sexual feelings, both at the time of the interview and retrospectively. The entry criteria for Spitzer's study required some minimal report of change in sexual attraction, whereas, in Beckstead's and of Shidlo and Schroeder's studies the only requirement was that the subject claimed to be an ex-gay. Spitzer's study had essentially the same design and a similar recruitment strategy of ex-gay subjects as in the Beckstead (2001) and Shidlo and Schroeder (2002) studies. Spitzer raised the question of why so very few of their subjects gave answers consistent with a change in sexual orientation, whereas, the majority of Spitzer's subjects did give consistent answers. Spitzer believed that the critics were correct in claiming that significant response bias could have been present in his study but they certainly had not proved that it was present or that the study results suggested response bias. Spitzer also stated that there were some historical parallels in his study that were similar to studies of the past that focused on people with same sex attraction. One parallel was a study done by Hooker in 1957 which addressed the question of whether any homosexuals are without significant psychopathology; her study did not attempt to find out how often homosexuals were without psychopathology, just that some homosexuals did exhibit this. Another historical parallel is that many of the study critics asserted that Spitzer's subjects had deceived themselves into believing that their sexual orientation had changed, so, too, in the 1970s the belief was that when homosexuals said they were comfortable with their sexual orientation they were also deceiving themselves. The last parallel was a personal historical parallel to Spitzer in that he has experienced anger for doing this study as well as for his involvement in the removal of the diagnosis of homosexuality from DSM-II in 1973 (Repy by Spitzer, 2003).

APA Report

The American Psychological Association assigned a task force to report on "Appropriate Therapeutic Responses to Sexual Orientation" in 2007. In this report the APA wanted to answer three questions: (1) Are sexual orientation change efforts (SOCE) effective at changing sexual orientation? (2) Are SOCE harmful? (3) Are there any additional benefits that can be reasonably attributed to SOCE? The task force evaluated peer-reviewed journal articles from 1960 to 2007 which included 83 studies, mainly before 1978. In this evaluation they found that there were many methodological problems in the research and only a few studies met the standards for evaluating whether psychological treatments, such as efforts to change sexual orientation, were effective. The limited amount of methodologically sound research that recent SOCE have led the APA to claim that they were not effective. Methodological problems included internal validity concerns: lack of comparison groups, rare long term follow-up, client attrition and unreliable retrospective self reports. Construct validity concerns included inconsistent definition of sexual orientation, unclear study treatments, unreliable measures and client knowledge of the study. Additional limitations included problems with conclusion validity (the ability to make inferences from the data) due to small or skewed samples, unreliable measures, and inappropriate selection and performance of statistical tests (APA Task Force, 2009).

The APA task force reviewed the research done by the peer-refereed empirical research which described the beneficial or harmful evidence on the outcomes associated with SOCE. The task force looked at the results from the early experimental studies of aversive techniques which provided some evidence that these treatments could reduce self-reported and physiological sexual arousal for some men. An important element in the results of these experiments was that

rarely did a study compare treatment outcomes to an untreated control group. One study that did was conducted in 1974 by Dr. Barry Tanner that compared homosexual men who received aversion therapy with those who did not (APA Task Force, 2009). Tanner assigned eight men identifying themselves as homosexuals to an automated aversive conditioning group (shock) and eight others to a waiting list control group. At the end of eight weeks, the aversive conditioning group showed significant decreased in erectile responses to slides of male nudes, in self-rated arousal to male slides, and on the Mf scale of the MMPI, while showing significant increases in reports of frequency of sex with females, frequency of socializing with females, and the frequency of sexual thoughts about females vs. males. Because Tanner's study compared people who received treatment with people who did not, it could, therefore, rule out the possibility that other factors, such as being motivated to change, were the true cause of any change the researchers observed in the study participants. The task force's research concluded that the average proportion of men who were reported to change in uncontrolled studies is almost double the average proportion of men who reported to change in controlled studies. Overall, the early studies showed modest short-term effects on reducing same-sex sexual arousal may be obtained for a minority of clients through some forms of SOCE, mainly interventions involving aversion procedures such as electric shock (Tanner, 1974).

The task force looked at early studies that attempted to decrease same sex sexual behavior and found that the more rigorous the study the greater the decrease in short-term same-sex sexual behavior for a minority of men. Quasi-experimental results were that that a minority of men reported reductions in same-sex sexual behavior following SOCE. The non-experimental studies found that clients reported reduced behavior but also found that reductions in same-sex sexual behavior, when reported, were not always sustained. The task force looked at early

studies that attempted to increase other sex sexual attraction and found that the research provided little support for the ability of interventions to develop other-sex sexual attraction where it did not previously exist, though it may be possible to accentuate other-sex sexual attraction among those who already experience it. The task force looked at early studies that attempted to increase other sex sexual behavior and found that the studies indicate that while some people who undergo SOCE do engage in other-sex sexual behavior afterward, the balance of the evidence suggests that SOCE is unlikely to increase other-sex sexual behavior. The task force looked at early studies that attempted to improve mental health and found that the lack of high-quality data on mental health outcomes of efforts to change sexual orientation provide no sound basis for claims that people's mental health and quality of life improvement (APA Task Force, 2009).

More recent studies investigated whether people who participated in conversion therapy reported decreased same-sex sexual attractions (Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003) or how people evaluated their overall experiences of SOCE (Beckstead & Morrow 2004; Shidlo & Schroeder, 2002; Wolkomir, 2001). Because these studies used designs that did not permit cause-and-effect attributions to be made, the task force concluded that none of the recent studies could address the efficacy of SOCE or its promise as an intervention, whether it was measuring attraction or behavior. However, these studies could be useful in describing people who pursued SOCE and their experiences of SOCE. The task force looked at studies that showed some evidence to indicate that individuals experienced harm from SOCE. Early studies document iatrogenic effects of aversive forms of SOCE. High dropout rates in early aversive treatment studies have been an indicator that research participants experienced these treatments as harmful. Recent studies indicated that there were individuals who believed they had been harmed and others who believed they had benefited from SOCE treatment. It was unclear what

specific individual characteristics and diagnostic criteria would prospectively distinguish those clients who benefited from treatment and from those who had been harmed (APA Task Force, 2009).

The task force next looked at the problem of sexual orientation distress, as it existed in the lives of individuals who sought sexual orientation change. The recent literature that the APA task force reviewed identified a population of mostly white men who were strongly religious, and participated in conservative religious faiths. The studies reported both benefits and harm that the individuals experienced when trying to change their sexual orientation. The benefits included social and spiritual support, a lessening of isolation, an understanding of values and faith and sexual orientation identity reconstruction. The harms included depression, increased chance of suicide, decreased self-esteem, decreased authenticity to others, increased self-hatred, negative perceptions of homosexuality, decline in faith and a perception of having wasted time and resources. Because of the lack of empirical research in this area, the task force concluded that the results be viewed as tentative. The task force emphasized that the benefits from the conversion therapy were not unique to SOCE and could be provided within a competent and affirmative therapeutic framework that could reduce the unhealthy aspects of SOCE by addressing sexual stigma while understanding the importance of religion and social needs. The task force recommended affirmative therapeutic interventions for adults who desired to change their sexual orientation or their sexual behavior that provided (1) acceptance and support (unconditional acceptance and support for the various aspects of the client), (2) assessment, (3) active coping (both cognitive and emotional strategies to manage stigma and conflicts), (4) social support, and (5) identity exploration and development (offering permission and opportunity to explore a wide range of options) (APA Task Force, 2009).

The task force looked at issues involving children and adolescents and recommended that therapists avoid treatments that attempted to prevent homosexuality in adulthood by promoting stereotyped gender-normative behavior in children to diminish behaviors that were perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood and provide instead multicultural, client-centered, and affirmative treatments that are developmentally appropriate. The task force questioned involuntary and coercive interventions and residential centers for adolescents due to their advocacy of treatments that have no scientific basis and potential for harm due to coercion, stigmatization, inappropriateness of treatment level and type, and restriction of liberty. The task force recommended that the therapists assess the adolescent's ability to understand treatment options, provide age appropriate informed consent to treatment that was consistent with the adolescent's level of understanding and obtain the child's assent to treatment (APA Task Force, 2009).

The task force pointed out that the results of the research relevant to the ethical concerns that were important in the area of SOCE indicated that it was unlikely that individuals could reduce same-sex attractions or increase other-sex sexual attractions through SOCE. The task force cautioned therapists against promising sexual orientation change to clients. The task force pointed out that Principle A of the APA Ethics Code, Beneficence and Non-malfeasance, established that psychologists aspire to provide services that maximized benefits and minimized harm. Scholars and health care professionals highly prioritize the avoidance of harm for the client. The literature on effective treatments and interventions stresses that effective interventions do not have serious negative side effects. The task force believed the research on harm from SOCE was limited and suffered from methodological limitations that make it difficult to draw accurate conclusions. Early experiments that used aversive and behavioral interventions

caused harmful mental health effects such as increased anxiety, depression, suicidality, and loss of sexual functioning. Because of this the task force encouraged therapists to consider affirmative treatment options when the clients presented requests for sexual orientation change (APA Task Force, 2009).

Summary

Before 1973, there had been studies done to "cure" or change the sexual orientation of people with same sex attraction. The success experienced in these tests ranged from 25-50% of people strengthening or changing their attraction from homosexual to heterosexual. Common methods used included 1) aversion therapies such as electric shock, nausea and chemical; 2) desensitization, 3) orgasmic reconditioning, 4) classical conditioning, 5) cognitive-behavioral therapy treatments such as recording thoughts and behaviors, changing self-talk, and distracting or reframing sexual feelings. Other methods included visual imagery treatments; hypnosis; medicinal or hormonal treatments, and psychoanalytic treatment. After homosexuality was removed from the DSM, the number of studies decreased and the methods of treatment changed. Conversion or reorientation therapy became the common means to help people decrease or change their unwanted same sex attraction to heterosexual attraction after the 1970's. Conversion therapies included psychoanalysis, increasing masculinity, forgiveness, male mentoring and group therapy among others. Success rates for conversion therapies ranged from 10-25% on average. The benefits of the therapy included decreasing same sex attraction and increasing heterosexual attraction; increased self acceptance, self identity, sense of belonging; enhanced gender identity, insight and hopefulness. Because of the APA's acknowledging homosexuality as a healthy way to express one's sexuality, studies have been done on the harmful effects of conversion therapies. These harmful effects included lowered sense of self;

negative image of sexuality and self; hopelessness, depression, guilt, social withdrawal, sexual dysfunction, false hopes, damaged parental relationship, wasted time and suicidality. Dr. Spitzer, who was a major influence to remove homosexuality from the DSM, conducted a study that showed people can change their same sex attractions to heterosexual attractions with little risk of being harmed. The APA does not consider studies based on individuals self reports as valid measures when looking at the harmful effects or change rates of people with same sex attraction. However, the APA does recommend that people who have same sex attraction not attempt to change because it can be harmful and probably ineffective.

Chapter 3

Research Design

Introduction

This study attempted to determine if it was possible to change one's same sex attraction through re-orientation therapy and if it was harmful or helpful in terms of the individual's well-being. The American Psychiatric Association and the American Psychological Association (APA) and many other medical organizations recommended that people with same sex attraction not attempt to change their sexuality because it can be harmful and probably ineffective (APA Task Force, 2009). The APA made this claim despite evidence from past and current studies that showed that individuals had experienced success in their attempts to change their unwanted same sex attraction and also claimed that there was not any mental, physical, emotional or spiritual harm or side effects that they experienced during the re-orientation therapeutic process (Karten, 2010; Spitzer, 2001; Nicolosi, Byrd & Potts, 2000). The APA did not validate these studies because the studies did not show long term effects or the studies were based on self reports. The APA discouraged individuals from trying to change their same sex attraction despite the ethical principal that APA stressed in their code of conduct to recognize and respect the client's autonomy or self determination which ultimately respects the rights of the client's to hold values, attitudes, and opinions that differ from the therapists (APA website- Ethical Principles of Psychologists and Code of Conduct).

Problem Statement

, Can individuals change their same-sex thoughts, feelings and/or behaviors to opposite-sex-directed thoughts, feelings and/or behaviors after receiving reparative therapy. Is reparative therapy helpful or harmful for people who have same sex attraction.

Research Design

The instrument used to measure the effects of re-orientation therapy on men was an on-line survey. The researcher contacted ex-gay ministry groups and affiliated private therapists throughout the United States, known to have individuals who were involved in conversion therapy efforts. These contact people informed qualified individuals who had been through or were currently in therapy for their same sex attraction about their interest in taking the survey. These qualified individuals were given an internet link to fill out the survey on-line through www.constantcontact.com in January of 2011. The survey was confidential in that the participants who filled out the survey were not required to give out their name or any other form of identification. The website was secured with a firewall and password only available to the researcher who conducted the survey. The survey was comprised of 88 multiple choice questions designed to answer three pertinent questions of the study. The survey included 18 questions that attempted to answer the first pertinent question that assessed change in homosexual and heterosexual thoughts, feelings and behaviors. There were 54 questions that attempted to answer the second and third pertinent questions on the survey about helpful and harmful counseling experiences. After the survey participants completed the on-line survey through Constant Contact, the results were automatically tabulated through Constant Contact. The participants involved in the study were adult men who participated in any form of conversion intervention (e.g., any type of therapy administered by a mental health professional, a support group or any activity aimed at changing homosexual attraction and/or behavior). The participants were required to have some past or current form of same sex attraction, but did not necessarily have to possess more homosexual feelings than heterosexual feelings to be included. The homosexual attraction was unwanted for the individual in that he desired to change.

Description of Sample

The participants were adult men who participated in any form of conversion intervention (e.g., any type of therapy administered by a mental health professional, a support group or any activity aimed at changing homosexual attraction and/or behavior). The participants were required to have some past or current form of same sex attraction, but did not necessarily have to possess more homosexual feelings than heterosexual feelings to be included. The survey participants desired to change their unwanted homosexual attraction.

There were a total of 197 surveys completed, but only 158 men and women completed the entire surveys, an 80% response rate. Thirty-nine other surveys were immediately disqualified because they were only partially filled out or left blank. Twenty five surveys (15.8%) were filled out by men living outside the United States and eight surveys (6.4%) were filled out by women living inside (seven) and outside (one) of the United States. It was decided that only men living in the United States who filled out the survey would be included in the survey's findings. The other men who filled out the surveys living outside of the United States represented different cultures, customs and societal beliefs and it was hypothesized that those survey results would skew the reliability of the survey. The results of the survey of men living in the United States and those living outside the United States will be compared in a later section of this study. The surveys completed by females only represented a small percentage of the entire survey responses (5.1%) and were also left off the survey because of the low returns.

One hundred twenty five (125) men living in the United States participated in this study ranging in age from 18 to over 65 who were approached by a varied list of contact persons and/or organizations. There were 18 participants (14.3%) who were between the ages of 18-25; thirty-five participants (28%) who were between the ages of 26-35; twenty-three participants (18.4%)

Table 1. Survey Participants' Age Range

Age	Number of Responses	Percentage
18-25	18	14.3%
26-35	35	28.0%
36-45	23	18.4%
46-55	29	23.2%
55-65	19	15.2%
66+	1	<1%
Total	125	100%

who were between the ages of 36-45; twenty-nine participants (23.2%) who were between the ages of 46-55; nineteen participants (15.2%) who were between the ages of 55-65; and one participant (.8%) who was over the age of 65.

Table 2. Survey Participants' Residency

	Number of Response(s)	Response Ratio
East USA	24	19.2%
Central USA	45	36%
South USA	16	12.8%
West USA	39	31.2%
Other	1	.8%
No Responses	0	0.0%
Total	125	100%

One hundred and twelve participants (89.6%) identified as White/Caucasian. The others by frequency were: Hispanic (6), African-American (2), Multi-racial (2), Asian/ Pacific Islander (1), and one Middle-Eastern (1). One participant did not provide any information on race/ ethnicity. Twenty four participants (19.2%) were from East USA (East Coast and North East); 45 participants (36%) from Central USA (Mid West, Central and Mid East); 16 participants (12.8%) from South USA (South and South East) and 39 participants (31.2%) from the West USA (West Coast, North West). One participant (.8%) was from multiple regions of the USA (because of military service). The participants represented a group of well educated men. Only three participants (2.4%) had not entered college but graduated high school. Thirty participants (24%) had some college and forty five participants (36%) had earned a bachelor degree. Thirty five

participants (28%) had completed a master's degree and eleven participants (8.6%) have completed their doctorates.

Table 3. Survey Participants' Education Level

	Number of Response(s)	Response Ratio
Grade school	0	0.0%
High school	3	2.4%
Trade School	0	0.0%
Some college (including associates degree)	30	24.0%
Bachelors Degree	45	36.0%
Masters Degree	35	28.0%
Doctoral Degree	11	8.7%
No Responses	1	<1%
Total	125	100%

One participant did not provide any information on education. The annual income was spread across the board. There were eight participants (6.4%) whose income was $10,000 or less; nineteen participants whose income was between $10,001-$25,000; twenty-four participants (19.2%) whose income was between $25,001-$50,000; twenty one participants (16.8%) whose income was between $50,001-$75,000; twenty participants (16%) whose income was between $75,001-$100,000; seventeen participants (13.6%) whose income was between $100,000-$150,000; and twelve participants (9.6%) whose income was over $150,000.

Table 4. Survey Participants' Income Range

	Number of Response(s)	Response Ratio
$0-10,000	8	6.4%
$10,001-$25,000	19	15.2%
$25,001-$50,000	24	19.2%
$50,001-$75,000	21	16.8%
$75,001-$100,000	20	16.0%
$100,001-$150,000	17	13.6%
$150,000+	12	9.6%
No Responses	4	3.2%
Total	125	100%

There was not a large diversity of religious preference; most participants' described themselves as Christians. Sixty eight participants (54.4%) identified as Protestant (Baptist, Methodist, Episcopalian, other Christian and non-denominational Christian); thirty-five participants (28%) as Mormon; thirteen participants (10.4%) identified as Jewish; eight participants (6.4%) as Catholic; and one participant (.8%) identified as Bahai. Ten participants

Table 5. Survey Participants Faith/Denomination

	Number of Response(s)	**Response Ratio**
Other Christian	43	34.4%
Mormon	35	28%
Non-Denominational Christian	17	13.6%
Jewish	13	10.4%
Roman Catholic	8	6.4%
Baptist	5	4.0%
Methodist	2	1.6%
Episcopalian	1	.8%
Bahai	1	.8%
Lutheran	0	0.0%
Buddhist	0	0.0%
Muslim	0	0.0%
Atheist (unbelief in God)	0	0.0%
Agnostic (existence of God is unknowable)	0	0.0%
Total	125	100%

(8%) went to religious services daily; thirty-one (24.8%) attended religious services a few times a week; sixty-nine (55.2%) attended religious services weekly; ten participants (8%) attended religious services a few times a month; two participants (1.6%) attended religious services on major holidays; and three participants (2.4%) attended religious services rarely or never. At the time of the study, fifty-two participants (41.6%) were married and seventy-three were single (58.4%). Of the seventy three single men, sixty six participants (52.8%) had never been married; five participants (4%) were divorced; one participant (.8%) was engaged and one participant (.8%) was widowed. Of the fifty-seven participants that were married or divorced, thirteen participants were married from one to five years (10.4%); five participants were married six to

ten years (4%); twenty-one participants were married eleven to twenty-five years (16.8%); and eighteen participants were married twenty six to fifty years (14.3%). Fifty-two men (41.6%) had children, 64 men (51.2%) did not and nine men (7.2%) did not respond to the question. Of the participants that had children, six participants had one child (4.8%); twelve participants had two children (9.6%); seventeen participants had three children (13.6%); eleven participants had four children (8.7%) and six participants had five or more children (4.8%). Most participants (52.1%) identified as middle class, with 31.6% identifying as upper middle class, and 6% as upper class. Only 9.4 % of the sample identified as lower middle class or lower class.

Description of Survey

The survey was comprised of 88 multiple choice questions designed to answer the three pertinent questions of the paper:

1. To what extent does a convenience sample of former and current clients of SOCE report changes in same sex and opposite sex thoughts, feelings and/or behaviors after receiving reparative therapy?
2. What does a convenience sample of former and current clients of SOCE report to have found helpful about their experiences of reparative therapy?
3. What does a convenience sample of former and current clients of SOCE report to have found harmful about their experiences of reparative therapy?

Most of the questions were taken from the studies done by Karten (2010), Spitzer (2001) and Shidlo and Schroeder (2002) whose studies desired to answer similar questions about the change efforts of people with same sex attraction. The survey included 18 questions that attempted to answer the first pertinent question that assessed change in homosexual and heterosexual

thoughts, feelings and behaviors. There were 54 questions that attempted to answer the second and third pertinent questions on the survey about helpful and harmful counseling experiences. These questions assessed the length of time, effectiveness and harmfulness of the different modes of therapy experienced by the participants and how the mode of therapy impacted their well being.

Survey Procedure

The researcher contacted ex-gay ministry groups and affiliated private therapists throughout the United States, known to have individuals who were involved in conversion therapy efforts (e.g., Courage, National Association for the Research and Therapy of Homosexuality (NARTH), Jews Offering New Alternatives to Homosexuality (JONAH)). The nature of the study was explained and assistance in the recruitment of participants to be surveyed was requested. Once the therapists were contacted, they were asked to obtain names of other individuals that offered conversion therapy whom the researcher could contact regarding the study. These contact people informed qualified individuals who had been through or currently in therapy for their same sex attraction about their interest in taking a survey. Some potential participants e-mailed the researcher about their interest in taking the study. These people were given an internet link to fill out the survey on-line through the company Constant Contact. Other interested participants were e-mailed the on-line link directly by the contact person to take the survey on-line. Inside the link the survey first explained the purpose of the study and gave directions on how to complete the survey questions. By completing the survey questions, participants were officially giving their consent for inclusion in the study. Participants were not required to sign any forms.

Data Collection

After the survey participants completed the on-line survey, the results were automatically tabulated through the Constant Contact service. All the survey results were tabulated, added and displayed in a bar graph format for the multiple choice answers for each question. Constant Contact also provided all the results of the survey on an Excel spread sheet that could be manipulated for other various mathematical calculations, including statistical.

Validity

The validity of the survey was measured by the pre-test that was administered a month before the survey was made available to be filled out on-line. Seventeen pre-tests were filled out by hand by men at a Courage meeting held at a Roman Catholic Church in San Diego during a Saturday evening in mid December, 2010. Courage is a Roman Catholic organization that ministers to men who have unwanted same sex attraction. All of the men who filled out the pre-test surveys practiced Roman Catholicism. The pre-test contained the questions on the final survey. The validity was measured by determining if the pre-test answered the three pertinent questions. The three pertinent questions were:

1. To what extent does a convenience sample of former and current clients of SOCE report changes in same sex and opposite sex thoughts, feelings and/or behaviors after receiving reparative therapy?
2. What does a convenience sample of former and current clients of SOCE report to have found helpful about their experiences of reparative therapy?
3. What does a convenience sample of former and current clients of SOCE report to have found harmful about their experiences of reparative therapy?

The pre-test results showed that the answers were what were intended through the meaning of the three pertinent questions on the pre-test which determined that the survey was valid. However, the internal validity was affected because the sample was too homogeneous to generalize the results of the study. Most of the survey participants were Caucasian/ white (89.6%) and considered themselves Christian (88.8%). There was one apparent confound: the survey was a self-written test which was biased. This bias will affect the validity and reliability because of the way the questions were posed in the survey. There were no apparent issues to distort the external validity of the survey such as problems with the selection, characteristics and interaction of the subjects; or difficulties with the pre and post-test conditions.

Reliability

The second goal of the pre-test was to measure the reliability to determine consistency in the answers. The reliability of the survey was measured by comparing the results of the pre-test with the results of the actual survey itself. The answers of the three pertinent questions from the respondents on the pre-test were consistent when compared to the results on the survey, therefore reliability could be considered high pertaining to the three pertinent questions.

Summary

One hundred and fifty eight men and women completed valid surveys who participated in any form of conversion intervention (e.g., any type of therapy administered by a mental health professional, a support group or any activity aimed at changing homosexual attraction and/or behavior). One hundred twenty five men living in the United States participated in this study ranging in age from 18 to over 65. One hundred and twelve participants (89.6%) identified themselves as White/Caucasian. The participants were educated with over 70 percent earning a bachelor degree, master's degree or a doctorate. Almost 90 percent of the participants identified

themselves as Christian while 41.6% were married and 58.4% were single. The survey was made up of multiple choice questions that were taken from the studies done by Karten (2010), Spitzer (2001) and Shidlo and Schroeder (2002) whose studies desired to answer similar questions about the change efforts of people with same sex attraction. Ex-gay ministry groups and affiliated private therapists throughout the United States who were involved in conversion therapy efforts were contacted and asked to solicit individuals who were going through or had gone through some kind of conversion therapy. These people were given an internet link to fill out the survey on-line through the company Constant Contact. All the survey results were tabulated, added up and displayed in a bar graph format by Constant Contact. The validity of the survey was measured by the pre-test survey that was administered a month before the survey was made available to be filled out on-line. The pre-test results determined that the three pertinent questions could be validly answered regarding individuals reporting changes in same sex and opposite sex thoughts, feelings and/or behaviors and whether reparative therapy resulted in helpful or harmful effects. Both the pre-test and survey showed similar results, therefore, the reliability could be considered high pertaining to the three pertinent questions.

Chapter 4

Analysis of Data

Introduction

This study will attempt to determine if it is harmful or helpful, in terms of the individual's well being, to attempt to change one's same sex attraction through re-orientation therapy and to measure the effectiveness of re-orientation therapy. The American Psychiatric Association and the American Psychological Association (APA) and many other mental health professionals have recommended that people who have same sex attraction not attempt to change their sexuality because it can be harmful and likely ineffective (APA Task Force, 2009). Well known mental health professionals, from their own experience, showed that individuals have experienced success in their attempts to change their unwanted same sex attraction ((Sigmund Freud (Bauer, 2005), Alfred Adler (Chandler, 1995), Carl Jung (Hopcke, 1988), Irving Bieber (Bieber et al., 1962), Charles Socarides (Socarides, 1978) and Joseph Nicolosi (Nicolosi, 1991)). Modern day studies have shown that change is possible but also with little negative side effects for individuals who want to change their same sex attraction (Karten, 2010; Spitzer, 2001; Nicolosi, Byrd & Potts, 2000).

Problem Statement

Can men change their same sex thoughts, feelings and/or behaviors to opposite sex thoughts, feelings and/or behaviors after receiving reparative therapy? To what extent is reparative therapy helpful or harmful for men who have same sex attraction?

Research Design

The instrument used to measure the effects of re-orientation therapy on men was an on-line survey through the Constant Contact web site. Ex-gay ministry groups and affiliated private therapists were contacted to solicit qualified individuals who had been through or were currently

in therapy for their same sex attraction about their interest in taking the survey on-line in January 2011. The survey was comprised of 88 multiple choice questions designed to answer three pertinent questions of the paper. A pre-test was administered a month before the survey was made available to be filled out on-line. Seventeen pre-tests were filled out by hand by men at a Courage meeting held at a Roman Catholic Church in San Diego California in mid December, 2010. The pre-test contained the questions on the final survey.

One hundred and fifty eight men and women completed valid surveys, including 125 men living in the United States, which became the sample that would be used for the study. The other men and women who filled out the surveys living outside of the United States represented different cultures, customs and society beliefs whose results might skew the reliability of the survey. However, the results of the survey of men living in the United States and those living outside the United States were compared with data collected on the sample. Of the 125 men living in the United States who participated in this study, their ages ranged from 18 to over 65. The majority of the participants were single, White, Christian, well educated males between the age ranges of 26-55 who attended religious services on a weekly basis.

Data Summary

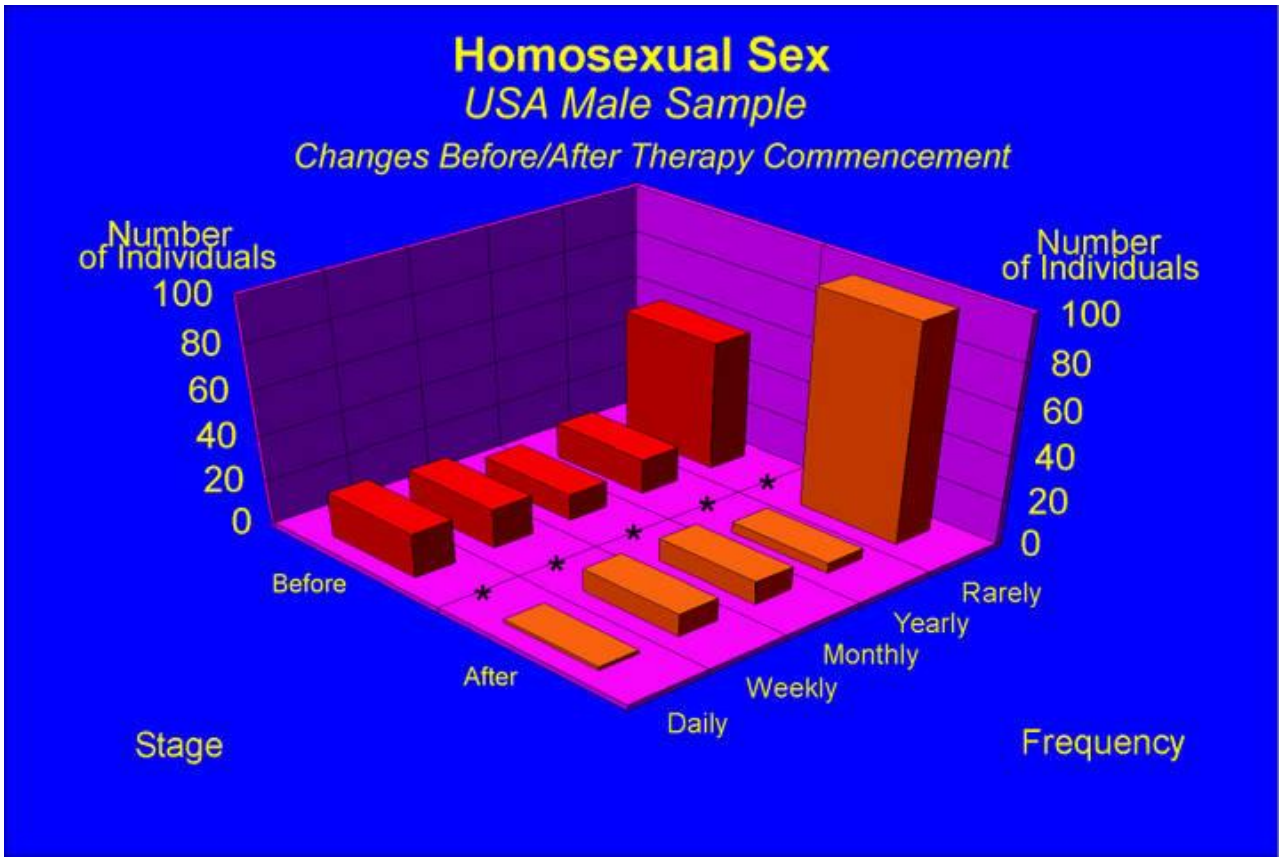
The survey focused on three pertinent questions of:

1. To what extent does a convenience sample of former and current clients of SOCE report changes in same sex and opposite sex thoughts, feelings and/or behaviors after receiving reparative therapy?
2. What does a convenience sample of former and current clients of SOCE report to have found helpful about their experiences of reparative therapy?

3. What does a convenience sample of former and current clients of SOCE report to have found harmful about their experiences of reparative therapy?

The results from the survey pertaining to the first pertinent question, specifically homosexual sexual behavior, showed six months before the 125 male participants sought out help for their same sex attraction, 52.8% or 66 men, described themselves as engaging in homosexual sex either on a daily, weekly, monthly or yearly basis (homosexual sex for the purpose of the survey was defined as either kissing or touching genitals, anal or oral sex). The survey then showed after the men received re-orientation therapy, 27 men, or 21.6%, at the time the survey was taken, described themselves as engaging in homosexual sex either on a daily, weekly, monthly or yearly basis, a 59% decrease in homosexual activity, which was statistically

Table 6. Participants' engagement in homosexual sex

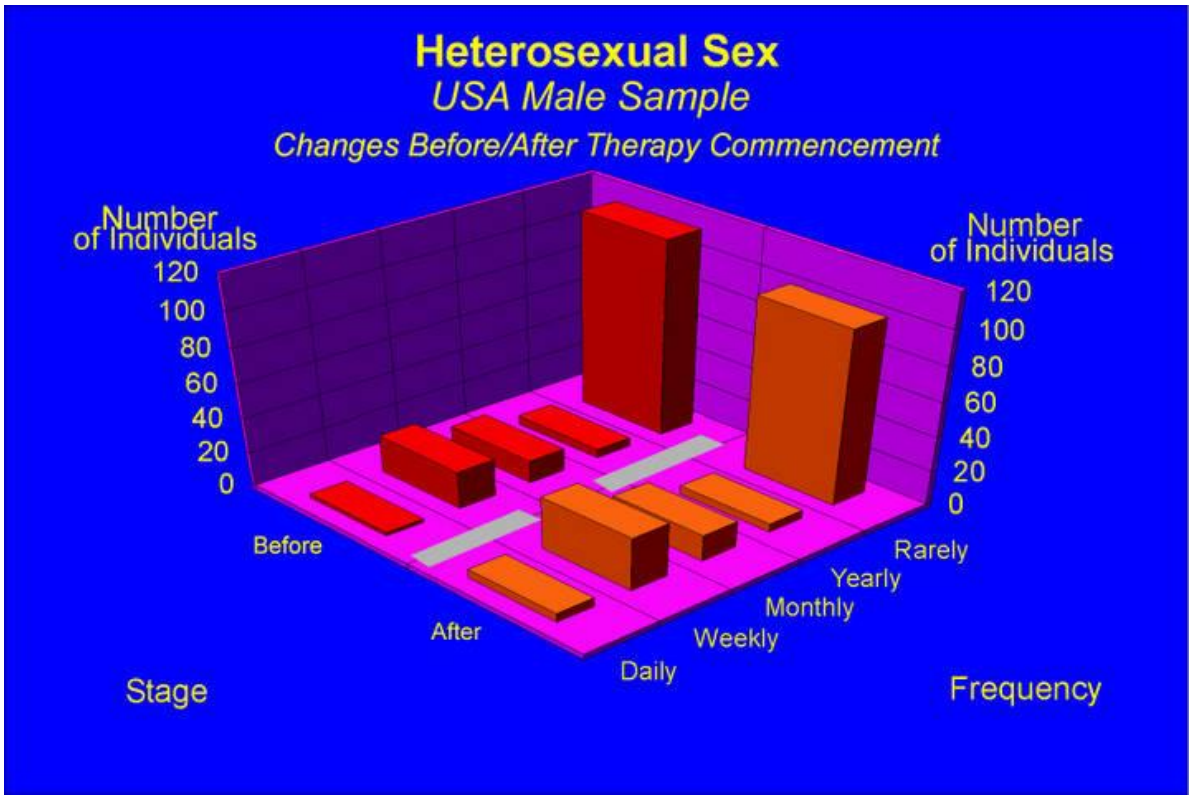


* denotes statistically significant p <0.001

significant p< 0.001 (A chi-squared test was used). The survey results rendered six months before the 125 male participants sought out help for their same sex attraction, 58 men, or 46.4%, described themselves as engaging in homosexual sex almost never. The survey then indicated, after the re-orientation therapy for the men's same sex attraction was received, that 97 men, or 77.6%, described

themselves as engaging in homosexual sex almost never, a 67.2% increase in abstaining from homosexual activity. The survey presented that men between the ages of 46-55 experienced the most homosexual sex on a daily, weekly, monthly or yearly basis before therapy (18 total, 62% of that age group) then the men between 56-65 (14 total, 73.7% of that age group) followed by the men in the 26-35 age group (13 total, 37.1% of that age group), the men in the 36-45 age group (11 total, 47.8% of that age group), the men in the 18-24 age group (nine total, 50% of that age group) and one man who is age 66.

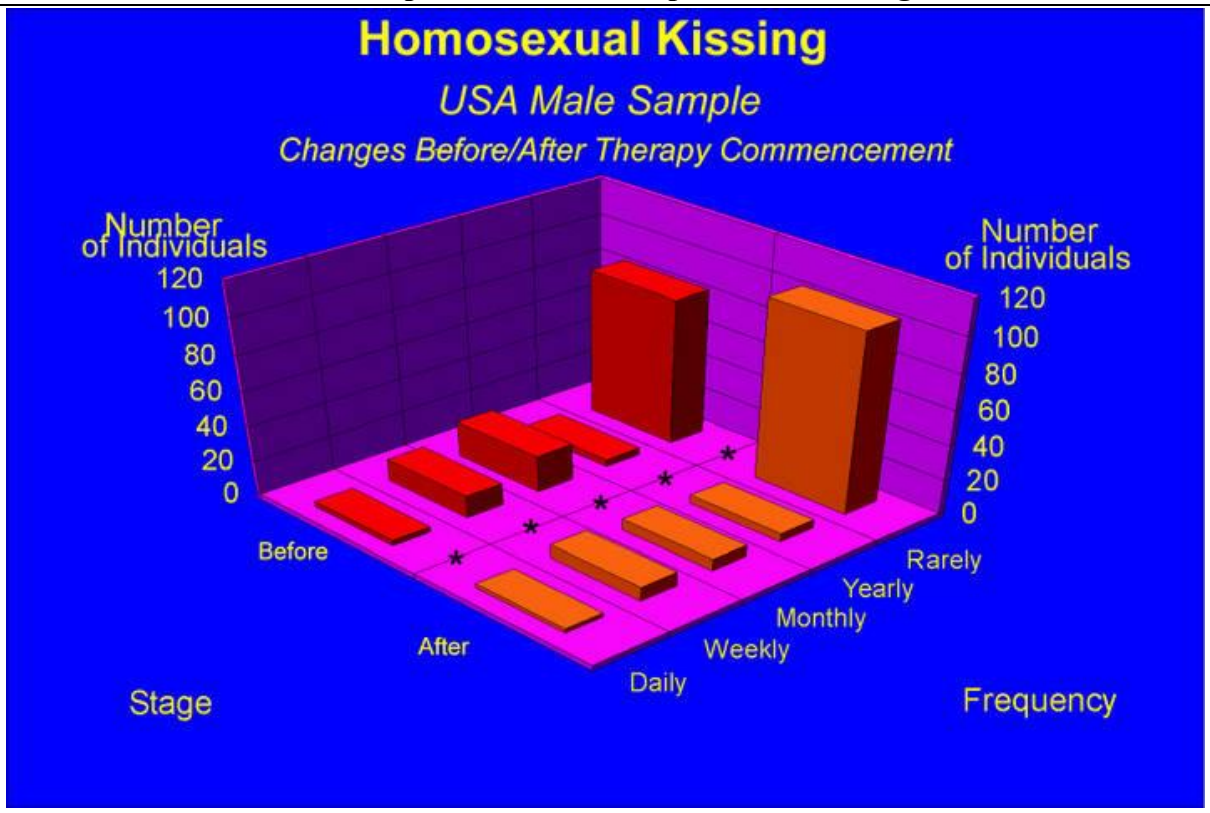
Table 7. Participants' engagement in heterosexual sex



Grey bar denotes not statistically significant p >0.05

The results from the survey pertaining to heterosexual sex, six months before the 125 male participants sought out help for their same sex attraction, determined 35 men, or 28%, described themselves as engaging in heterosexual sex either on a daily, weekly or monthly basis (heterosexual sex for the purpose of the survey was defined as either kissing or touching genitals, vaginal, anal or oral sex). The survey then demonstrated, after the men received some kind of re-orientation therapy, 45 men, or 36%, at the time the survey was taken, described themselves as engaging in heterosexual sex either on a daily, weekly, monthly or yearly basis, a 28.5% increase in heterosexual sex activity, which was not statistically significantly p>0.05. The survey established that men between the ages of 46-55 experienced the most heterosexual sex (14 total, 48.3% of that age group) on a daily, weekly, monthly or yearly basis before therapy followed by the men between 56-65 (9 total, 47.3% of that age group), then men in the 26-35 age

Table 8. Participants' homosexual passionate kissing

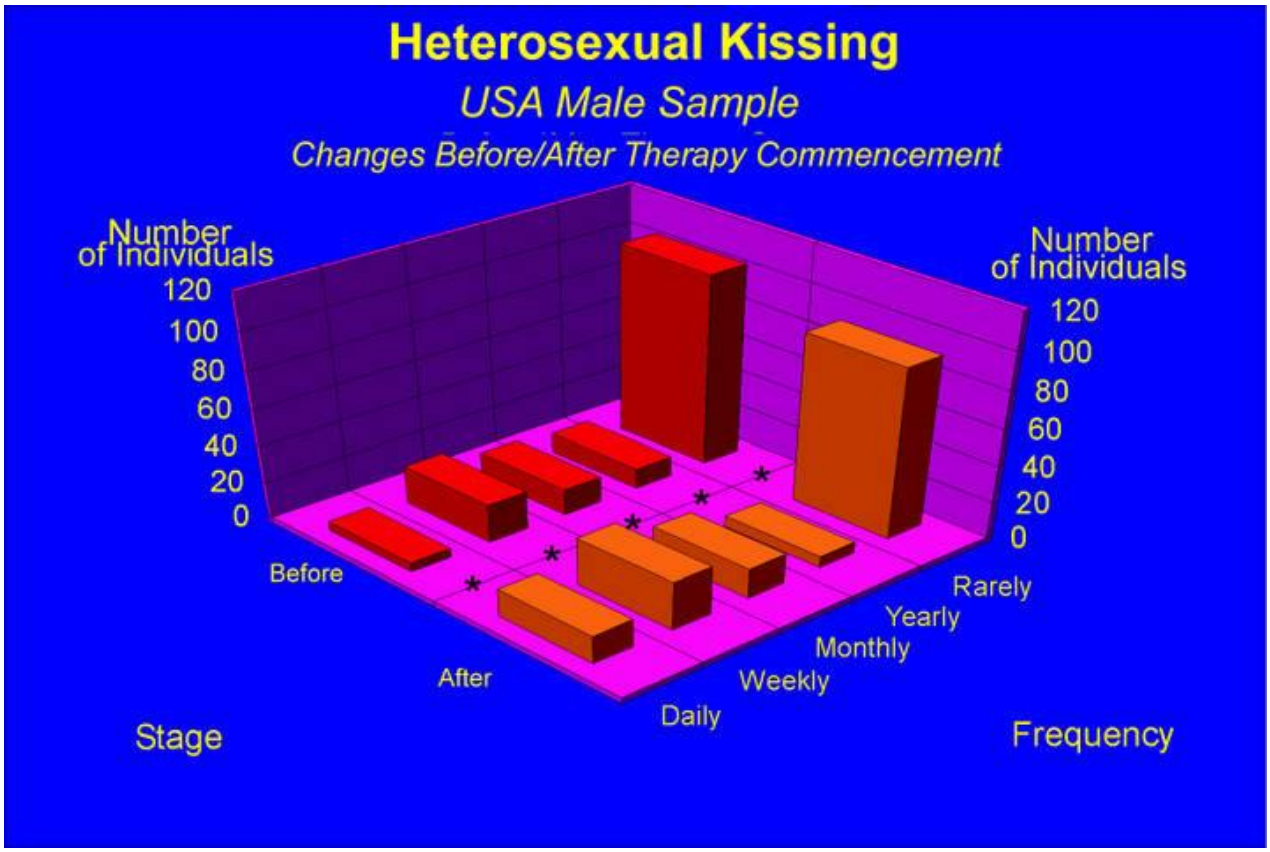


* denotes statistically significant p <0.001

group (six total, 17.1% of that age group), men in the 18-24 age group (one total, 5.6% of that age group) and men in the 36-45 age group (one total, 4.3% of that age group).

The results from the survey, six months before getting help for their same sex attraction, showed 32.8%, or 41 men, described themselves as experiencing homosexual passionate kissing either on a daily, weekly, monthly or yearly basis. The survey then indicated, after the men received some kind of re-orientation therapy, 20 men, or 16%, at the time the survey was taken, described themselves as experiencing homosexual passionate kissing either on a daily, weekly, monthly or yearly basis, a 48.8% decrease, which was statistically significantly p<0.001. The survey results determined, six months before the 125 male participants sought out help for their same sex attraction, 41 men, or 32.8%, described themselves as experiencing heterosexual

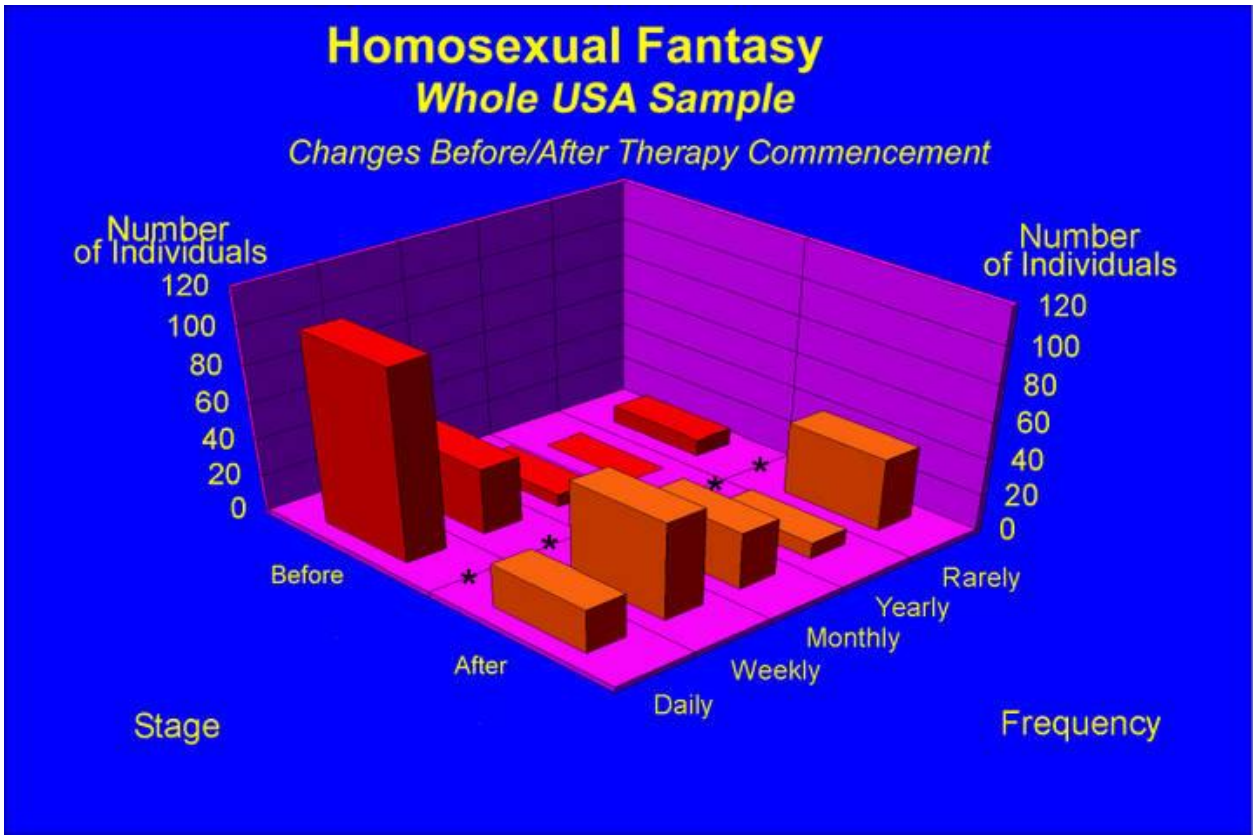
Table 9. Participants' heterosexual passionate kissing



* denotes statistically significant p <0.001

passionate kissing either on a daily, weekly, monthly or yearly basis. The survey then demonstrated, after the re-orientation therapy for the men's same sex attraction was received, that 53 men, or 42.4%, described themselves as experiencing heterosexual passionate kissing either on a daily, weekly monthly or yearly basis, a 29.3% increase, which was statistically significant p< 0.001. The survey established that men between the ages of 46-55 experienced the most homosexual passionate kissing (12 total, 42.9% of that age group) on a daily, weekly, monthly or yearly basis before therapy followed by the men between 56-65 (nine total, 47.4% of that age group), then men in the 26-35 age group (seven total, 20% of that age group), men in the 18-24 age group (six total, 33.3% of that age group) and men in the 36-45 age group (five total, 20% of that age group).

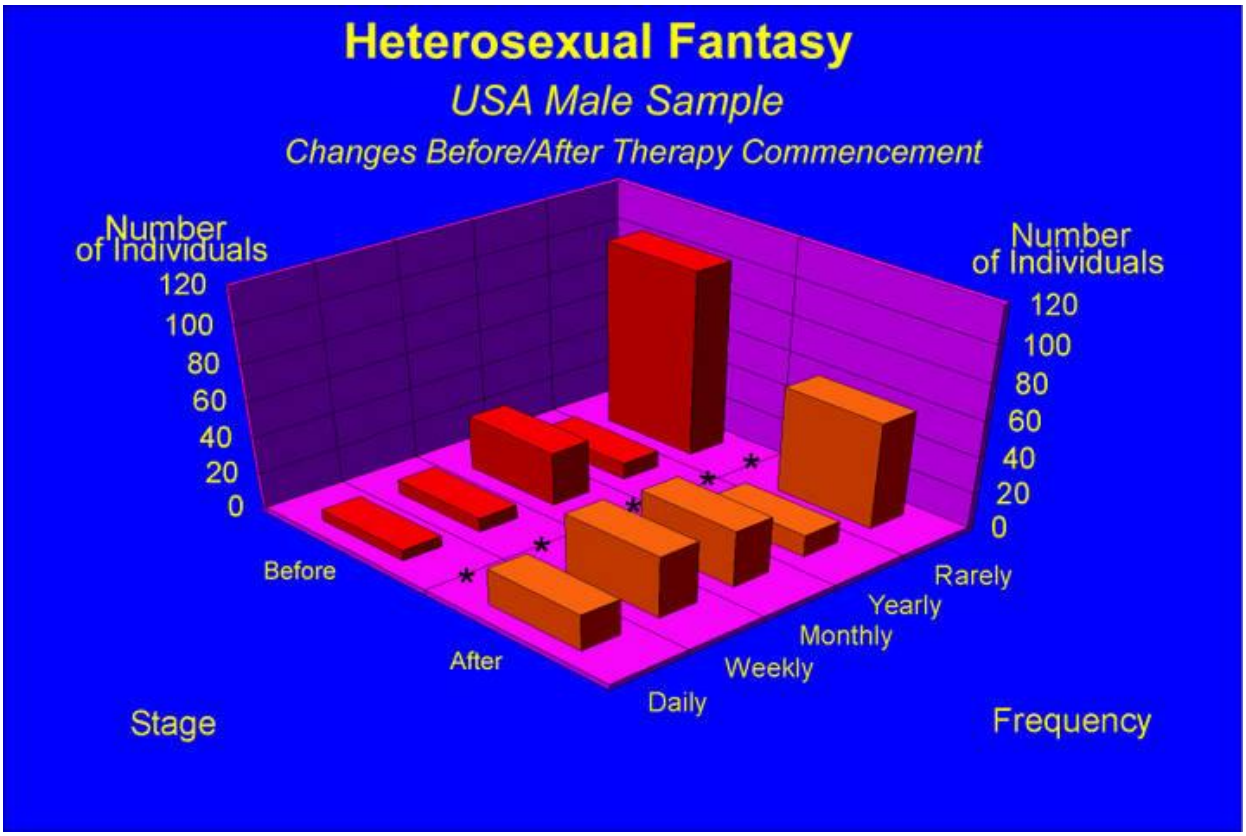
Table 10. Participants' lusting or daydreaming about homosexual sex



* denotes statistically significant p <0.001

The results from the survey, six months before getting help for their same sex attraction, showed 96.8%, or 121 men, described themselves as daydreaming or lusting about homosexual sex either on a daily, weekly or monthly basis. The survey then revealed, after the men received some kind of re-orientation therapy, 96 men, or 76.8%, at the time the survey was taken, described themselves as daydreaming or lusting about homosexual sex either on a daily, weekly, monthly or yearly basis, a 20.7% decrease, which was statistically significant p< 0.001. The survey results indicated, six months before the 125 male participants sought out help for their same sex attraction, 4 men, or 3.2%, described themselves as daydreaming or lusting about homosexual sex almost never. The survey then determined, after the re-orientation therapy for the men's same sex attraction was received, that 28 men, or 22.4%, described themselves as day-

Table 11. Participants' lusting or daydreaming about heterosexual sex

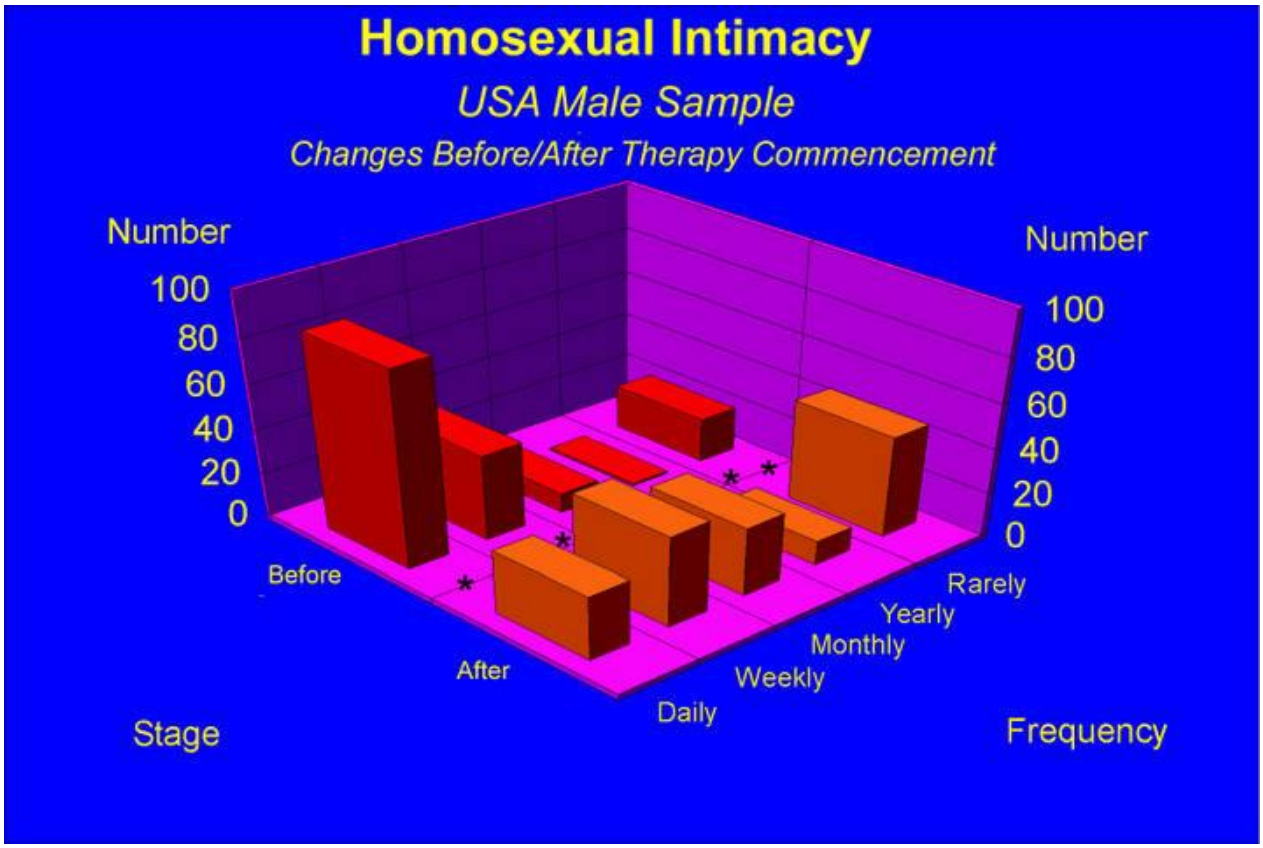


* denotes statistically significant p <0.001

dreaming or lusting about homosexual sex almost never, an increase of 24 men in abstaining from daydreaming or lusting about homosexual sex. The results from the survey pertaining to lusting or daydreaming about heterosexual sex, six months before getting help for their same sex attraction, demonstrated 36.8% or 46 men, described themselves as daydreaming or lusting about heterosexual sex either on a daily, weekly, monthly or yearly basis. The survey then established, after the men received re-orientation therapy, 85 men, or 68%, at the time the survey was taken, described themselves as daydreaming or lusting about heterosexual sex either on a daily, weekly, monthly or yearly basis, an 84.7% increase, which was statistically significant p< 0.001.

The results from the survey, six months before getting help for their same sex attraction, showed 84%, or 105 men, described themselves as desiring romantic, emotional, homosexual

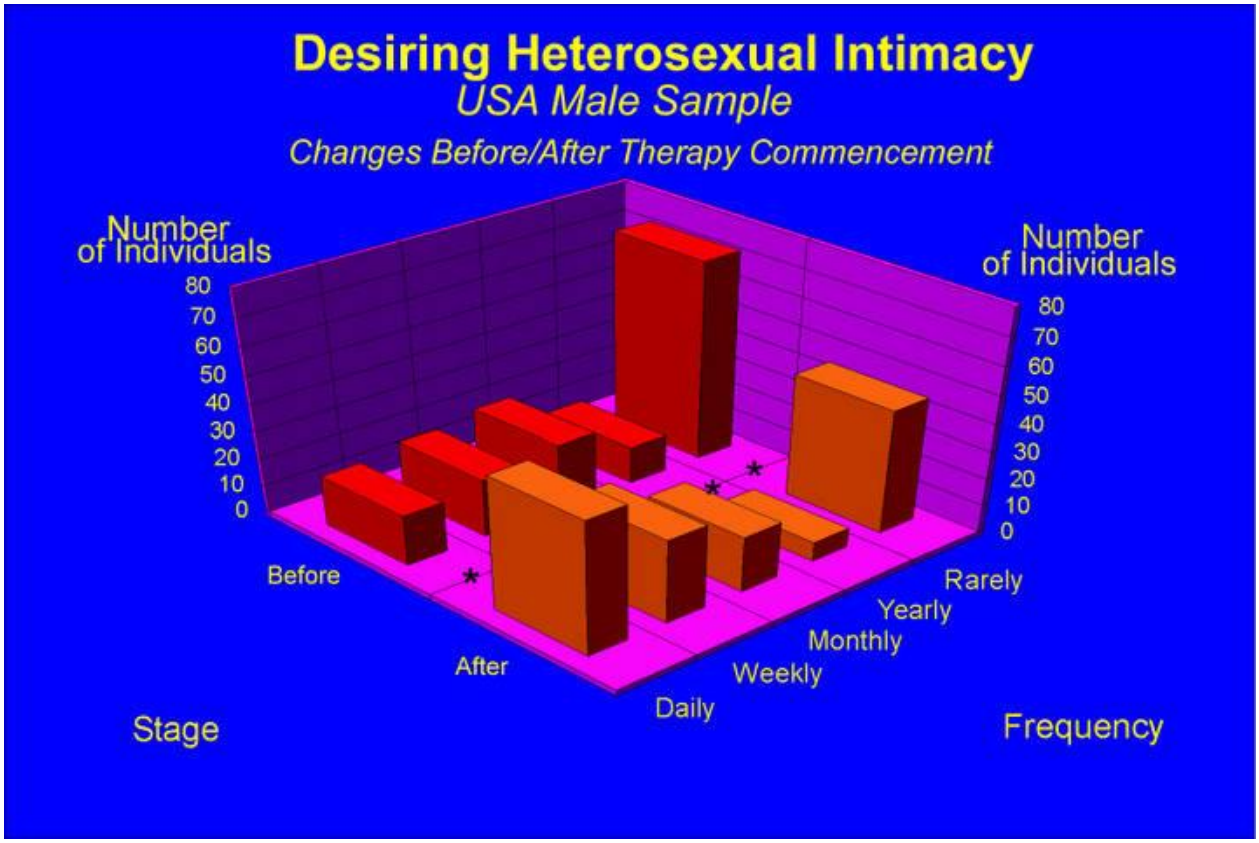
Table 12. Participants' desiring romantic, emotional, homosexual intimacy



* denotes statistically significant p <0.001

intimacy either on a daily, weekly, monthly or yearly basis. The survey then revealed, after the men received some kind of re-orientation therapy, 89 men, or 71.2%, at the time the survey was taken, described themselves as desiring romantic, emotional, homosexual intimacy either on a daily, weekly, monthly or yearly basis, a 15.2% decrease, which was statistically significant p< .001. The results from the survey, six months before getting help for their same sex attraction, indicated 55.2% or 69 men, described themselves as desiring romantic, emotional, heterosexual intimacy either on a daily, weekly, monthly or yearly basis. The survey then determined, after the men received re-orientation therapy, 95 men, or 76%, at the time the survey was taken, described themselves as desiring romantic, emotional, heterosexual intimacy either on a daily, weekly, monthly or yearly basis, a 37.7% increase, which was statistically significant p< 0.001.

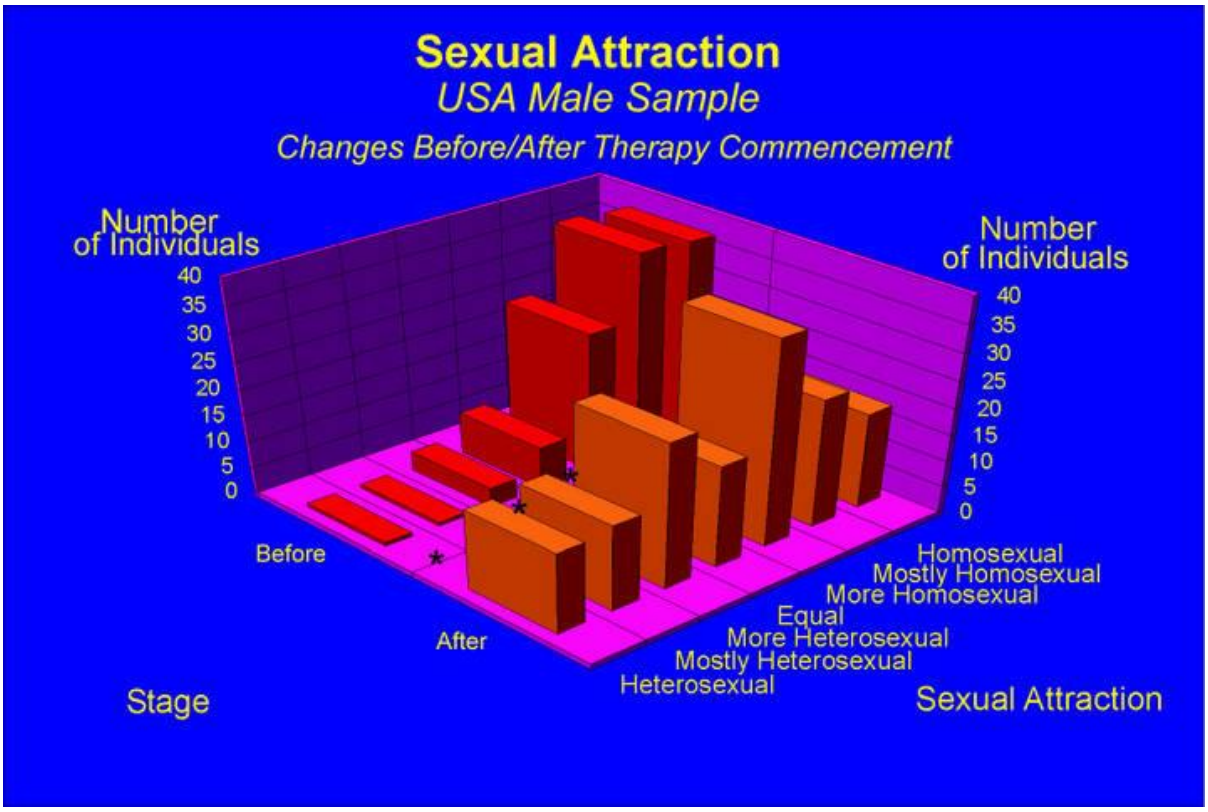
Table 13. Participants' desiring romantic, emotional, heterosexual intimacy



* denotes statistically significant p <0.001

The results from the survey demonstrated, six months before the 125 male participants sought out help for their same sex attraction, 88% or 110 men described themselves as homosexual, almost entirely homosexual or more homosexual than heterosexual. The survey then established after the same 125 men had received re-orientation therapy for their same sex attraction, that 61 men, or 48.8% of the men, at the time the survey was taken, described themselves as homosexual, almost entirely homosexual or more homosexual than heterosexual, a 80.3% decrease in homosexual attraction after reorientation therapy was received, which was statistically significant p< .001. The survey results showed six months before the 125 male participants sought out help for their same sex attraction, 4 men described themselves as more heterosexual than homosexual (3.2%) and one described himself as almost entirely heterosexual (.8%). The survey then revealed, after the re-orientation therapy for the men's same sex

Table 14. **Participants' sexual attraction**



* denotes statistically significant p <0.001

attraction was received, that 24 men rated their sexual attraction as more heterosexual than homosexual (19.2%) and 24 men rated their sexual attraction as almost entirely heterosexual and heterosexual (19.2%). These numbers increased from a total of five men rating their sexual attraction at either more heterosexual than homosexual or almost entirely heterosexual before reorientation therapy to 48 men rating their sexual attraction at either more heterosexual than homosexual or almost entirely heterosexual after reorientation therapy. These results indicated that there was a decrease in the data for homosexual thoughts, feelings and behaviors after the participants received reorientation therapy for their unwanted same sex attraction as well as a consistent increase in heterosexual thoughts, feelings and behaviors. Of the 125 participants who took the survey, 78 of the men classified themselves as homosexual or almost entirely homo-sexual six months before they sought out reorientation therapy to change their unwanted same sex attraction. After receiving reorientation therapy, at the time of the survey, 11 of the 78 men now classified themselves as either almost entirely heterosexual (four men) or heterosexual (seven men) for a total of 14% change rate; 26 men still classified themselves as homosexual (12 men) and almost entirely homosexual (14 men) for a total of 33.3%. The rest of the 78 men had decreased their homosexual attraction and increased their heterosexual attraction by various

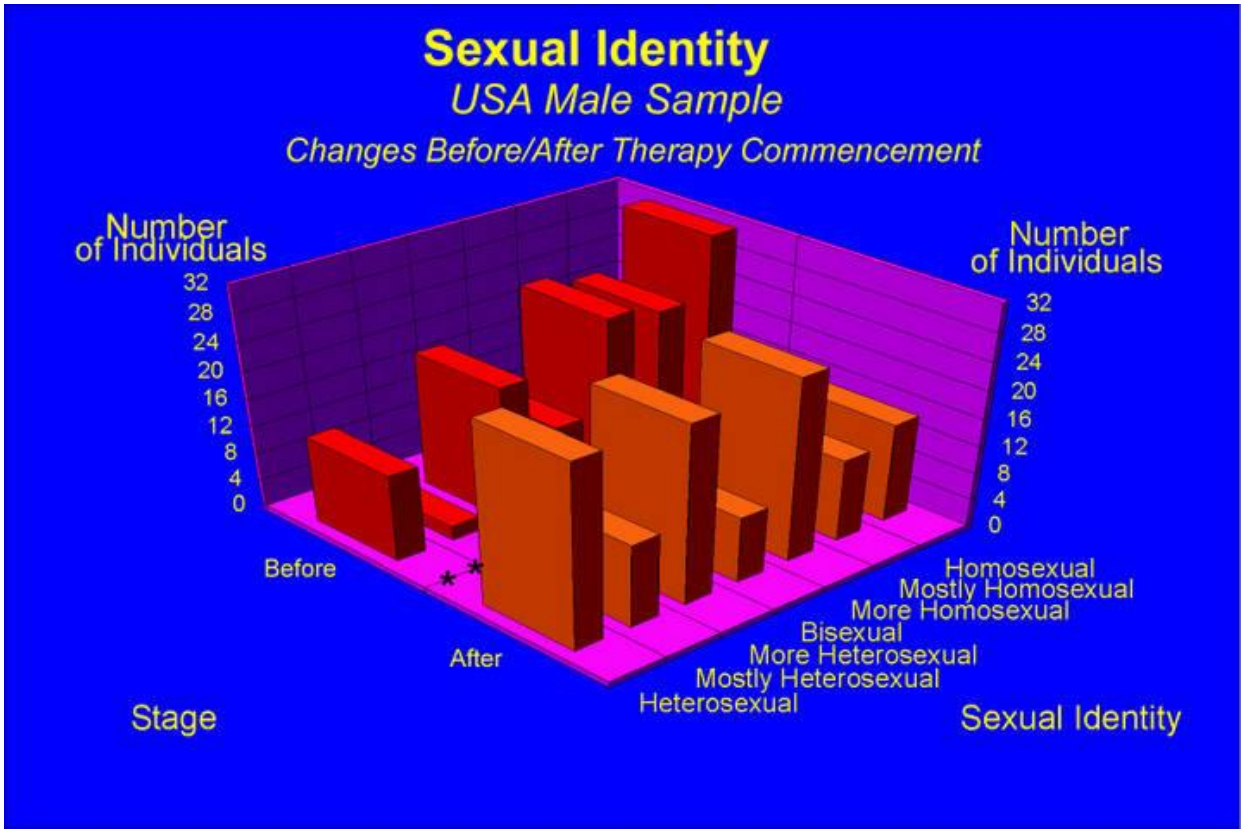
Table 15. Participants', who originally classified themselves as either homosexual or almost entirely homosexual, sexual attraction at the time of the survey

	Number of Response(s)	**Response Ratio**
more homosexual than heterosexual	21	28.6%
almost entirely homosexual	14	17.9%
homosexual	12	15.4%
more heterosexual than homosexual	10	12.8%
bi-sexual	9	11.5%
heterosexual	7	9%
almost entirely heterosexual	4	5.1%
no responses	1	1.3%
Total	78	100%

degrees. The overall change rate for people taking the survey who classified their feelings as either heterosexual (12 men, 9.6%) or almost entirely heterosexual (12 men, 9.2%) was 19.2%.

The results from the survey determined, six months before the 125 male participants sought out help for their same sex attraction, 67.2% or 84 men described their identity as homosexual, almost entirely homosexual or more homosexual than heterosexual. The survey then demonstrated after the same 125 men had received re-orientation therapy for their same sex attraction, that 48 men, or 38.4% of the men, at the time the survey was taken, described their identity as homosexual, almost entirely homosexual or more homosexual than hetero-sexual, a 42.9% decrease in defining their identity as mostly homosexual after reorientation therapy was received, which was statistically significant $p < 0.001$.

Table 16. **Participants' sexual identity**

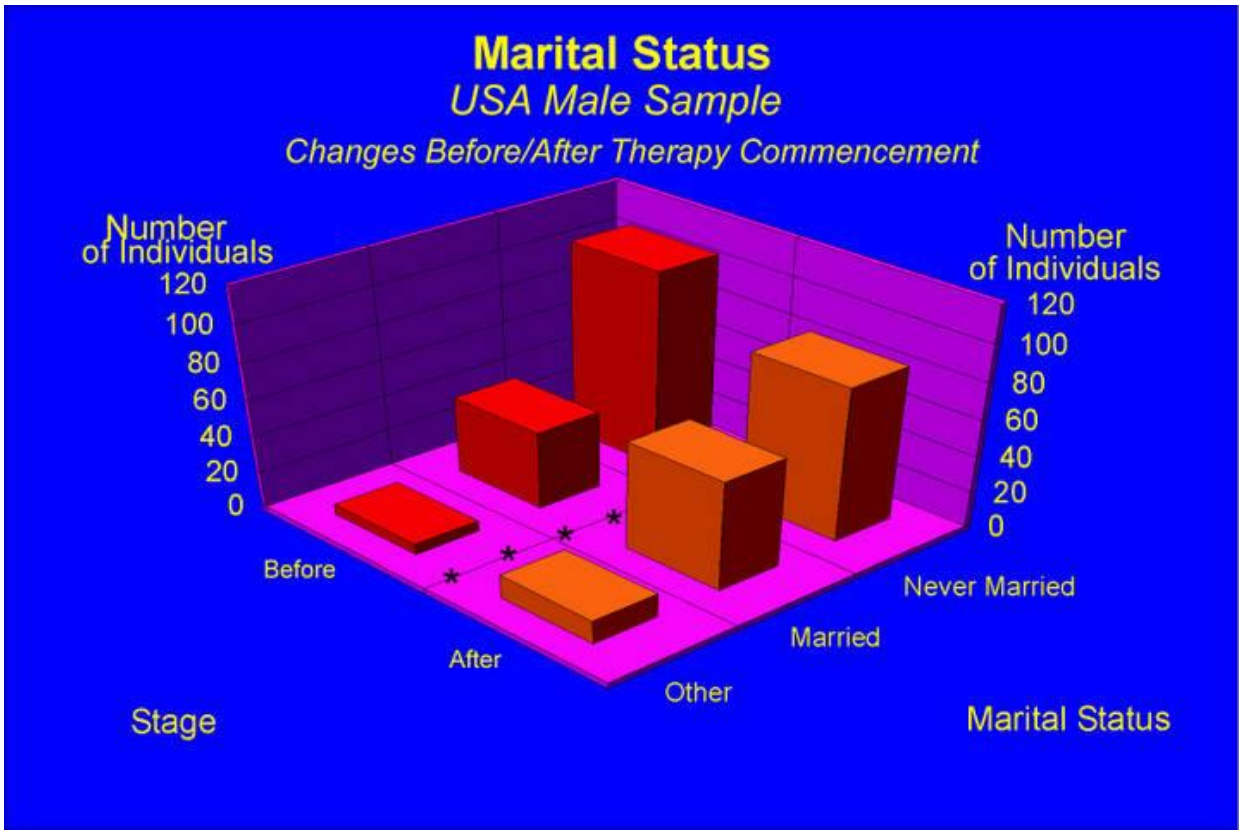


* denotes statistically significant p <0.001

The results from the survey, six months before the 125 male participants sought out help for their same sex attraction, established 22.4% or 28 men described their identity as heterosexual, almost entirely heterosexual or more heterosexual than homosexual. The survey then showed after the same 125 men had received re-orientation therapy for their same sex attraction, that 68 men, or 54.4% of the men, at the time the survey was taken, described their identity as heterosexual, almost entirely heterosexual or more heterosexual than homosexual, a 142.9% increase in defining their identity as mostly to completely heterosexual after reorientation therapy was received.

The results from the survey revealed, six months before the 125 male participants sought out help for their same sex attraction, 28% or 35 men were married. At the time of the survey,

Table 17. Participants' marital status before and after therapy commencement



* denotes statistically significant p <0.001

after receiving therapy for their same sex attraction 40.8% or 51 men stated they had made a marriage commitment, a 45.7% increase in matrimony among the men surveyed, which was statistically significant $p < 0.001$.

The demographics indicated similarities and differences for the 24 survey participants' who described themselves as heterosexual or almost entirely heterosexual at the time of the survey and the 28 participants' who described themselves as homosexual or almost entirely homosexual at the time of the survey. The similarities included the ethnicity of both groups were

Table 18. Participants' age range at the time of the survey

	Heterosexual & Almost entirely Heterosexual	Homosexual & Almost Entirely Homosexual
18-25	1	4
26-35	6	9
36-45	4	4
46-55	7	7
56-65	6	4
Total	24	28

pre-dominantly Caucasian and education levels showed that most of the individuals in both groups had achieved at least some college all the way up to doctorate levels. Most of the individuals in both groups attended a religious service once a week, 75% for the 24 heterosexual and almost entirely heterosexual men and 82% for the 28 homosexual or almost entirely

Table 19. Participants' household income at the time of the survey

	Heterosexual & Almost entirely Heterosexual	Homosexual & Almost Entirely Homosexual
$0- 10,000	1	4
$10,000-$25,000	2	4
$25,000-$50,000	5	6
$50,000-$75,000	4	4
$75,000-$100,000	4	5
$100,000-$150,000	4	4
$150,000+	4	1
Total	24	100%

homosexual men. The differences included most of the individual's who described themselves a heterosexual or almost entirely heterosexual at the time of the survey were between the ages of 26-65, while the age range was more evenly spread for those who described their attraction as homosexual and almost entirely homosexual particularly in the younger age range (18-35). Fourteen of the 24 heterosexual/ almost entirely heterosexual men were married (58.3%), most

Table 20. Participants' marital status at the time of the survey

	Heterosexual & Almost entirely Heterosexual	Homosexual & Almost Entirely Homosexual
Never been married	10	17
Married	14	7
Engaged	0	1
Divorced	0	2
Separated	0	0
Widowed	0	0
Total	24	28

between 11-50 years and 14 of the 24 men (58.3%) also had children. Seven of the 28 homosexual/ almost entirely homosexual men were married (25%), most between 11-50 years and nine of the 28 men had children (32.1%). The income range of the participants' differed in that there were more homosexual or almost entirely homosexual men earning on the lower end of the scale

($0-25,000) and more heterosexual and almost entirely heterosexual men earning on the higher

Table 21. Participants' US residency at the time of the survey

	Heterosexual & Almost entirely Heterosexual	Homosexual & Almost Entirely Homosexual
Central USA	8	15
South USA	8	3
East USA	5	6
West USA	3	3
Total	12	100%

end ($150,000+). The U.S. residency of the groups differed in that there were more men from the Southern USA that were in the heterosexual group and more men in the Central USA in the

Table 22. Participants' number of children at the time of the survey

# of children	Heterosexual & Almost entirely Heterosexual	Homosexual & Almost Entirely Homosexual
1	3	0
2	1	5
3	4	2
4	5	0
5+	1	2
None	10	15
No Responses	0	4
Total	24	28

homosexual group. The faith references, in general, of both groups were similar. Most participants' in both groups described themselves as Christian, yet the denomination of both groups varied. The homosexual/ almost entirely homosexual group predominately proclaimed

Table 23. Participants' faith/ denomination at the time of the survey

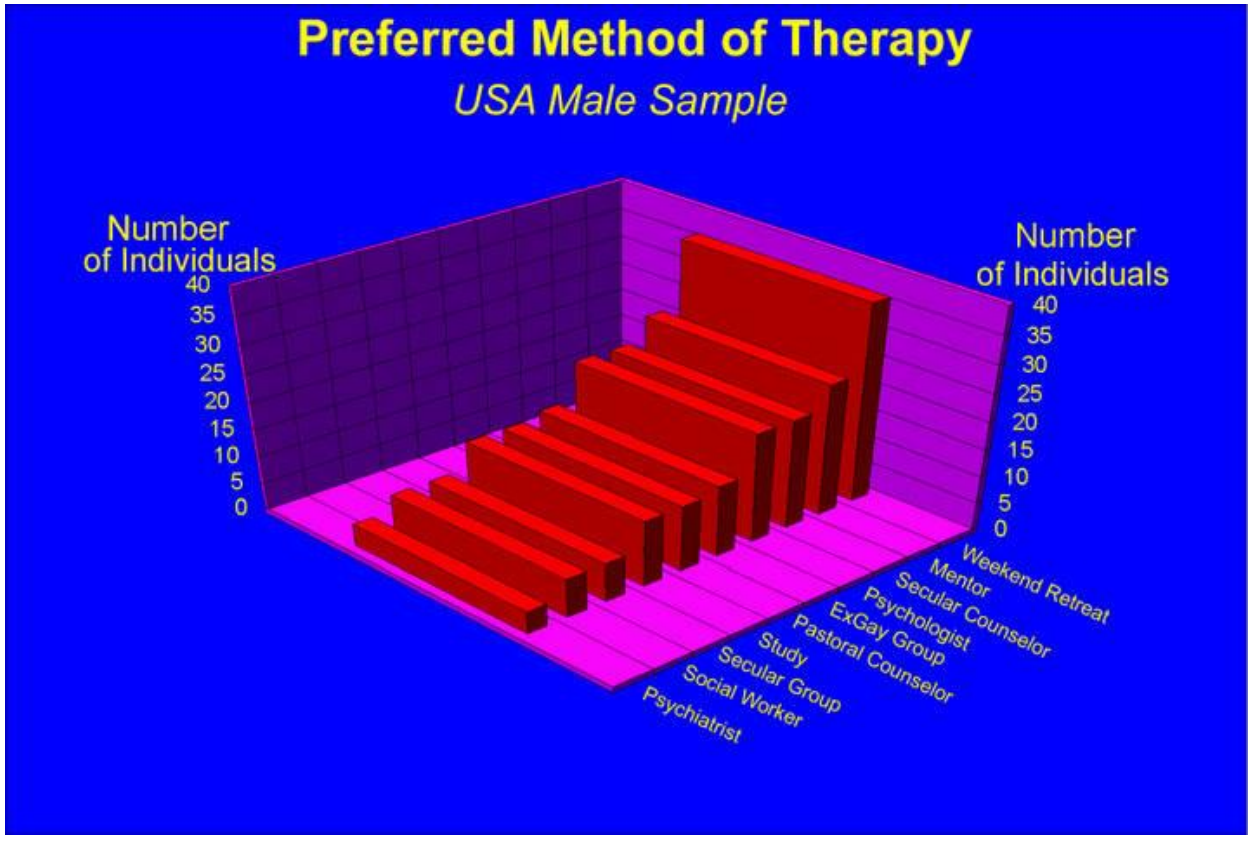
	Heterosexual & Almost entirely Heterosexual	Homosexual & Almost Entirely Homosexual
Baptist	2	1
Roman Catholic	2	0
Episcopalian	1	0
Methodist	1	1
Lutheran	0	0
Other Christian	5	11
Non-Denominational Christian	7	2
Mormon	3	11
Jewish	3	2
Buddhist	0	0
Muslim	0	0
Agnostic (existence of God is unknowable)	0	0
Atheist (unbelief in God)	0	0
Total	24	28

"Other Christian" and "Mormon" faiths or denominations. The heterosexual/ almost entirely heterosexual group was more evenly spread out among more of the faith and denominations surveyed. The hypothesis of the convenience sample of former clients of SOCE can diminish or

eliminate their same sex thoughts, feelings and behaviors and acquire a heterosexual orientation by increasing and having thoughts, feelings and behaviors for the opposite sex through psychotherapy (reparative therapy) is accepted.

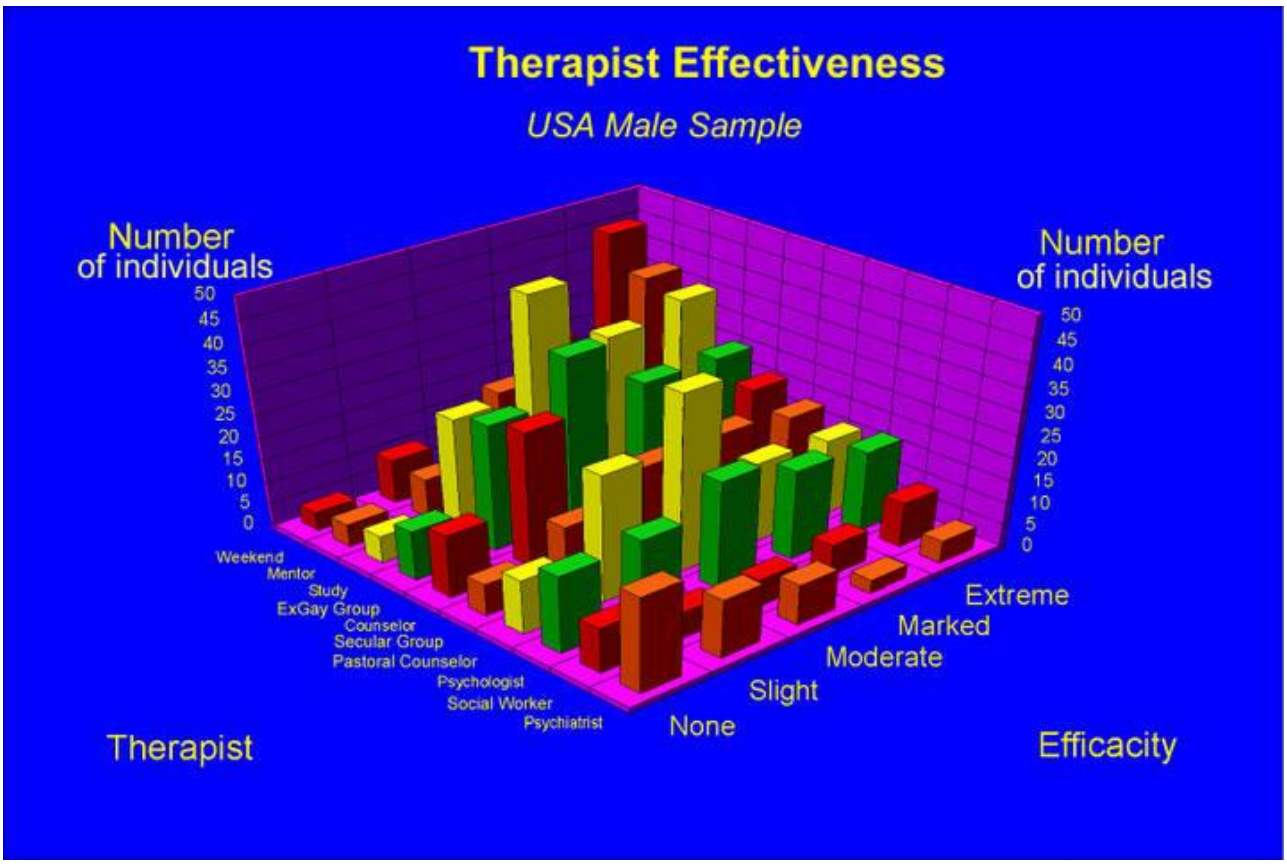
The second pertinent question addressed what the sample found helpful about their experiences of reparative therapy. The results from the survey addressing the second pertinent question, specifically pertaining to the mode of therapy or intervention vehicle used, determined that the most effective intervention was the participation in a same sex gender weekend/ retreat by 26.4% of the men surveyed, followed by seeing a mental health, family or marriage counselor (13.6%), seeing a psychologist (12.8%) and having a mentoring relationship with an individual (12%). Grouping all the professional counseling organizations together (psychiatrist, psychologist, social worker, mental health/ family/ marriage counselor, and pastoral counselor)

Table 24. Therapy interventions the survey participants found to be most helpful



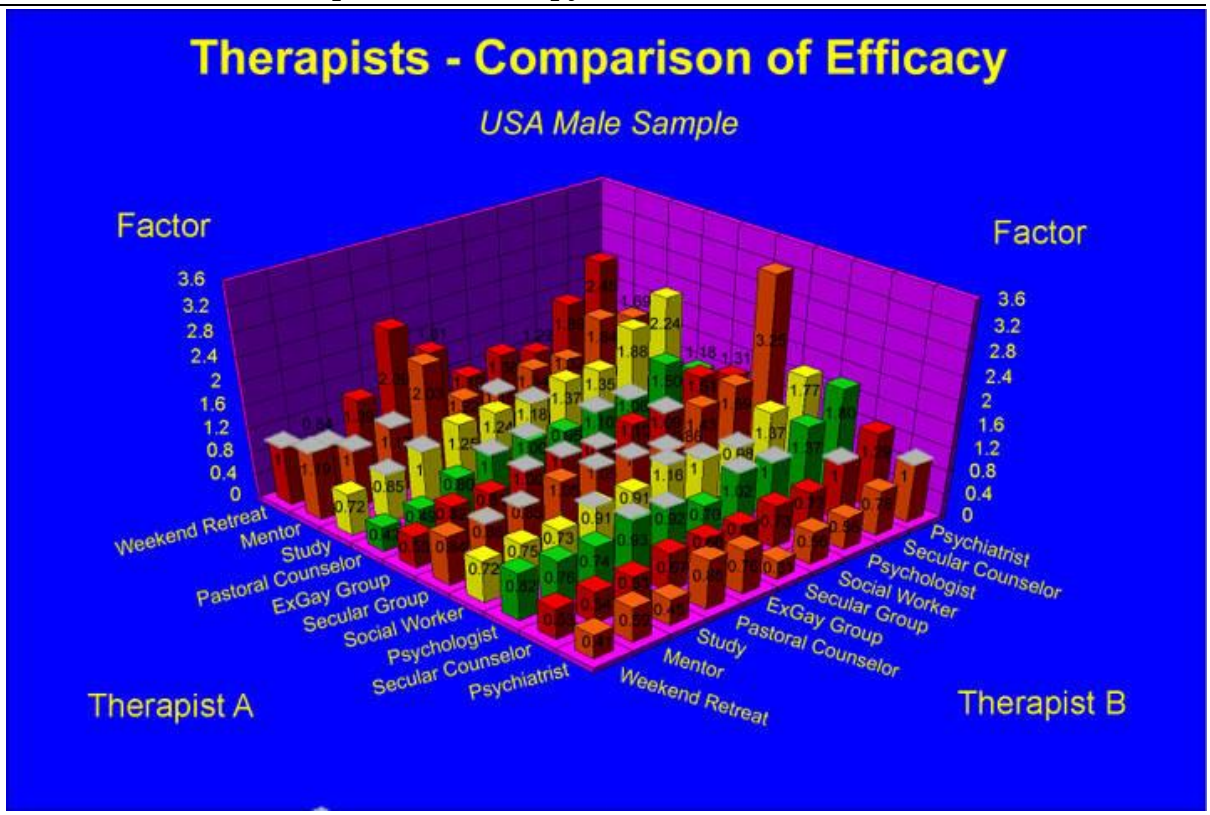
resulted in the most popular helpful intervention (52 men, 41.6%), yet, breaking the professional counseling down to specific types shows that the mental health/ family/ marriage counselor was the most helpful according to the survey. A comparison of the interventions showed that the non-religious or secular group was over three times more effective than a psychiatrist, the weekend retreat was approximately two and a half times more effective than a psychiatrist and a pastoral counselor according to the study results. The most accepted therapist interventions that were tried by the men surveyed showed that 118 men (94.4%) had used individual study, 105 (84%) men had tried a former gay or other religious support group and 94 men (75.2%) had seen a pastoral counselor. The most popular professional counseling interventions were pastoral counselors (84 men, 67.2%) followed by the mental health/ family/ marriage counselor (82 men,

Table 25. Therapy interventions effectiveness



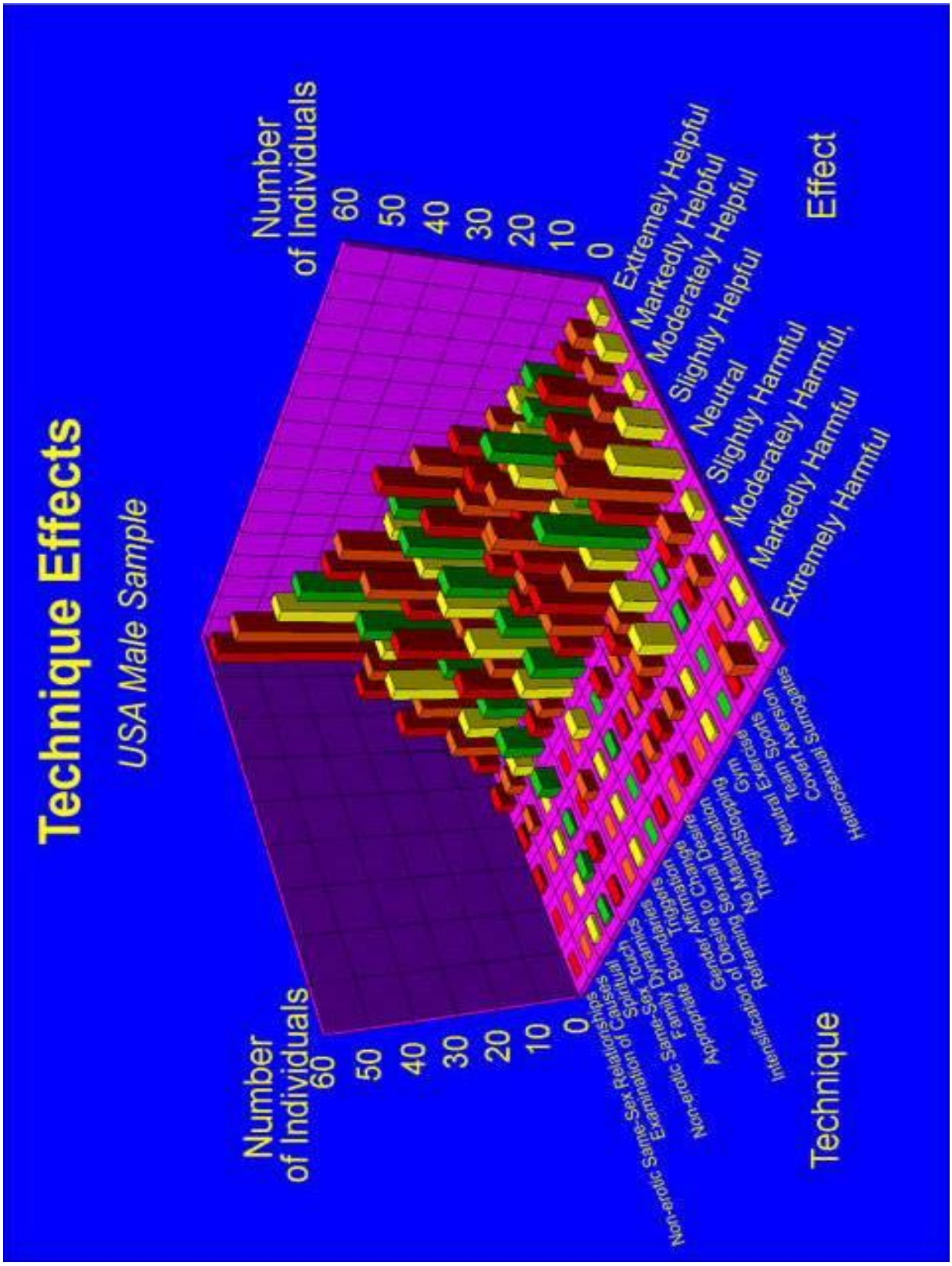
65.6%) and then the psychologist (73 men, 58.4%). The 24 participants, who classified their feelings as heterosexual or almost entirely heterosexual at the time of the survey, believed that the same gender weekend/ retreat was the most helpful intervention (seven men, 29.1%), followed by the mental health, family or marriage counselor (four men, 16.7%) and then the psychologist and non religious support group (three men each, 12.5%). The 28 participants in the survey who classified their feelings as homosexual or almost entirely homosexual at the time of the survey, believed that a same gender mentoring relationship was the most helpful intervention (five men, 17.9%), followed by a psychologist, former gay or other religious support group and a same gender weekend/ retreat (all three interventions had four men each with a 14.3% rate). These results were similar to the overall results for the entire sample of 125 men that took the survey.

Table 26. Comparison of therapy interventions effectiveness



Grey top denotes not statistically significant (all other bars statistically significant p<0.001)

Table 27. Therapy techniques found to be most effective

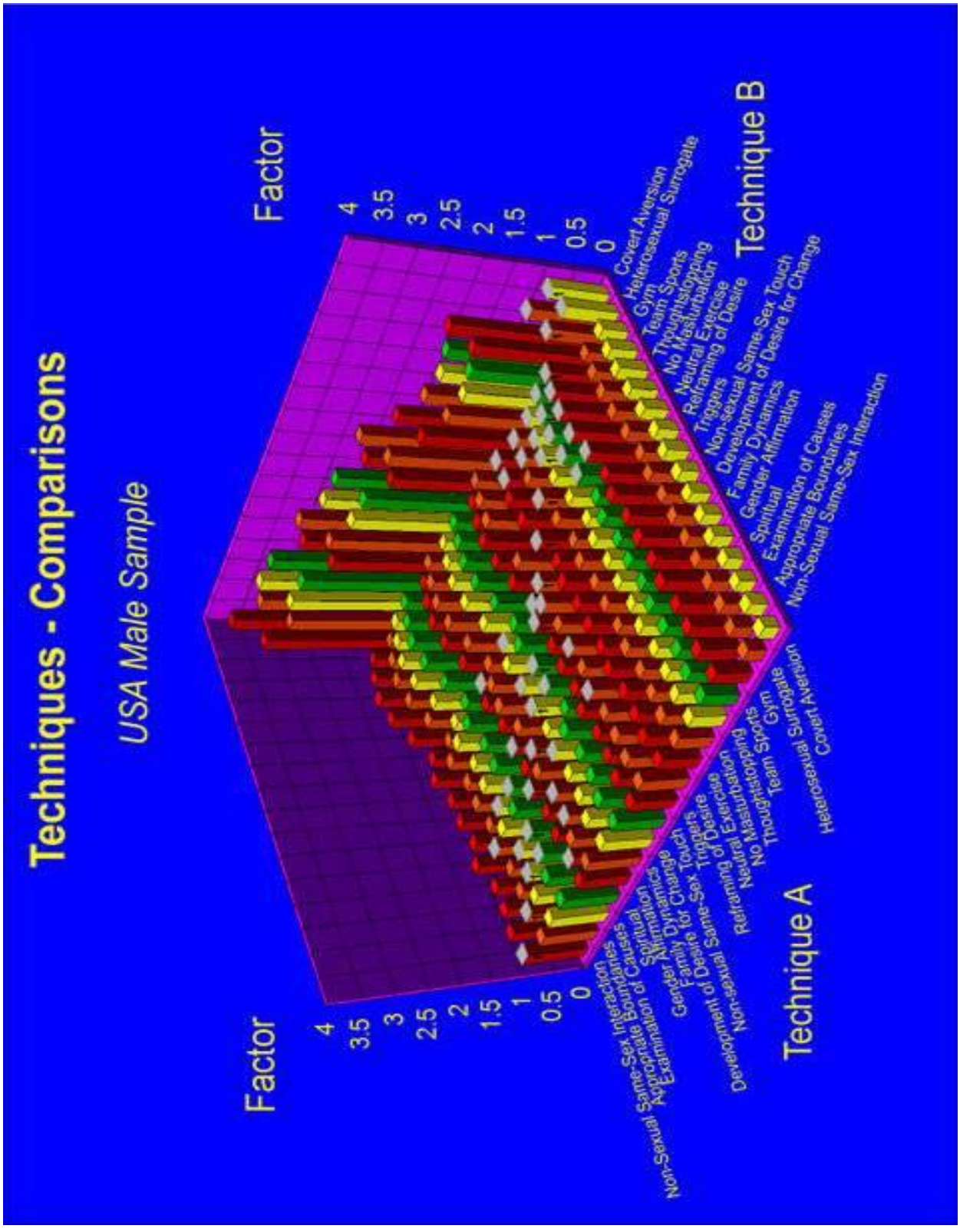


The therapeutic techniques that survey participants found to be the most helpful overall ("extremely", "markedly", "moderately" combined) were "developing nonsexual relationships with same-sex peers, mentors, family members and friends " (109), "understanding better the causes of your homosexuality and your emotional needs and issues" (104), "meditation and spiritual work" (104), "exploring linkages between your childhood and family experiences and your same-sex sexual attraction or behavior" (97) and "learning to maintain appropriate boundaries" (95). The therapeutic techniques that the survey participants found to be the most "extremely" helpful were "developing nonsexual relationships with same-sex peers, mentors, family members and friends" (60), "understanding better the causes of your homosexuality and your emotional needs and issues" (57), "meditation and spiritual work"- e.g., scripture study, praying, confession to spiritual leader, faith in God, experiencing God's love, acceptance, and forgiveness (49), "receiving healthy non-sexual touch from someone of the same sex" (46) and "exploring linkages between your childhood and family experiences and your same sex sexual attraction and behavior" (41). A comparison of the techniques demonstrated that most of the techniques were twice as effective as the aversion and heterosexual surrogate techniques, led by non-sexual same sex interaction technique at more than three times as effective. In general, the overall effectiveness of the techniques was similar and between two times as effective as the aversion and heterosexual surrogate techniques. The 24 participants in the survey who classified their feelings as heterosexual or almost entirely heterosexual at the time of the survey, believed that "developing nonsexual relationships with same-sex peers, mentors, family members and friends" (18 men) as well as "understanding better

the causes of your homosexuality and your emotional needs and issues" (18 men) were the most extremely helpful therapeutic techniques along with "exploring linkages between your childhood

and family experiences and your same-sex sexual attraction or behavior" (15 men). The 28

Table 28. Comparison of therapy techniques effectiveness

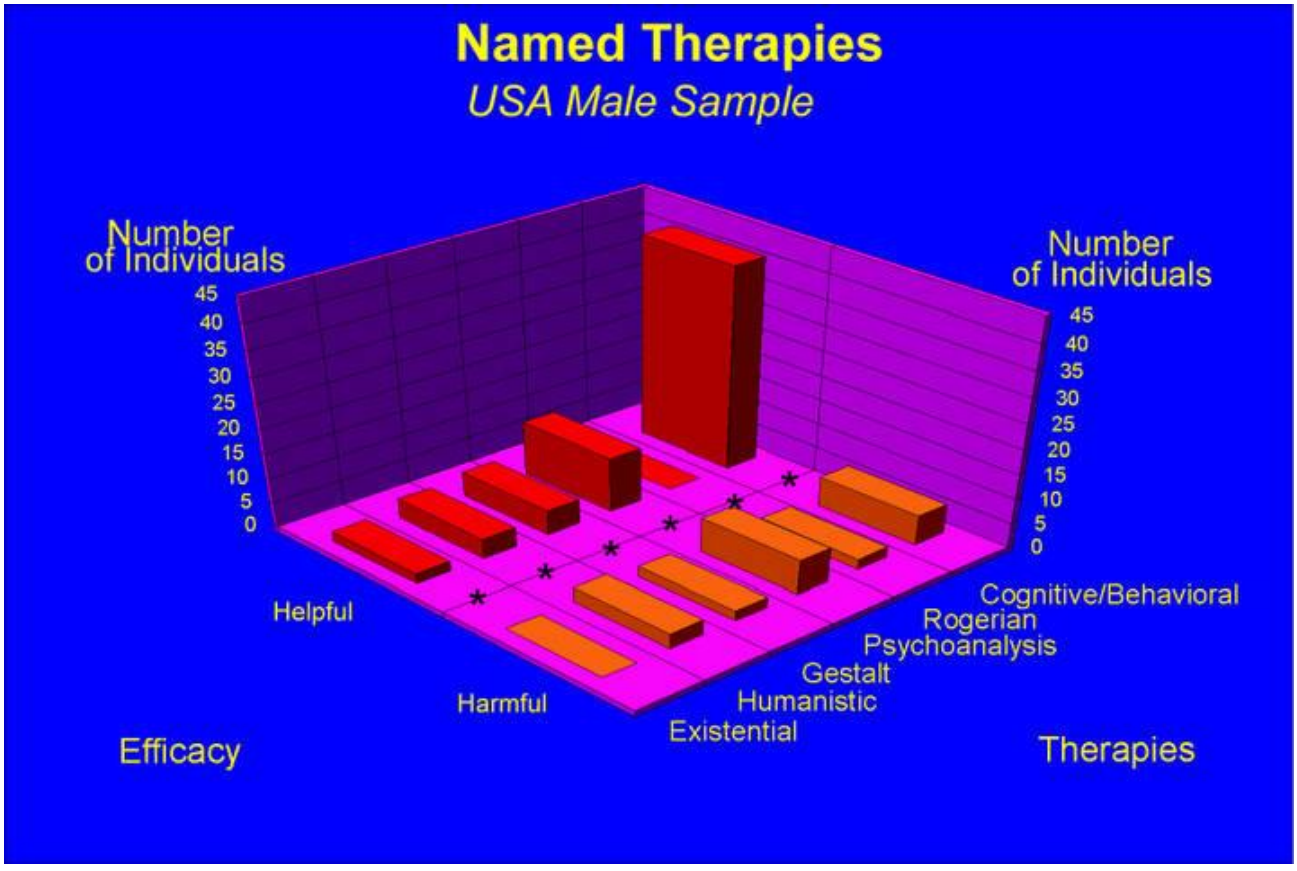


Grey top denotes not statistically significant (all other bars statistically significant p<0.001)

survey participants', who classified their feelings as homosexual or almost entirely homosexual at the time of the survey, felt that the most extremely helpful, therapeutic techniques were "developing nonsexual relationships with same-sex peers, mentors, family members and friends" (eight men), "understanding better the causes of your homosexuality and your emotional needs and issues" (six men), "exploring linkages between your childhood and family experiences and your same-sex sexual attraction or behavior" (five men), "meditation and spiritual work" (five men) and "developing nonsexual relationships with same-sex peers, mentors, family members and friends" (five men).

The most helpful approach that the participants experienced during their therapy was cognitive behavioral (26.4%) followed by psychoanalysis and gestalt (4% each). Most of the

Table 29. Therapy approaches found to be most helpful and harmful

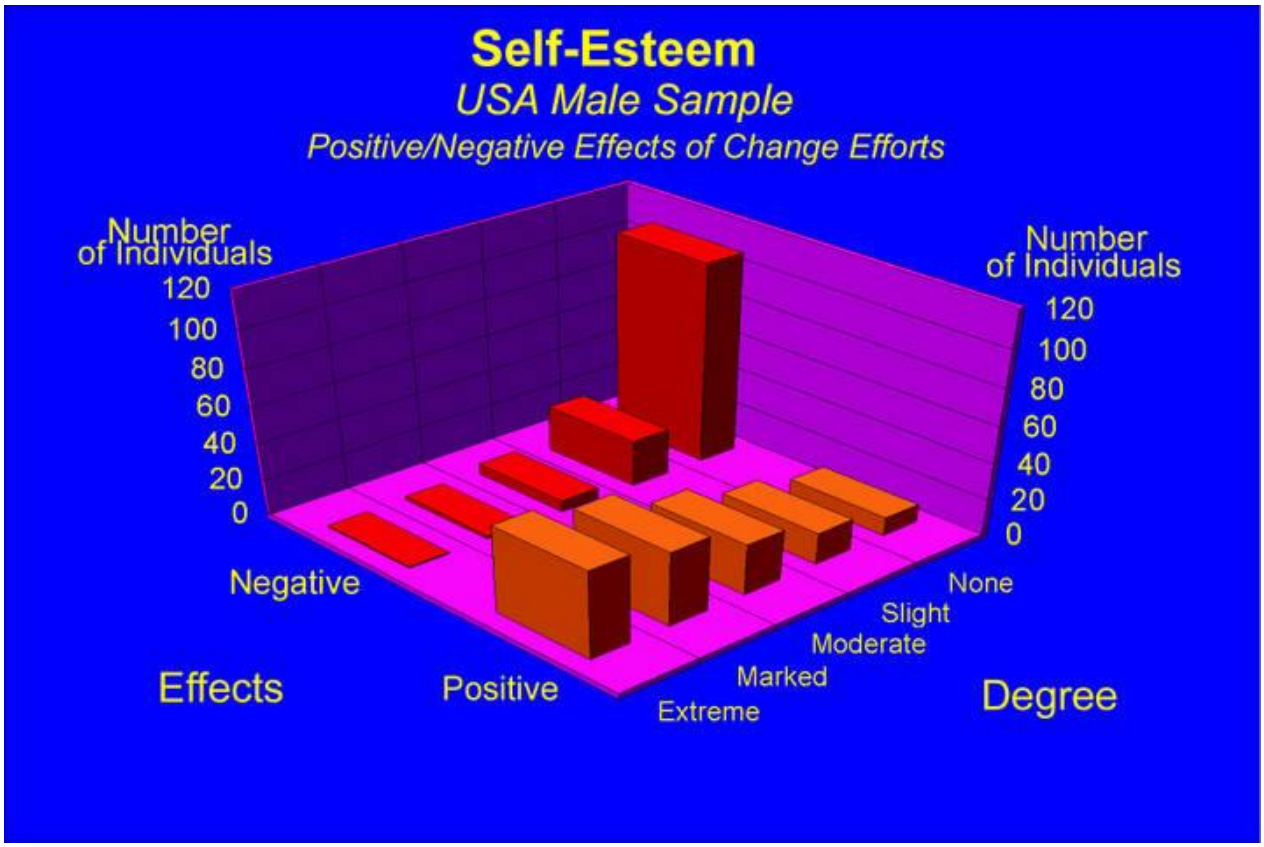


* Denotes statistically significant p < 0.001

participants' surveyed did not know the therapeutic approach used by the clinician (55.2%). The 28 participants in the survey who classified their feelings as homosexual or almost entirely homosexual at the time of the survey, believed that the most helpful approach that they experienced during their therapy was cognitive behavioral (7 men, 28.6%) while 13 men (46.4%) did not know the therapeutic approach that the clinician used. The 24 participants who classified their feelings as heterosexual or almost entirely heterosexual at the time of the survey, also believed that the most helpful approach that they experienced during their therapy was cognitive behavioral (7 men, 29%) while 12 men (50%) did not know the therapeutic approach that the clinician used.

The most popular benefit, or "positive change", that the survey participants found therapy

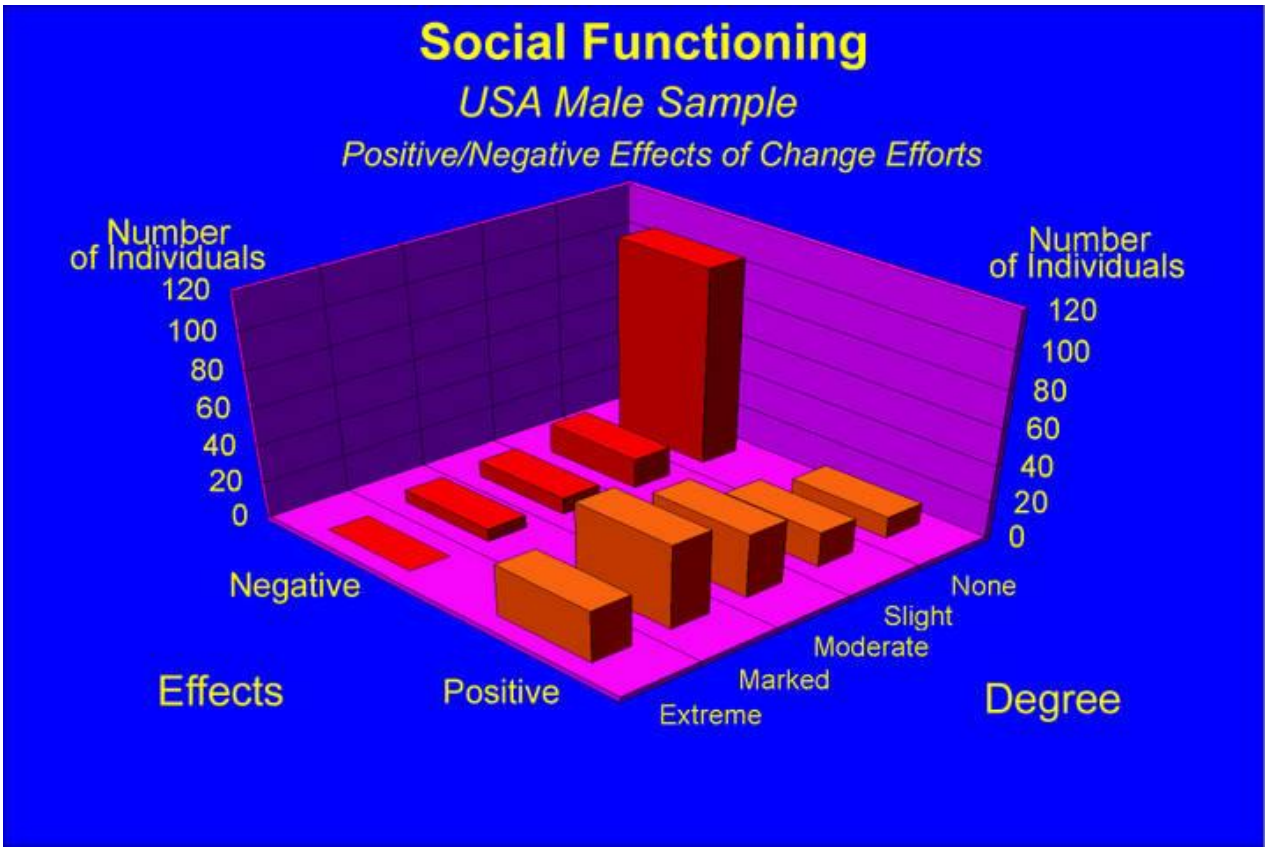
Table 30. Therapy effects on participants' self-esteem



to have on themselves, in terms of feelings and behaviors, was their self esteem, 118 men (94.4%), including 40 participants (32%) that answered “extremely so” and 38 participants (30.4%) that answered “markedly so”. Social functioning was another area that the survey participants experienced a positive change, 112 men (89.6%), including 21 (16.8%) who answered “extremely so” and 42 (33.6%) who answered “markedly so”. The survey participants believed that depression, 90 men (72%); self harmful behavior, 58 men (46.4%), thoughts or attempts at suicide, 45 men (36%), and alcohol and substance abuse, 21 men (16.8%), were all areas that were positively affected by their change efforts.

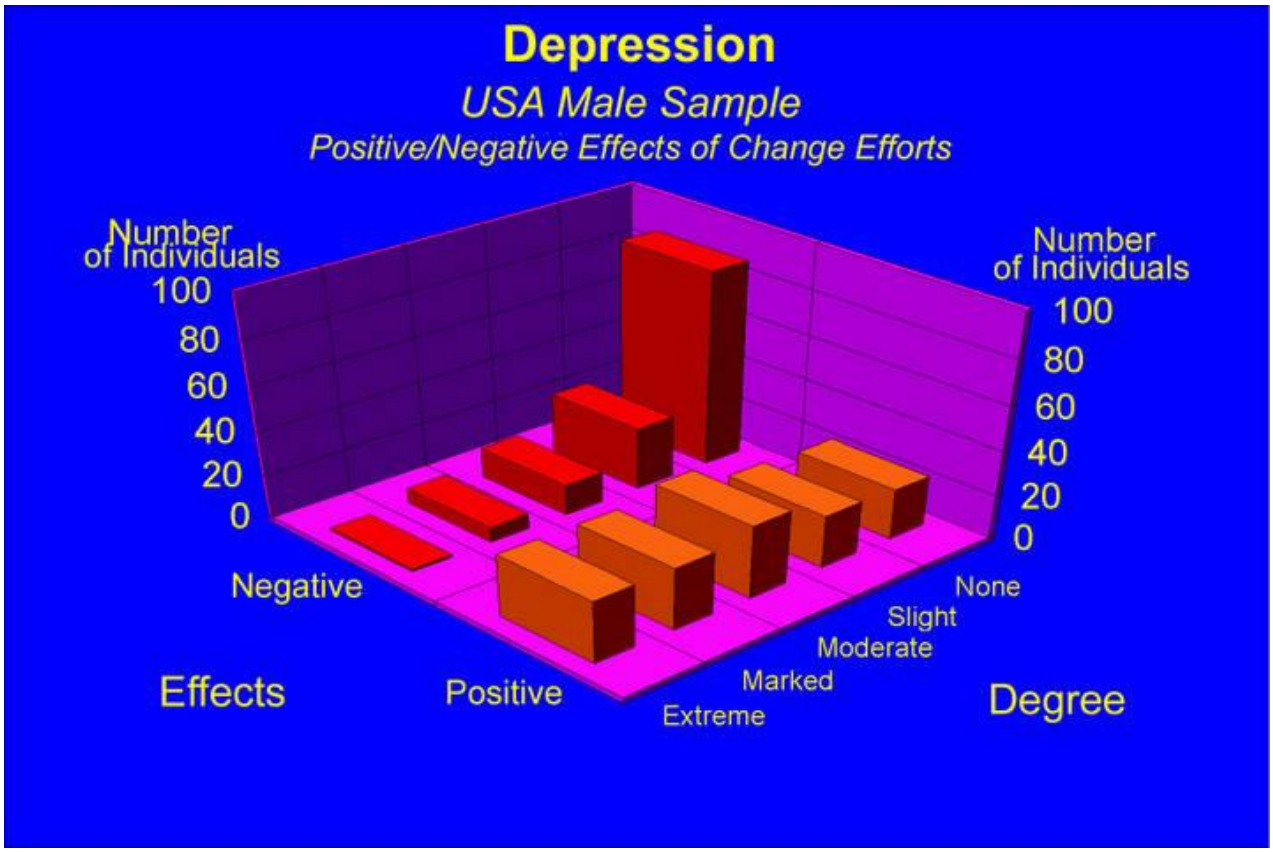
All of the 24 participants in the survey, (100%), who classified their feelings as heterosexual or almost entirely heterosexual at the time of the survey, felt that their change

Table 31. Therapy effects on participants’ social functioning



efforts had a positive effect on their self esteem and social functioning, 50% felt that their change efforts had a positive effect on their depression, 45.8% felt that their change efforts had a positive effect on their self harmful behavior and 33% felt that their change efforts had a positive effect on their alcohol and substance abuse and thoughts and attempts at suicide. Most the 28 survey participants, (85.7%), who classified their feelings as homosexual or almost entirely homosexual at the time of the survey, felt that their change efforts had a positive effect on their self esteem, 89.3% of them felt that their change efforts had a positive effect on their social functioning, 71.4% felt that their change efforts had a positive effect on their depression, 42.8% felt that their change efforts had a positive effect on their self harmful behavior and 39.2% felt that their change efforts had a positive effect on their thoughts and attempts at suicide and 10.7%

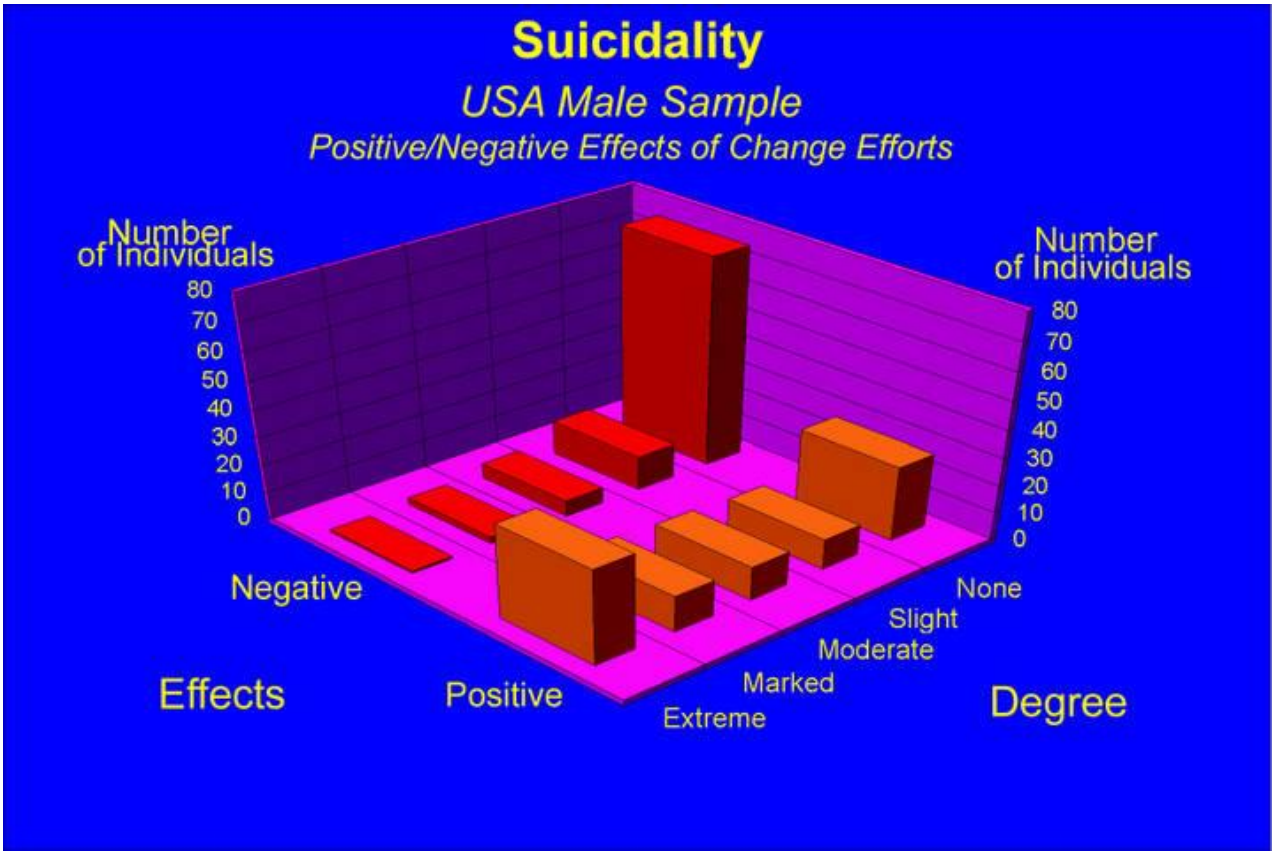
Table 32. Therapy effects on participants' depression



felt that their change efforts had a positive effect on their alcohol and substance abuse. The above information showed that the hypothesis of the convenience sample of former clients of SOCE found reorientation counseling helpful in increasing their self esteem, self acceptance and overall positive self outlook is accepted.

The third pertinent question that the survey addressed was, "What did people find harmful about their experiences of reparative therapy? The therapeutic techniques that the survey participants found to be the most harmful overall ("extremely", "markedly", "moderately" and "slightly" combined) were "going to the gym" (20), "imagining getting AIDS" (17), "stopping homosexual thoughts" (16) and "abstaining from masturbation" (13). The therapeutic techniques that the survey participants found to be the most "extremely" harmful

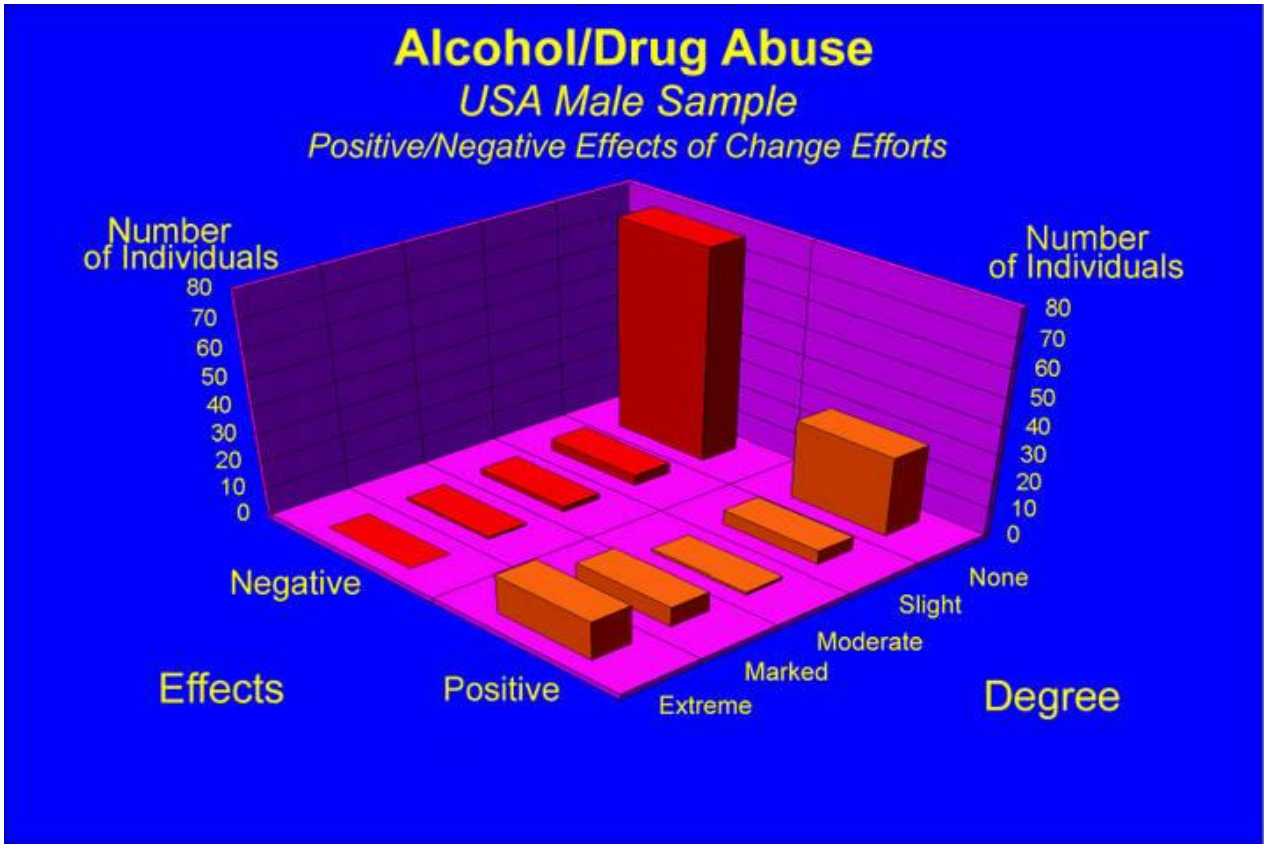
Table 33. Therapy effects on participants' suicidality



were “imagining getting aids” (six), “abstaining from masturbation” and “using heterosexual surrogates” (two each). The 28 participants in the survey who classified their feelings as homosexual or almost entirely homosexual at the time of the survey, believed that “imagining getting aids” (three), was most harmful followed by “abstaining from masturbation”, “meditation and spiritual work”, “developing a strong desire to change” and “using heterosexual surrogates” (one each). The 24 participants who classified their feelings as heterosexual or almost entirely heterosexual at the time of the survey, believed that “receiving same gender non-sexual touch” (two) was most harmful followed by “avoiding homosexual trigger situations”, “abstaining from masturbation”, and “imagining getting aids” (one each).

The most harmful approach that the participants experienced during their therapy was

Table 34. Therapy effects on participants’ alcohol drug abuse behavior



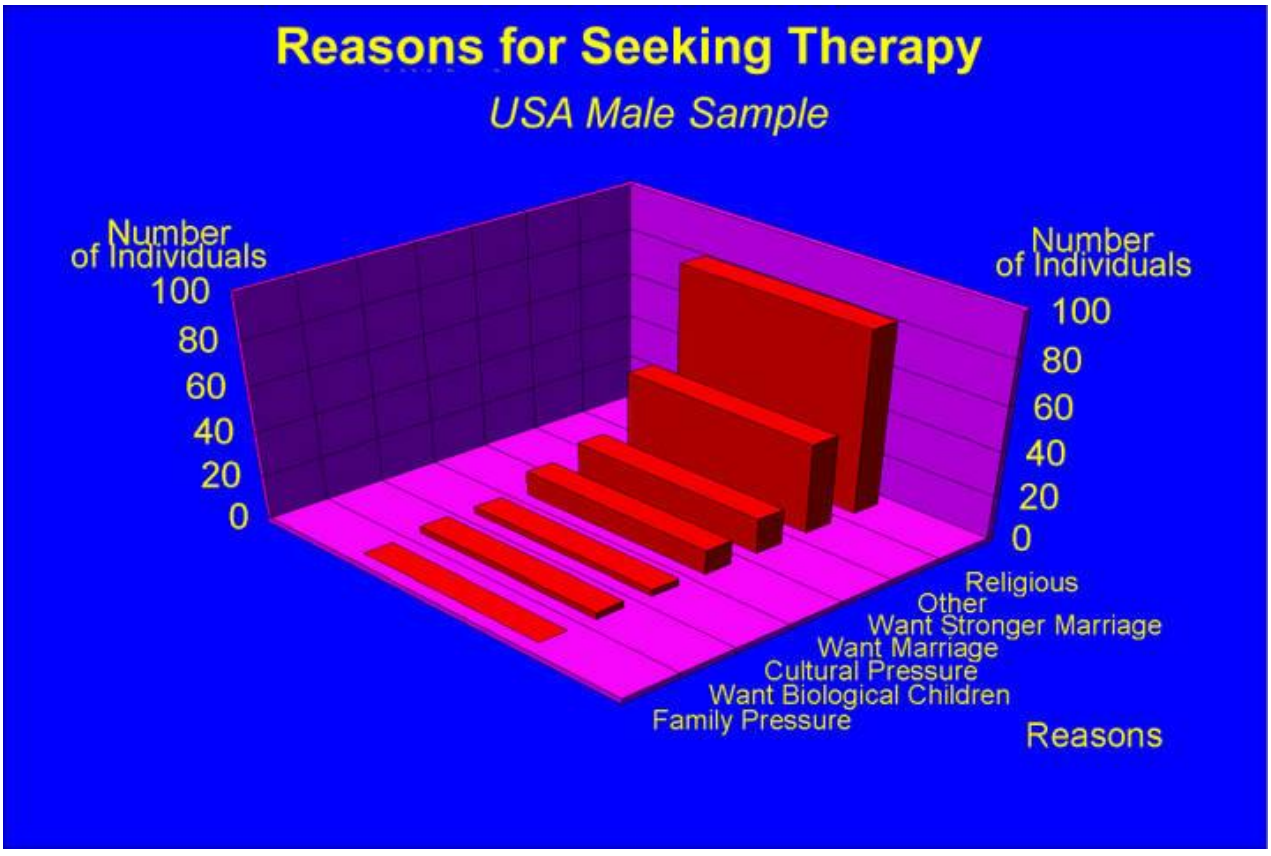
psychoanalysis (3.2%) followed by cognitive behavioral and humanistic (2.4% each). A majority of the participants surveyed did not know the therapeutic approach used by the clinician (72%). The 28 participants in the survey who classified their feelings as homosexual or almost entirely homosexual at the time of the survey, believed that the most harmful approach that they experienced during their therapy was Gestalt (one man, 3.6%). The 24 participants in the survey who classified their feelings as heterosexual or almost entirely heterosexual at the time of the survey, also believed that the most harmful approach that they experienced during their therapy was gestalt and psychoanalysis (one man each, 3.6%).

The drawbacks or "negative changes" that the survey participants found therapy to have on themselves, in terms of feelings and behaviors, included depression, (33.6%), including one participant (.8%) that answered "extremely so" and five participants (4%) that answered "markedly so". Self esteem was another area that the survey participants experienced a negative change, (22.4%), including zero who answered "extremely so" and two (1.6%) who answered "markedly so". Social functioning was negatively affected, (20.8%), including zero who answered "extremely so" and five (4%) who answered "markedly so". Thoughts or attempts at suicide (16.8%), self harm behavior (12%) and alcohol and substance abuse (4.8%) were all areas that were negatively affected by their change efforts.

Over half of the 28 survey participants, (64%), who classified their feelings as homosexual or almost entirely homosexual at the time of the survey felt that their change efforts had a negative effect on their depression, 46.4% of them felt that their change efforts had a negative effect on their self esteem, 39.2% of them felt that their change efforts had a negative effect on their social functioning, 28.5% felt that their change efforts had a negative effect on their thoughts and attempts at suicide, 21% felt that their change efforts had a negative effect on

their self harmful behavior, and 10.7% felt that their change efforts had a negative effect on their alcohol and substance abuse. Some of the 24 participants (12.5%) in the survey, who classified their feelings as heterosexual or almost entirely heterosexual at the time of the survey, felt that their change efforts had a negative effect on their depression and social functioning, 8.3% felt their change efforts had a negative effect on their self esteem, 4.2% felt that their change efforts had a negative effect on their self harmful behavior and thoughts and attempts at suicide and no one in the study felt that their change efforts had a negative effect on their alcohol and substance abuse. The survey results showed that the hypothesis of the convenience sample of former clients of SOCE found the therapeutic intervention of therapeutic touch to cause harm to themselves was supported.

Table 35. Survey participants' reason to change same sex thoughts, feelings and behaviors



The survey results showed the main reason that the 125 survey participants' decided to change their same sex thoughts, feelings and behaviors was their religious beliefs (63.2%) followed by strengthening their current marriage (11.2%) and desiring to marry a person of the opposite sex and unhappiness (7.2% each). Most of the 28 survey participants, (82%), who classified their feeling as homosexual or almost entirely homosexual at the time of the survey, felt "religious beliefs" were the main reason to try to change along with "finding peace" and "culture pressure and acceptance" with 2 each (7.1%). The 24 participants in the survey who classified their feelings as heterosexual or almost entirely heterosexual at the time of the survey felt that religious beliefs were also the main reason to attempt change, eight participants (33%), followed by "unhappiness", "personal desire" and "strengthen a current marriage" with three participants each (12.5%).

Table 36. Participants' in therapy current sexual attraction.

	Number of Response(s)	**Response Ratio**
more homosexual than heterosexual	14	26.9%
almost entirely homosexual	10	19.2%
more heterosexual than homosexual	8	15.3%
bi-sexual	6	11.5%
almost entirely heterosexual	5	9.6%
homosexual	4	7.6%
heterosexual	4	7.6%
No Responses	1	1.9%
Total	52	100%

The survey results for the male participants who were still in therapy were similar for the males who were not in therapy that took the survey. Overall, the participants who were no longer in therapy rated having more opposite sex thoughts, feelings, desires and behaviors and less same sex thoughts, feelings, desires and behaviors as compared to the participants who were still in therapy. The results from the survey showed that:

- 14 of the 52 who were still in therapy, or 26.9%, described themselves as engaging in homosexual sex either on a daily, weekly, monthly or yearly basis.
- 13 of the 72 men, or 18.1%, who were no longer in therapy, described themselves as engaging in homosexual sex either on a daily, weekly, monthly or yearly basis.
- 10 of the 52 participants who were still in therapy (19.2%) described themselves as engaging in homosexual passionate kissing either on a daily, weekly, monthly or yearly basis.
- 10 of the 72 men, or 13.9%, who were no longer in therapy, described themselves as engaging in homosexual passionate kissing either on a daily, weekly, monthly or yearly basis.
- 42 of the 52 participants who were still in therapy, or 80.7%, described themselves as looking with lust or daydreaming about having homosexual sex either on a daily, weekly, monthly or yearly basis.
- 53 of the 72 men, or 73.6%, who were no longer in therapy, described themselves as looking with lust or daydreaming about having homosexual sex either on a daily, weekly, monthly or yearly basis.

Table 37. Participants' not in therapy current sexual attraction.

	Number of Response(s)	Response Ratio
more homosexual than heterosexual	18	25.0%
more heterosexual than homosexual	16	22.2%
bi-sexual	9	12.5%
heterosexual	8	11.1%
homosexual	8	11.1%
almost entirely heterosexual	7	9.7%
almost entirely homosexual	6	8.3%
No Responses	0	0.0%
Total	72	100%

- 40 of the 52 participants who were still in therapy, or 76.9%, described themselves as desiring romantic homosexual intimacy either on a daily, weekly, monthly or yearly basis.
- 48 of the 72 men, or 66.7%, who were no longer in therapy, described themselves as desiring romantic homosexual intimacy either on a daily, weekly, monthly or yearly basis.
- 14 of the 52 participants who were still in therapy, or 26.9%, described themselves as having heterosexual sex either on a daily, weekly, monthly or yearly basis.
- 30 of the 72 men, or 41.6%, who were no longer in therapy, described themselves as having heterosexual sex either on a daily, weekly, monthly or yearly basis.
- 14 of the 52 participants who were still in therapy, or 26.9%, described themselves as having heterosexual passionate kissing either on a daily, weekly, monthly or yearly basis. The survey showed that 36 of the 72 men, or 50%, who were no longer in therapy, described themselves as having heterosexual passionate kissing either on a daily, weekly, monthly or yearly basis.
- 31 of the 52 participants who were still in therapy, or 59.6%, described themselves as looking with lust or daydreaming about having heterosexual sex either on a daily, weekly, monthly or yearly basis.
- 53 of the 72 men, or 73.6%, who were no longer in therapy, described themselves as looking with lust or daydreaming about having heterosexual sex either on a daily, weekly, monthly or yearly basis.
- 35 of the 52 participants who were still in therapy, or 67.3%, described themselves as desiring romantic heterosexual intimacy either on a daily, weekly, monthly or yearly basis.
- 59 of the 72 men, or 81.9%, who were no longer in therapy, described themselves as desiring romantic heterosexual intimacy either on a daily, weekly, monthly or yearly basis.

- 14 of the 52 participants who were still in therapy, or 26.9%, described their sexual attraction as homosexual or almost entirely homosexual and 9 of the 52 participants, or 17.3%, described their sexual attraction as heterosexual or almost entirely heterosexual.
- 14 of the 72 men, or 19.4%, who were no longer in therapy, described their sexual attraction as homosexual or almost entirely homosexual and 15 of the 72 participants, or 20.8%, described their sexual attraction as heterosexual or almost entirely heterosexual.

Male survey participants' residing outside the U.S.

There were 25 men who participated in the survey who resided outside the United States, and because of cultural, political and social differences, as compared to the US, those surveys were not included with those men residing in the United States. However, the results could still be analyzed and compared to the US results. The men resided all over the world including Israel, Canada, Brazil, Australia, Mexico, Germany and the United Kingdom. The majority was Caucasian, 26 -55 years of age, earned under $100,000, had earned a bachelor or masters degree, was Christian or Jewish.

The survey results showed six months before the 25 male participants sought out help for their same sex attraction, 13 men, or 52%, described themselves as engaging in homosexual sex. The survey then revealed, after the re-orientation therapy for the men's same sex attraction was received, five men, or 20%, described themselves as engaging in homosexual sex, a 61.5% decrease in homosexual activity. The survey results indicated that four men engaged in heterosexual sex six months before they sought out help for their same sex attraction and the same four men engaged in heterosexual sex after the re-orientation therapy for a zero change rate. The survey results determined six months before the 25 male participants sought out help for their same sex attraction, 10 men, or 40%, described themselves as engaging in homosexual

passionate kissing. The survey then demonstrated, after the re-orientation therapy for the men's same sex attraction was received, four men, or 20%, described themselves as engaging in homosexual passionate kissing, a 60% decrease. The survey results showed six months before the 25 male participants sought out help for their same sex attraction, four men, or 16%, described themselves as engaging in heterosexual passionate kissing. The survey then revealed, after the re-orientation therapy for the men's same sex attraction was received, six men, or 24%, described themselves as engaging in heterosexual passionate kissing, a 50% increase.

The survey results indicated six months before the 25 male participants sought out help for their same sex attraction, 20 men, or 80%, described themselves as looking with lust or daydreaming about having homosexual sex. The survey then demonstrated, after the re-orientation therapy for the men's same sex attraction was received, 15 men, or 60%, described themselves as looking with lust or daydreaming about having homosexual sex, a 25% decrease. The survey results showed six months before the 25 male participants sought out help for their same sex attraction, four men, or 16%, described themselves as looking with lust or daydreaming about having heterosexual sex. The survey then revealed, after the re-orientation therapy for the men's same sex attraction was received, nine men, or 36%, described themselves as looking with lust or daydreaming about having homosexual sex, a 112.5% increase. The survey results indicated six months before the 25 male participants sought out help for their same sex attraction, 24 men, or 96%, described themselves as desiring romantic, emotional, homosexual intimacy. The survey then demonstrated, after the re-orientation therapy for the men's same sex attraction was received, 17 men, or 68%, described themselves as desiring romantic, emotional, homosexual intimacy, a 33% decrease. The survey results showed six months before the 25 male participants sought out help for their same sex attraction, seven men, or 28%, described

themselves as desiring romantic, emotional, heterosexual intimacy. The survey then revealed, after the re-orientation therapy for the men's same sex attraction was received, 10 men, or 40%, described themselves as desiring romantic, emotional, heterosexual intimacy, a 42.9% increase. The survey results indicated six months before the 25 male participants sought out help for their same sex attraction, 14 men, 56%, rated their sexual attraction as homosexual, six men, 24%, rated almost entirely homosexual, four men, 16%, rated more homosexual than heterosexual and one man, 4%, rated heterosexual. The survey then demonstrated, after the re-orientation therapy for the men's same sex attraction was received, five men, 20%, rated their sexual attraction as homosexual, six men, 24%, rated almost entirely homosexual, five men, 25%, rated more homosexual than heterosexual, two men, 8%, rated bisexual, two men, 8%, rated more heterosexual than homosexual, three men, 12%, rated almost entirely heterosexual and two men, 8%, rated heterosexual. The results showed a 45% decrease in homosexual and almost entirely homosexual rate and a 500% increase in heterosexual and almost entirely heterosexual rate.

In comparing the non-US men with the US men, similar results are seen in most of the categories. Before therapy, the majority of the participants classified their sexual attraction as homosexual, almost entirely homosexual and more homosexual than heterosexual, 88% of the US men and 96% of the non-US men. After therapy, at the time of the survey, there was a lower rate in homosexual attraction, 48.8% of the US men, or 44.5% decrease, and 68% in the non-US men, a 29.2% decrease. An increase in heterosexual attraction also resulted. Before therapy, few of the participants classified their sexual attraction as heterosexual, almost entirely heterosexual and more heterosexual than homosexual, four percent of the US men and the non-US men. After therapy, at the time of the survey, there was a higher rate in heterosexual attraction, 38.4% of the US men and 24% of the non-US men.

Female survey participants residing inside and outside the U.S.

Although not used in the summary of data, there were 7 females that participated in the survey, all of whom resided in the U.S. on the west coast or in the mid-west. The majority of women was single, Caucasian, 26 -35 years of age, earned under $50,000, had went or graduated from college with a bachelor degree, was Christian and went to church once a week. The results of the survey showed that five of the seven women had rated their sexual attraction at homosexual or almost entirely homosexual before therapy and then at the time of the survey, three women described themselves in those same two categories. The greatest change in attractions were one of the five women decreased her homosexual attraction to a bi-sexual attraction and the other women went from almost entirely homosexual attraction to more heterosexual than homosexual attraction. Before therapy not one of the females described their sexual attraction as heterosexual or almost heterosexual and at the time of the survey one woman described herself as almost entirely heterosexual. Popular effective interventions for the women included having a mentoring relationship with an individual and a mental health counselor. The effective therapeutic techniques for the women included maintaining appropriate boundaries and developing a stronger desire to change. Social functioning was the top positive changes that all of the females noticed at the time of the survey and some of the females felt depression was the negative change that they noticed at the time of the survey.

Summary of the data in answer to the pertinent questions

The survey answered the first pertinent question of "To what extent does a convenience sample of former and current clients of SOCE report changes in same sex and opposite sex thoughts, feelings and/or behaviors after receiving reparative therapy?" The results of the survey revealed that the men who participated in the survey showed a 59% decrease in homosexual

activity, including a 67.2% increase in abstaining from homosexual activity and a 28.5% increase in heterosexual sex activity after receiving reparative therapy. The results from the survey indicated that the men experienced a 20.7% decrease pertaining to lusting or daydreaming about homosexual sex and that 28 men, or 22.4%, described themselves as daydreaming or lusting about homosexual sex almost never, an increase of 700% from four men in abstaining from daydreaming or lusting about homosexual sex after therapy. The survey demonstrated that 85 men, or 68%, at the time the survey was taken, described themselves as daydreaming or lusting about heterosexual sex either on a daily, weekly, monthly or yearly basis, an 84.7% increase after therapy. The survey established that 89 men, or 71.2%, at the time the survey was taken, desired romantic and emotional homosexual intimacy, a 15.2% decrease; as well as 95 men, or 76%, at the time the survey was taken, described themselves as desiring romantic, emotional, heterosexual intimacy either on a daily, weekly, monthly or yearly basis, a 37.7% increase. The survey results showed that 61 men, 48.8%, described their sexual attraction as homosexual, almost entirely homosexual or more homosexual than heterosexual, an 80.3% decrease in homosexual attraction after reorientation therapy was received. The survey revealed, after the re-orientation therapy that 19.2 percent of the men rated their sexual attraction as more heterosexual than homosexual and 19.2 percent of the men rated their sexual attraction as almost entirely heterosexual and heterosexual. These numbers jumped from four men rating their sexual attraction as more heterosexual than homosexual to 24 men and one man rating his sexual attraction as almost entirely heterosexual before reorientation therapy to 24 men rating their sexual attraction as either almost entirely heterosexual or heterosexual after reorientation therapy. These results indicated that there was a decrease in homosexual thoughts, feelings and

behaviors after the participants received some kind of reorientation therapy for their unwanted same sex attraction as well as an increase in heterosexual thoughts, feelings and behaviors.

The survey answered the second pertinent question of: What does a convenience sample of former and current clients of SOCE report to have found helpful about their experiences of reparative therapy? The results of the survey demonstrated that the most effective therapeutic intervention was the participation in a same sex gender weekend/ retreat (26.4%) followed by seeing a mental health, family or marriage counselor (13.6%), seeing a psychologist (12.8%) and having a mentoring relationship with an individual (12%). The therapeutic techniques that the survey participants found to be the most helpful were "understanding better the causes of your homosexuality and your emotional needs and issues" (94.4%), "meditation and spiritual work" (93.6%), "exploring linkages between your childhood and family experiences and your same-sex sexual attraction or behavior" (92.8%), "developing nonsexual relationships with same-sex peers, mentors, family members and friends" (92%) and "learning to maintain appropriate boundaries" (87.2%). The most helpful therapeutic approach that the participants experienced during their therapy was cognitive behavioral (26.4%) followed by psychoanalysis and gestalt (4% each). The "positive change" that the survey participants found therapy to have on themselves, in terms of feelings and behaviors, included their self esteem (94.4%), social functioning (89.6%), depression (72%) self harmful behavior (46.4%), thoughts or attempts at suicide (36%) and alcohol and substance abuse (16.8%).

The survey also answered the third pertinent question of: What does a convenience sample of former and current clients of SOCE report to have found harmful about their experiences of reparative therapy? The results of the survey showed that the therapeutic techniques that the 125 survey participants found to be the most harmful included "going to the

gym" (16%), "imagining getting AIDS" (13.6%), "stopping homosexual thoughts" (12.8) and "abstaining from masturbation" (10.4%). The most harmful approach that the participants experienced during their therapy was psychoanalysis (3.2%) followed by cognitive behavioral and humanistic (2.4% each). The "negative changes" that the survey participants found therapy to have on themselves included depression (33.6%), self-esteem (22.4%), social functioning (20.8%), thoughts or attempts at suicide (16.8%), self-harm behavior (12%) and alcohol and substance abuse (4.8%).

Results of Study

The first hypothesis that the study attempted to answer was "The convenience sample of former and current clients of SOCE can diminish or eliminate their same sex thoughts, feelings and behaviors and acquire a heterosexual orientation by increasing and having thoughts, feelings and behaviors for the opposite sex through psychotherapy (reparative therapy)". The results of the data determined that the participants in the survey had decreased, and in some cases eliminated, their same sex thoughts, feelings and behaviors and acquired and increased their thoughts feelings and behaviors for the opposite sex after reparative therapy. Therefore the first hypothesis was accepted.

The second hypothesis that the paper attempted to answer was "The convenience sample of former and current clients of SOCE found reorientation counseling helpful in increasing their self esteem, self acceptance and overall positive self outlook". The results of the data demonstrated that 94.4% of the participants in the survey found reparative therapy to have a "positive change" on their self esteem and 89.6% on their social functioning. The participants experienced a "negative change" in their self-esteem (22.4%) and social functioning (20.8%) after receiving reparative therapy. The survey established that reparative therapy had a negative

and positive effect on some participants at the same time because some participants answered both positively and negatively regarding their self esteem and social functioning. A majority of the survey participants experienced a positive change in their self esteem and social functioning, therefore the second hypothesis was accepted.

The third hypothesis that the paper attempted to answer was "The convenience sample of former and current clients of SOCE found the therapeutic intervention of therapeutic touch to cause harm to themselves". The results of the data demonstrated that 37.1% of the participants in the survey found the therapeutic intervention of same gender non-sexual touch to be extremely helpful and 7.2% of the participants showed same gender non-sexual touch to be harmful. A minority of the survey participants experienced harm after experiencing the therapeutic intervention of same gender non-sexual touch, therefore the third hypothesis was not supported.

Validity Analysis

The validity of the survey could be measured by the pre-test that was administered a month before the survey was made available to be filled out on-line. Seventeen pre-tests were filled out by hand by men at a Courage meeting held at a Roman Catholic Church in San Diego during a Saturday evening in mid December, 2010. Courage is a Roman Catholic organization that helps men with their unwanted same sex attraction. All of the men who filled out the pre-test surveys practiced Roman Catholicism. The pre-test contained the questions on the final survey. One of the goals of the pre-test was to measure the validity: did the pre-test answer the pertinent questions. The pre-test results for first pertinent question of: what are the changes in same sex and opposite sex thoughts, feelings and/or behaviors after receiving reparative therapy, showed that eleven of the seventeen men (64.7%) currently kept their same sex attraction since they started their therapy. Five of the seventeen men (29.4%) were able to change their

homosexual attraction to some degree since they started therapy. Two men (11.7%) were able to change their same sex attraction from "almost entirely attracted to men" to attracted to "more men than women". One individual (5.8%) was able to change his attraction from "almost entirely men" to "equally men and women". Two individuals (11.7%) were able to change their attraction from "equally men and women" to "almost entirely women". One individual (5.8%) did not answer the set of questions measuring sexual attraction before and after therapy. These results revealed that the first pertinent question can be validly answered regarding individuals reporting changes in same sex and opposite sex thoughts, feelings and/or behaviors after receiving reparative therapy.

The pre-test results for the second and third pertinent questions of: what was helpful and harmful about people's experiences of reparative therapy, found that 78 percent of the people's answers on the survey found that the therapeutic techniques that they experienced in reparative therapy were helpful. Eight percent of the people's answers on the survey found that the therapeutic techniques that they experienced in reparative therapy were harmful. Fourteen percent of the people's answers on the survey found that the therapeutic techniques that they experienced in reparative therapy were not helpful or harmful. Of the people who participated in the pre-test, ninety one percent found that reparative therapy helped their self esteem; eighty two percent found that reparative therapy helped their social functioning; forty five percent found that reparative therapy helped their depression, self harmful behavior and thoughts/ attempts of suicide; and eighteen percent found that reparative therapy helped their alcohol and substance abuse. Conversely, eighteen percent the people who participated in the pre-test found that reparative therapy contributed to their depression and nine percent found that reparative therapy harmed their social functioning. These results revealed that the second and third pertinent

questions can be validly answered regarding individuals reporting to have found helpful and harmful about their experiences of reparative therapy.

The internal validity was affected because the sample was too homogeneous to generalize the results of the study. Most of the survey participants were Caucasian/ white (89.6%) and considered themselves Christian (88.8%). There was one apparent confound: the survey is a self written test which is biased. This bias will affect the validity and reliability because of the way the questions were posed in the survey. There were no apparent issues to distort the external validity of the survey.

Reliability

The second goal of the pre-test was to measure the reliability, did the pre-test show consistency in the answers. The reliability of the survey was measured by comparing the results of the pre-test with the results of the actual survey itself. In measuring the first pertinent question, a change in sexual attraction, the pre-test results showed that six months before getting help to attempt to change their same sex attraction 73.3 percent of the male participants considered their sexual attraction homosexual and almost entirely homosexual, 13.3 percent considered their sexual attraction more homosexual than heterosexual, 6.6 percent considered their sexual attraction equally homosexual and heterosexual (bi-sexual) and 6.6 percent considered their sexual attraction more heterosexual than homosexual. The pre-test indicated that currently, after the male participants received help to change their same sex attraction, 46.6 percent of the male participants considered their sexual attraction entirely or almost entirely homosexual, 26.6 percent considered their sexual attraction more homosexual than homosexual, 6.6 percent considered their sexual attraction equally homosexual and heterosexual (bi-sexual) and 13.3 percent considered their sexual attraction almost entirely heterosexual. The actual

survey determined six months before getting help to attempt to change their same sex attraction, 62.4 percent of the male participants considered their sexual attraction entirely and almost entirely homosexual, 25.6 percent considered their sexual attraction more homosexual than homosexual, 8 percent considered their sexual attraction equally homosexual and heterosexual (bi-sexual), 3.2 percent considered their sexual attraction more heterosexual than homosexual and 1 percent considered their sexual attraction almost entirely heterosexual.

The survey demonstrated that at the time of the survey, after the male participants received help to change their same sex attraction, 22.4 percent of the male participants considered their sexual attraction entirely or almost entirely homosexual, 26.4 percent

Table 38. Survey Participants' Sexual Attraction Six Months Before Getting Help

	Number of Responses	Response Ratio
almost entirely homosexual	43	34.4%
homosexual	35	28.0%
more homosexual than heterosexual	32	25.6%
bi-sexual	10	8.0%
more heterosexual than homosexual	4	3.2%
almost entirely heterosexual	1	<1%
heterosexual	0	0.0%
Total	125	100%

considered their sexual attraction more homosexual than heterosexual, 12 percent considered their sexual attraction equally homosexual and heterosexual (bi-sexual), 19.2 percent considered their sexual attraction more heterosexual than homosexual and 19.2 percent considered their sexual attraction heterosexual and almost entirely heterosexual. The results of measuring sexual change in the pre-test and the actual survey are very similar on many areas. Both surveys established that the majority of participants considered themselves as having mostly and more homosexual attractions before they attempted to change (pre-test: 86.6%, survey: 88%). Both surveys showed that after change attempts were made, there was a trend in decreasing

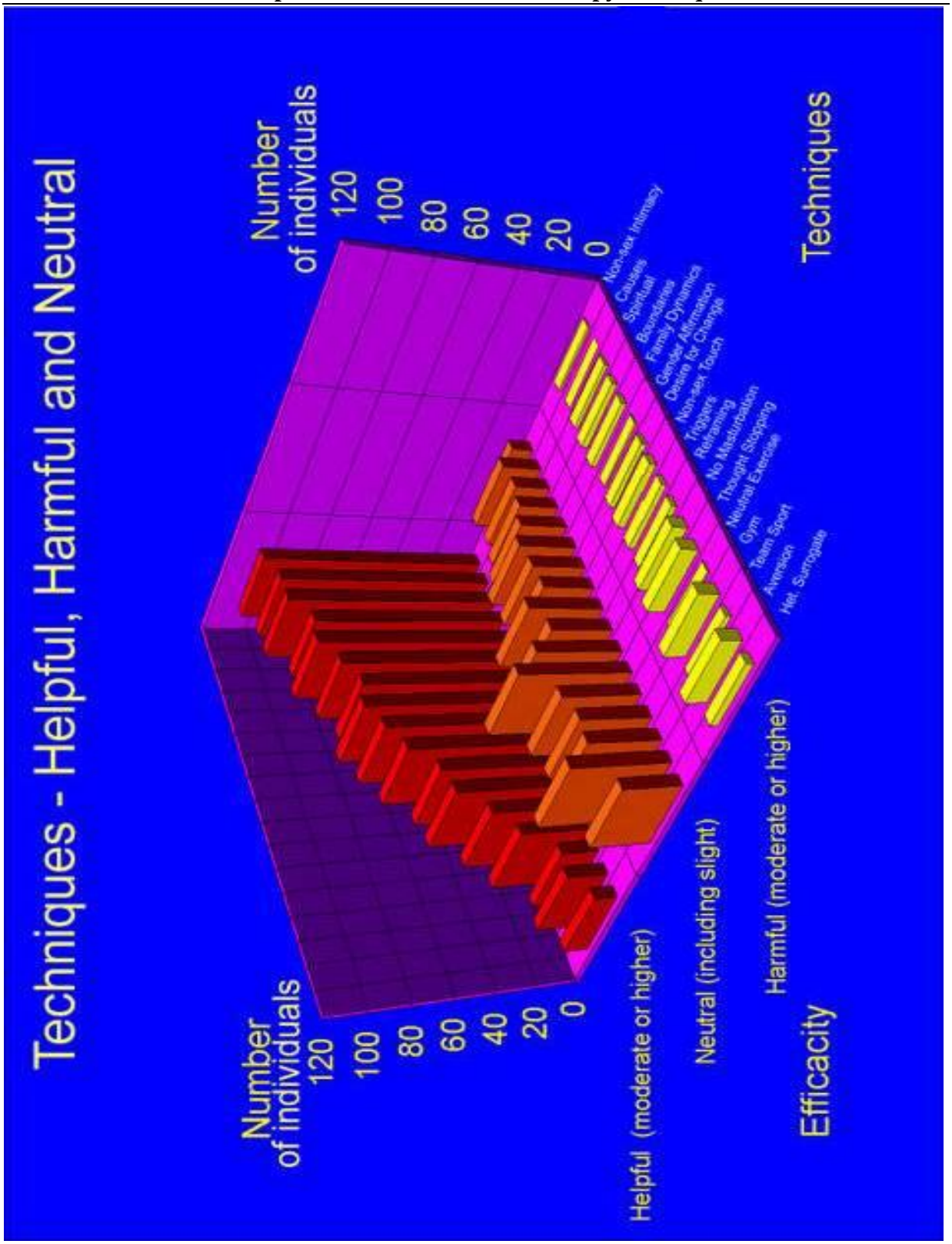
Table 39. Survey participants' current sexual attraction

	Number of Responses	Response Ratio
more homosexual than heterosexual	33	26.4%
more heterosexual than homosexual	24	19.2%
almost entirely homosexual	16	12.8%
bi-sexual	15	12.0%
homosexual	12	9.6%
almost entirely heterosexual	12	9.6%
heterosexual	12	9.6%
Total	124	100%

homosexual attraction and increasing heterosexual attraction. Both surveys revealed the participants achieving almost all heterosexual and all heterosexual attraction (pre-test: 13.3%, survey: 19.2%). Both the pre-test and survey indicated similar results, therefore, the reliability can be considered high pertaining to the first pertinent question.

Comparing the second and third pertinent questions, the helpfulness and harmfulness of therapeutic techniques, of the pre-test to the survey demonstrated that in the pre-test 78 percent of the participant's answers on the survey found that the therapeutic techniques that they experienced in reparative therapy was helpful. Eight percent of the people's answers on the survey found that the therapeutic techniques that they experienced in reparative therapy were harmful. Fourteen percent of the people's answers on the survey found that the therapeutic techniques that they experienced in reparative therapy were not helpful or harmful. The survey's results established 82 percent of the people's answers on the survey found that the therapeutic techniques that they experienced in reparative therapy were helpful; 10.5 percent of the people's answers the therapeutic techniques that they experienced were harmful; and seven and one half percent of the people's answers on the survey found that the therapeutic techniques that they experienced were not helpful or harmful. The results of measuring helpfulness and harmfulness in the pre-test and the actual survey are similar. Both surveys showed that the majority of the

Table 40. Helpfulness/ harmfulness of therapy techniques



participant's answers found that the therapeutic techniques experienced in reparative therapy were helpful (pre-test: 78%, survey: 82%). Both revealed that the minority of the participant's answers found that the therapeutic techniques experienced in reparative therapy were harmful (pre-test: 8%, survey: 10.5%) as well as neither harmful nor helpful (pre-test:14%, survey: 7.5%). Both the pre-test and survey indicated similar results, therefore, the reliability can be considered high pertaining to the second and third pertinent questions.

Comparing the helpfulness and harmfulness of the participants' view of self, thoughts and behaviors of the pre-test with the survey shows similar results which make the questions reliable. The results of the pre-test determined 91 percent of the participants found that reparative therapy helped their self esteem; 82 percent found that reparative therapy helped their social functioning; 45 percent found that reparative therapy helped their depression, self harmful behavior and thoughts/ attempts of suicide; and 18 percent found that reparative therapy helped their alcohol and substance abuse. Conversely, 18 percent the people who participated in the pre-test found that reparative therapy contributed to their depression and nine percent found that reparative therapy harmed their social functioning.

The results of the survey demonstrated that 94 percent of the participants found that reparative therapy helped their self esteem; 90 percent found that reparative therapy helped their social functioning; 73 percent found that reparative therapy helped combat their depression, 46

Table 41. Survey participants' self esteem helped by reorientation therapy

	Number of Response(s)	Response Ratio
extremely so	40	32.0%
markedly	36	28.7%
moderately	26	20.8%
slightly	15	12.0%
none	7	4.8%
Total	124	100%

percent found that reparative therapy helped reduce their self harmful behavior; 38 percent found that reparative therapy helped reduce their thoughts/ attempts of suicide; and 17 percent found that reparative therapy helped reduce their alcohol and substance abuse. The results of the survey also established that 22.6 percent of the participants found that reparative therapy harmed their self esteem; 21 percent found that reparative therapy harmed their social functioning; 34 percent found that reparative therapy increased their depression, 12 percent found that reparative therapy increased their self harmful behavior; 17 percent found that reparative therapy increased their thoughts/ attempts of suicide; and 4.8 percent found that reparative therapy increased their alcohol and substance abuse.

The questions about the helpfulness and harmfulness of therapy experienced regarding self esteem, depression, self harm behavior, suicide, social functioning and alcohol and substance abuse were split into two different questions in the survey. The survey results for the questions that measured the helpfulness and harmfulness of therapy on the participants self esteem, depression and social functioning added up to more than 100 percent (self esteem- helpful: 94%, harmful: 22.6%; depression- helpful: 73%, harmful: 34%; social functioning- helpful: 90%, harmful: 21%). These results showed that some of the participants believe that the therapy they experienced both helped and hurt their self esteem (25 participants), depression (32 participants), self harmful behavior (11 participants), thoughts/ attempts suicide (12 participants), social functioning (24 participants) and alcohol and substance abuse (one participant). These answers given by the participants revealed that the therapy experienced regarding self esteem, depression, self harm behavior, suicide, social functioning and alcohol and substance abuse can be either helpful or harmful and sometime both helpful and harmful to the individual.

The validity of the survey was measured by the pre-test survey that was administered a month before the survey was made available to be filled out on-line. The pre-test results indicated that the three pertinent questions can be validly answered regarding individuals reporting changes in same sex and opposite sex thoughts, feelings and/or behaviors and whether reparative therapy resulted in helpful or harmful effects. Both the pre-test and survey determined similar results, therefore, the reliability can be considered high pertaining to the three pertinent questions.

Summary of the statistical graphs

After therapy, the following results were statistically significant $p < 0.001$:

- Decrease in homosexual sex.
- Decrease in homosexual kissing.
- Increase in heterosexual kissing.
- Decrease in homosexual fantasy.
- Increase in heterosexual fantasy.
- Decrease in desiring homosexual intimacy.
- Increase in desiring heterosexual intimacy.
- Increase in heterosexual attraction.
- Increase in heterosexual identity.

The following are the results of the graphs regarding positive and negative effects of therapy.

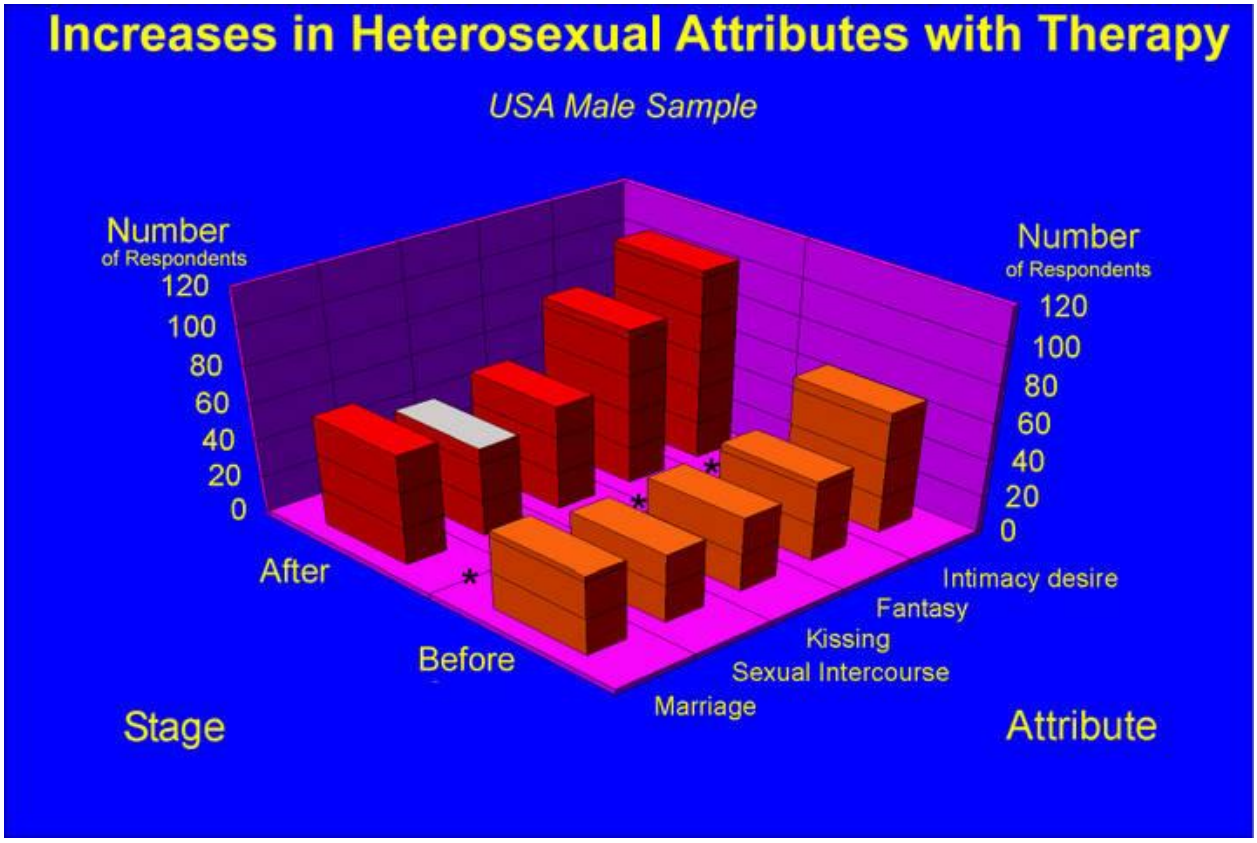
- The weekend retreat, individual study and male mentoring were the preferred and most effective method of therapy.
- Non-erotic same sex relationship, examination of causes and spirituality was the most effective therapeutic technique.

- Most participants' found the therapeutic techniques at least moderately helpful.
- Few participants' found the therapeutic techniques at least moderately harmful.
- Some participants' found the therapeutic techniques at least slightly neutral.
- Cognitive behavioral was the most helpful therapy approach.
- Therapy helped the participants' self esteem, social functioning, depression, thoughts/ actions of suicide, alcohol and drug abuse.
- Religious reasons were the most popular for participants' seeking therapy.

Summary

The results of the survey demonstrated that after the participants received re-orientation therapy their homosexual sexual behavior decreased by 59% (66 participants' engaged in

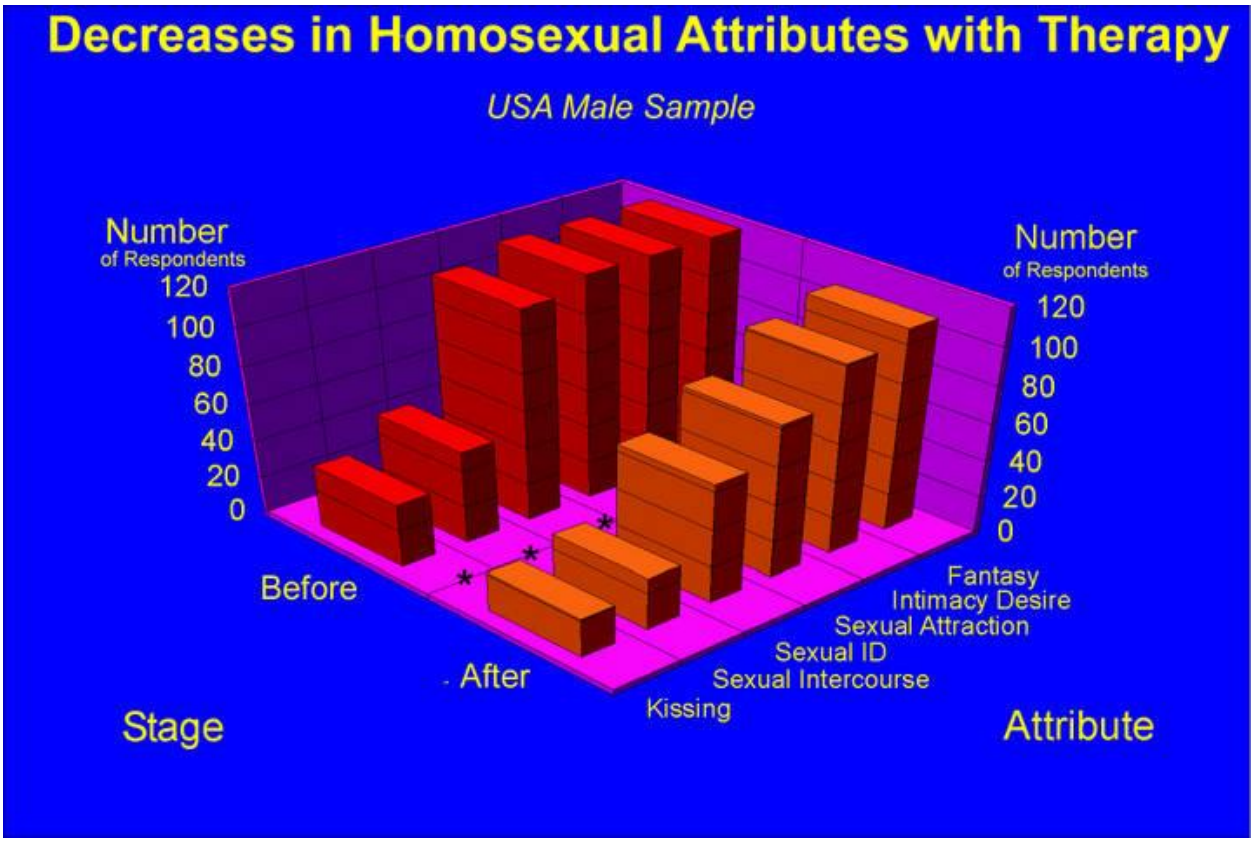
Table 41. Heterosexual attributes before and after therapy



* Denotes statistically significant p < 0.001
Grey bar denotes statistically not significant p >0.05

homosexual sex on a daily, weekly, monthly or yearly basis before re-orientation therapy as compared to 28 participants' after re-orientation therapy) and their heterosexual behavior increased by 28.5% (35 participants before re-orientation therapy and 45 participants' after re-orientation therapy). The results established that after the participants received re-orientation therapy they decreased their lusting or daydreaming about homosexual sex by 20.7% (121 participants before re-orientation therapy and 96 participants' after re-orientation therapy) and their lusting or daydreaming about heterosexual sex increased by 84.7% (46 participants before re-orientation therapy and 85 participants' after re-orientation therapy). The survey results showed that 19.2% of the participants who completed the survey (24 out of 125 men) rated their current sexual attraction, after they had experienced re-orientation therapy, as either heterosexual

Table 24. Homosexual attributes before and after therapy



* Denotes statistically significant $p < 0.001$

or almost heterosexual as compared to one participant who rated his sexual attraction as almost entirely heterosexual before he experienced re-orientation therapy. The results of the survey revealed that the most effective therapeutic intervention for the participants who completed the survey was participating in a same sex gender weekend/ retreat (26.4%). The therapeutic technique that the survey participants found to be the most helpful was "understanding better the causes of your homosexuality and your emotional needs and issues" (94.4%). The greatest positive change that the survey participants found therapy to have on themselves, in terms of feelings and behaviors, was their self esteem (94.4%) and social functioning (89.6%). The results of the survey determined that the therapeutic technique that the 125 survey participants found to be the most harmful was "going to the gym" (16%). The greatest negative change that the survey participants found re-orientation therapy to have on themselves was depression (33.6%). The results of the survey demonstrated that the participants' of the survey diminished, while some eliminated, their same sex thoughts, feelings and behaviors and the participants' increased, while some acquired, their thoughts, feelings and behaviors for the opposite sex through re-orientation therapy. Therefore the first hypothesis was accepted. The results of the survey established that the most of the participants in the survey found reparative therapy to have a "positive change" on themselves, in terms of their self esteem (94.4%) and social functioning (89.6%). Therefore the second hypothesis was accepted. The pre-test results showed that the three pertinent question can be answered, therefore, the survey is valid. The pre-test and survey revealed similar results in answering the three pertinent questions, therefore, the reliability can be considered high.

Chapter 5:

Conclusions and Recommendations

Introduction

The author decided to conduct this study because of the current position of the American Psychological Association (APA) which states that people with same sex attraction should not attempt to change and acquire opposite sex attractions through the process of reparative therapy because it is rarely successful and potentially harmful (APA Task Force, 2009). This position contrasts with the fact that many mental health professionals believe such change can be done with little risk of harm (Nicolosi, Byrd & Potts, 2000; Spitzer, 2003; Karten, E., & Wade, J., 2010) and that thousands of people have claimed to have done so by suffering no ill effects and also claimed to have benefitted from the process (Whitehead, N. & Whitehead, B., 2010). Research has shown that there have been several types of therapeutic techniques used to attempt to change an individual's same sex attraction from aversion therapies, desensitization, orgasmic reconditioning, classical conditioning, cognitive-behavioral therapy and, after the 1970's, conversion or re-orientation therapy. Success rates for conversion therapies ranged from 10-30% on average (Schaeffer et al.2000, Jones, Yarhouse, 2007, Nicolosi, Byrd & Potts, 2000). The benefits of the therapy included decreasing same sex attraction and increasing heterosexual attraction, increased self acceptance, self identity, sense of belonging, enhanced gender identity, insight and hopefulness (Jones, Yarhouse, 2007; Nicolosi, Byrd & Potts, 2000; Spitzer, 2003). The harmful effects of therapy include lowered sense of self, negative image of sexuality and self, hopelessness, depression, guilt, social withdrawal, sexual dysfunction, false hopes, damaged parental relationship, wasted time and thoughts of suicide (Beckstead & Morrow, 2004; Haldeman, 2001; Shidlo & Schroeder, 2002). This is a descriptive and quantitative study which acquired its data through a review of previously conducted research and a survey of persons who

previously had received professional assistance to diminish their unwanted same sex attraction and enhance their opposite sex attraction through psychotherapy. The goal of the study was to examine the results of the convenience survey of men's same sex and opposite sex thoughts, feelings and/or behaviors after receiving reparative therapy. The study also sought to discover what the participants found helpful and harmful about their experiences of reparative therapy. Past research has shown that individuals who have attempted to change their same sex attraction to opposite sex attraction have met with both success and failure. It is intended that this study will benefit those individuals who desire to change their sexual attraction from same sex to opposite sex. This study also supports an individual's right to seek professional care to resolve their unwanted homosexual attractions which right should be considered self-evident and inalienable.

Summary of Findings

The survey produced findings and results pertaining to the first pertinent question of: "To what extent does a convenience sample of former and current clients of SOCE report changes in same sex and opposite sex thoughts, feelings and/or behaviors after receiving reparative therapy?" The results indicated that after receiving therapy for their unwanted same sex attraction, the 125 men participating in the survey:

- Decreased in the behavior of homosexual sex and homosexual passionate kissing and increased in the behavior of heterosexual sex and heterosexual passionate kissing.
- Decreased in lusting or daydreaming about homosexual sex and increased in lusting or daydreaming about heterosexual sex.

- Decreased in desiring romantic, emotional, homosexual intimacy and increased in desiring romantic, emotional, heterosexual intimacy.
- Decreased their homosexual attraction and increased in heterosexual attraction.

The survey showed a 14% change rate to heterosexual attraction by the men who classified their sexual attraction as homosexual before therapy and a 19.2% change rate to heterosexual or almost entirely heterosexual attraction for the entire survey of 125 men. These survey results determined that the hypothesis of the convenience sample of former clients of SOCE can diminish or eliminate their same sex thoughts, feelings and behaviors and acquire a heterosexual orientation by increasing and having thoughts, feelings and behaviors for the opposite sex through psychotherapy (reparative therapy) was accepted.

The survey produced findings pertaining to the second pertinent question of: "What does a convenience sample of former and current clients of SOCE report to have found helpful about their experiences of reparative therapy?" The results for the 125 men that participated in the survey, after they received therapy for their unwanted same sex attraction, revealed the effective therapeutic interventions were the participation in a same sex gender weekend/ retreat, seeing a mental health, family or marriage counselor or seeing a psychologist and having a mentoring relationship with an individual. The helpful therapeutic techniques were understanding the causes of homosexuality and the emotional needs and issues, meditation and spiritual work and exploring linkages between childhood and family experiences and same-sex sexual attraction or behavior. The helpful therapeutic approaches were cognitive behavioral, psychoanalysis and gestalt. However, the majority of the survey participants answered they didn't know the exact type of therapy being used. The benefits of therapy were improving the participants' self esteem, social functioning and depression. These survey results determined that

the hypothesis of the convenience sample of former clients of SOCE found reorientation counseling helpful in increasing their self esteem, self acceptance and overall positive self outlook was accepted.

The survey produced findings pertaining to the third pertinent question of: "What does a convenience sample of former and current clients of SOCE report to have found harmful about their experiences of reparative therapy?" The results for the 125 men that participated in the survey, after they received therapy for their unwanted same sex attraction, demonstrated that the therapeutic techniques found to be the most harmful were going to the gym, imagining getting AIDS and stopping homosexual thoughts. The harmful approaches that the 125 participants experienced during their therapy was psychoanalysis followed by cognitive behavioral and humanistic. However, most of the survey participants answered they didn't know the exact type of therapy being used. The drawbacks, or "negative changes", that therapy had on the participants' included depression, self esteem, social functioning. These survey results established that the hypothesis of the convenience sample of former clients of SOCE found the therapeutic intervention of therapeutic touch to cause harm to themselves was accepted.

Conclusions of Findings

This study answered the first pertinent question and demonstrated that the men surveyed with same sex attraction experienced change in their thoughts, feelings and behaviors after receiving therapy for their unwanted homosexual attraction. This study answered the second pertinent question and established that the men surveyed found various techniques and interventions of their therapy experience for their unwanted same sex attraction as helpful. This study answered the third pertinent question and revealed that the men surveyed found various techniques and interventions of their therapy experience for their unwanted same sex attraction

as harmful. The findings showed that over two thirds of the men surveyed found success from the therapy that they received to diminish or change their same sex attractions, including almost one fifth of the men who changed their same sex attraction to opposite sex attraction. The findings also showed that less than a third of the men surveyed did not find success from the therapy that they received to diminish or change their same sex attractions. Finally, the findings show that less than five percent of the men surveyed did not find success from the therapy that they received and experienced a stronger attraction for the same sex. The change rates from this study compare similarly to the change rates from the other studies that were analyzed. Based on the results of this study, the majority of the participants' reduced their unwanted same sex attraction experienced and didn't experience any harm from the therapy that they received.

Recommendations

Based on the conclusions, the study showed that the majority of the men surveyed who had unwanted same sex thoughts, feelings and or behaviors were satisfied with their opportunity to attempt to change and be given the opportunity to acquire opposite sex thoughts, feelings and or behaviors because this study and other similar studies have determined there can be success attained by some individuals. Men interested in going through therapy for their unwanted same sex attraction should be given the results of studies done on the effectiveness of the change rate of those men who have tried in the past. This study demonstrated the helpful techniques and interventions that the men surveyed experienced in their change efforts, which include same sex gender weekend/ retreat, receiving therapy from a mental health, family, marriage counselor or psychologist and having a mentoring relationship with an individual. It is recommended that these results be studied, understood and considered by therapists/ counselors who want to administer therapy to men with unwanted same sex attraction. It would be beneficial for

individuals, who want therapy for their unwanted same sex attraction, to be informed of the rate of harm and the rate of helpfulness that other men have experienced when receiving therapy their depression, self-esteem, social functioning, thoughts or attempts at suicide, self-harm behavior and alcohol and substance abuse. It is recommended that the APA (American Psychological Association) consider this study about the effectiveness, helpfulness and harmfulness of therapy for unwanted same sex thoughts, feelings and behaviors and re-evaluate their opinion of discouraging men from seeking therapy for their unwanted same sex attraction. The effectiveness rates for counseling people with unwanted same sex attraction compares similarly to the effectiveness rates of general counseling for all individuals. Studies have shown that the average person who received counseling for whatever reason is better off than 70-75% of the person who didn't receive counseling (Lambert, M. J. (2011). The current study showed that two thirds of the men surveyed had more heterosexual attraction after receiving therapeutic help for their unwanted same sex attraction. This study showed that receiving counseling assistance for unwanted same sex attraction is not going to result in complete sexual attraction change for most men, which is similar to other studies. However, the majority of people will experience a reduction in their same sex thoughts, feelings and behaviors and an increase in their opposite thoughts, feelings and behaviors. In multiple studies, there is evidence that shows more people have benefited from therapy for their unwanted same sex attraction than people that are harmed. The change rates that studies have shown have established enough evidence for the APA to consider re-evaluating their opinion of discouraging therapy to change one's same sex attraction. Individuals should have the right to choose how they would like to think, feel and behave, which the APA needs to respect.

Recommendations for Further Research

A longitudinal study of more than 10 years of the effectiveness of therapy for people with unwanted same sex attraction would show the long term effects of therapy. The long term study could also show if individuals had to continue therapy or specific interventions/ techniques to maintain their opposite sexual attraction. There is more research on men with same sex attraction. A study researching the effects of therapy specifically on women with unwanted same sex attraction, including the rates of change, effectiveness of interventions/ techniques and helpfulness and harmfulness of the therapeutic process, would add more knowledge to the subject. Further research can be done comparing the amount of time an individual has been in therapy for their unwanted same sex attraction to the change rates achieved.

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Appendix A

Focus Group Study Letter and Survey

This project is being conducted by Paul Santero, M.A. a doctoral student at Southern California Seminary in El Cajon California. The purpose of this research is to get a better idea of what factors contribute to or hinder the treatment effectiveness of same-sex sexual attraction and behavior. Your participation is important to the successful completion of the project and should only take a few minutes of your time.

It would be greatly appreciated if you would participate by completing a very brief survey about your experiences and answering a few questions about yourself. All of your answers are confidential and no records of personal information will be retained beyond the completion of this study.

The Southern California Seminary Institutional Review has reviewed this survey and approved its use.

Thank you for participation in this study.

Sincerely

Paul Santero

Please answer the following questions with respect to change your same-sex sexual attraction and/or behavior. Sex will be defined as: kissing, touching genitals, oral, anal, or vaginal intercourse.
Circle what best describes you:

Six months before getting help, how often did you:

1.	Have homosexual sex?	almost daily	weekly	monthly	yearly	almost never
2.	Have heterosexual sex?	almost daily	weekly	monthly	yearly	almost never
3.	Yearn for romantic, emotional, homosexual intimacy?	almost daily	weekly	monthly	yearly	almost never
4.	Yearn for romantic, emotional, heterosexual intimacy?	almost daily	weekly	monthly	yearly	almost never
5.	Looked with lust or daydreamed about having homosexual sex?	almost daily	weekly	monthly	yearly	almost never
6.	Looked with lust or daydreamed about having heterosexual sex?	almost daily	weekly	monthly	yearly	almost never

7. Please rate your sexual attraction six months before getting help:
Almost entirely men more men than women equally men and women more women than men almost entirely women

Currently, how often do you:

8.	Have homosexual sex?	almost daily	weekly	monthly	yearly	almost never
9.	Have heterosexual sex?	almost daily	weekly	monthly	yearly	almost never
10.	Yearn for romantic, emotional, homosexual intimacy?	almost daily	weekly	monthly	yearly	almost never
11.	Yearn for romantic, emotional, heterosexual intimacy?	almost daily	weekly	monthly	yearly	almost never
12.	Looked with lust or daydreamed about having homosexual sex?	almost daily	weekly	monthly	yearly	almost never
13.	Looked with lust or daydreamed about having heterosexual sex?	almost daily	weekly	monthly	yearly	almost never

14. Please rate your current sexual attraction:
Almost entirely men more men than women equally men and women more women than men almost entirely women

THERAPEUTIC INTERVENTIONS

Please circle the helpfulness of each intervention in your change efforts:

	none	**slightly**	**moderately**	**markedly**	**extremely so**	**not applicable**
15. Psychiatrist (MD)	1	2	3	4	5	0
16. Psychologist	1	2	3	4	5	0
17. Social Worker	1	2	3	4	5	0
18. Mental Health, family/ marriage counselor	1	2	3	4	5	0
19. Pastoral counselor	1	2	3	4	5	0
20. Ex-gay or other religious support group	1	2	3	4	5	0
21. Non-religious peer support group	1	2	3	4	5	0
22. Men's Weekend/Retreat	1	2	3	4	5	0
23. A mentoring relationship/ the purpose of changing same-sex sexual attraction/ behavior	1	2	3	4	5	0
24. Intense individual study (books, papers, tapes, videos, internet, conference presentations) to change same-sex sexual attraction/ behavior	1	2	3	4	5	0

25. If you checked off more than one of the above ten kinds of help, circle the question number that was most helpful.
15 16 17 18 19 20 21 22 23 24

Circle all of the kinds of help that you received to change your same-sex sexual attraction and/or behavior?
Circle the total number of sessions/meetings (include telephone, individual and group session

26. Psychiatrist (medical doctor)	1-10	10-25	25-50	50-100	100-200	200+
27. Psychologist	1-10	10-25	25-50	50-100	100-200	200+
28. Social worker	1-10	10-25	25-50	50-100	100-200	200+
29. Mental health, family or marriage counselor	1-10	10-25	25-50	50-100	100-200	200+
30. Pastoral Counselor	1-10	10-25	25-50	50-100	100-200	200+
31. Ex-gay or other religious support group	1-10	10-25	25-50	50-100	100-200	200+
32. Non-religious peer support group	1-10	10-25	25-50	50-100	100-200	200+

33. Men's weekend/Men's retreat	1-10	10-25	25-50	50-100	100-200	200+
34. A mentoring relationship with an individual	1 month	1-6 months	6-12 months	1-2 years	2+ years	
35. Intense individual study of books, papers, media info.	1 month	1-6 months	6-12 months	1-2 years	2+ years	

THERAPEUTIC TECHNIQUES

Please circle the <u>helpfulness</u> or the <u>harmfulness</u> of each technique in your change effort:

0=not applicable; **1**=not at all; **2**=slightly; **3**=moderately; **4**=markedly; **5**=extremely

	Helpful	**Harmful**
36. Getting healthy non-sexual touch from other men	0 1 2 3 4 5	0 1 2 3 4 5
37. Doing things that made you feel manly	0 1 2 3 4 5	0 1 2 3 4 5
38. Meditation and spiritual work (e.g, scripture study, praying, confession to spiritual leader, faith in God, experiencing God's love, acceptance, and forgiveness)	0 1 2 3 4 5	0 1 2 3 4 5
39. Exploring linkages between your childhood and family experiences & your same-sex sexual attraction &/or behavior	0 1 2 3 4 5	0 1 2 3 4 5
40. Understanding better the causes of your homosexuality and your emotional needs and issues	0 1 2 3 4 5	0 1 2 3 4 5
41. Learning to maintain appropriate boundaries	0 1 2 3 4 5	0 1 2 3 4 5
42. Thought stopping (e.g. stopping homosexual thoughts)	0 1 2 3 4 5	0 1 2 3 4 5
43. Avoiding situations that trigger homosexual feelings	0 1 2 3 4 5	0 1 2 3 4 5
44. Developing nonsexual relationships with same-sex peers mentors, family members & friends	0 1 2 3 4 5	0 1 2 3 4 5
45. Developing a stronger desire to change	0 1 2 3 4 5	0 1 2 3 4 5
46. The cognitive reframing of homosexual desire as a symptom of emotional distress in order to explain away such desire while lessening fear and guilt	0 1 2 3 4 5	0 1 2 3 4 5
47. Imagining getting AIDS or another aversion image when aroused by the same sex (covert desensitization)	0 1 2 3 4 5	0 1 2 3 4 5
48. Abstaining from masturbation	0 1 2 3 4 5	0 1 2 3 4 5
49. Using heterosexual surrogates	0 1 2 3 4 5	0 1 2 3 4 5
50. Playing team sports	0 1 2 3 4 5	0 1 2 3 4 5
51. Going to the gym	0 1 2 3 4 5	0 1 2 3 4 5

52. Which therapeutic re-orientation approach did you find most helpful used by the clinician?

Cognitive Behavioral Rogerian Psychoanalysis Gestalt Humanistic Existential None listed

52. Which therapeutic re-orientation approach did you find most harmful used by the clinician?

Cognitive Behavioral Rogerian Psychoanalysis Gestalt Humanistic Existential None listed

As a result of your change efforts, circle the <u>positive</u> changes you have noticed in the following areas.

	none	**slightly**	**moderately**	**markedly**	**extremely so**	**not applicable**
53. Self-esteem	1	2	3	4	5	0
54. Depression	1	2	3	4	5	0
55. Self-harmful behavior	1	2	3	4	5	0
56. Thoughts /attempts of suicide	1	2	3	4	5	0
57. Social functioning	1	2	3	4	5	0
58. Alcohol and substance abuse	1	2	3	4	5	0

As a result of your change efforts, circle the <u>negative</u> changes you have noticed in the following areas.

	none	**slightly**	**moderately**	**markedly**	**extremely so**	**not applicable**
59. Self-esteem	1	2	3	4	5	0
60. Depression	1	2	3	4	5	0
61. Self-harmful behavior	1	2	3	4	5	0
62. Thoughts /attempts of suicide	1	2	3	4	5	0
63. Social functioning	1	2	3	4	5	0
64. Alcohol and substance abuse	1	2	3	4	5	0

The next set of questions has to do with aspects of your life <u>six months prior</u> to your getting help to change your same-sex sexual attraction and/or behavior. Please answer the next series of questions with respect to six months prior to your getting help about your sexual issues.

65. What was your marital status?
1. Single 2. Married 3. Engaged 4. Divorced 5. Separated 6. Widowed Other:_____

66. In those six months, how did you define your sexual identity?
1. Homosexual 2. More homosexual than heterosexual 3. Equally homosexual and heterosexual
4. More heterosexual than homosexual 5. Heterosexual

The next set of questions has to do with aspects of your life at the current time. Please answer the next series of questions with respect to your current situation.

67. What is your marital status?
1. Single 2. Married 3. Engaged 4. Divorced 5. Separated 6. Widowed Other:_____

68. How do you define your sexual identity?
1. Homosexual 2. More homosexual than heterosexual 4. Equally homosexual and heterosexual
5. More heterosexual than homosexual 5. Heterosexual

70. Why did you decide to try to change your same sex thoughts, feelings and behaviors?
1. Religious beliefs 2. Desire to have children 3. Desire to marry a person of the opposite sex.
4. Cultural pressure/ acceptance 5. Family pressure/ acceptance 6. Strengthen a current marriage

BACKGROUND INFORMATION

69. Where do you live in the USA now?
West coast Mid West Central Mid East East Coast North East South South East

70. If presently married, how many years? 1-5 5-10 10-25 25-50 50+

71. Do you have any children? No Yes If yes, how many? 1 2 3 4 5+

72. If employed, what kind of work do you do? _____

73. How would you describe your socioeconomic status?
1. lower class 2. lower middle class 3. middle class 4. upper middle class 5. upper class

74. Your Age: 18-25 26-35 36-45 46-55 55-65 66+

75. Ethnicity:
African American/Black Asian/Pacific islander Native American Hispanic
Caucasian/White Arabic Multi racial Other (please specify)_____

76. Annual <u>household</u> income before taxes:
$0 - $10,000 $10,001 - $25,000 $25,001 - $50,000 $50,001 - $75,000
$75,001 - $100,000 $100,000 - $150,000 $150,001+

77. Your Highest level of education:
Grade school High School Trade School Some College (including Associates Degree) Bachelors Degree
Masters Degree Doctoral Degree

78. How often do you attend church services or synagogue?
Daily Few times a week Once a week A few times a month Major holidays Rarely or Never

79. Faith/Denomination:
Assembly of God Baptist Catholic Christian Church Episcopal EvangelicalFree Jewish
Lutheran Methodist Nazarene Non-Denominational Pentecostal/Charismatic
Seventh Day Adventist Agnostic Other (please specify) _____

Appendix B

Study Introduction Letter and Survey

You are invited to participate in a research project being conducted by myself, Paul Santero, M.A. a doctoral student at Southern California Seminary in El Cajon California . The purpose of this research is to get a better idea of what factors contribute to or hinder the treatment effectiveness of same-sex attraction and behavior. Dr. Joseph Nicolosi, Dr. Arthur Goldburg, Dr. Philip Sutton and many others are supporting this project and recommend that I encourage those who have sought treatment for their same sex attraction to complete this survey. Your participation is important to the successful completion of the project and should only take a few minutes of your time.

It would be greatly appreciated if you would participate by completing a very brief survey about your experiences and answering a few questions about yourself. All of your answers are confidential and no records of personal information will be retained beyond the completion of this study.

The Southern California Seminary Institutional Review has reviewed this survey and approved its use.

Thank you for participation in this study.

Sincerely,

Paul Santero

Please answer the following questions with respect to getting help by attempting to change your same-sex attraction and/or behavior. Sex will be defined as: touching genitals, oral, anal, or vaginal intercourse. Circle what best describes you:

Six months before getting help, how often did you:

7.	Have homosexual sex?	almost daily	weekly	monthly	yearly	almost never
8.	Experience homosexual passionate kissing?	almost daily	weekly	monthly	yearly	almost never
9.	Look with lust or daydream about having homosexual sex?	almost daily	weekly	monthly	yearly	almost never
10.	Desire romantic, emotional, homosexual intimacy?	almost daily	weekly	monthly	yearly	almost never
11.	Have heterosexual sex?	almost daily	weekly	monthly	yearly	almost never
12.	Experience heterosexual passionate kissing?	almost daily	weekly	monthly	yearly	almost never
13.	Look with lust or daydream about having heterosexual sex?	almost daily	weekly	monthly	yearly	almost never
14.	Desire romantic, emotional, heterosexual intimacy?	almost daily	weekly	monthly	yearly	almost never

9. Please rate your sexual attraction six months before getting help:

Homosexual Almost entirely homosexual More homosexual than heterosexual Bi-sexual
More heterosexual than homosexual Almost entirely heterosexual Heterosexual

Currently, how often do you:

10.	Have homosexual sex?	almost daily	weekly	monthly	yearly	almost never
11.	Experience homosexual passionate kissing?	almost daily	weekly	monthly	yearly	almost never
12.	Look with lust or daydream about having homosexual sex?	almost daily	weekly	monthly	yearly	almost never
13.	Desire romantic, emotional, homosexual intimacy?	almost daily	weekly	monthly	yearly	almost never
14.	Have heterosexual sex?	almost daily	weekly	monthly	yearly	almost never
15.	Experience heterosexual passionate kissing?	almost daily	weekly	monthly	yearly	almost never
16.	Look with lust or daydream about having heterosexual sex?	almost daily	weekly	monthly	yearly	almost never
17.	Desire romantic, emotional, heterosexual intimacy?	almost daily	weekly	monthly	yearly	almost never

18. Please rate your current sexual attraction:

Homosexual Almost entirely homosexual More homosexual than heterosexual Bi-sexual
More heterosexual than homosexual Almost entirely heterosexual Heterosexual

Please answer the next series of questions with respect to six months prior to your getting help about your same sex attraction. Marriage for this survey's purpose will be defined between a man and woman.

19. What was your marital status?

1. Single 2. Married 3. Engaged 4. Divorced 5. Separated 6. Widowed Other:_____

20. In those six months, how did you define your sexual identity?

Homosexual Almost entirely homosexual More homosexual than heterosexual Bi-sexual
More heterosexual than homosexual Almost entirely heterosexual Heterosexual

Please answer the next series of questions with respect to your current situation.

21. What is your marital status?

1. Single 2. Married 3. Engaged 4. Divorced 5. Separated 6. Widowed Other:_____

22. How do you define your sexual identity?

Homosexual Almost entirely homosexual More homosexual than heterosexual Bi-sexual
More heterosexual than homosexual Almost entirely heterosexual Heterosexual

Circle all of the kinds of help that you received to change your same-sex sexual attraction and/or behavior?

Circle the total number of sessions/meetings (include telephone, individual and group session

23. Psychiatrist (medical doctor)	1-10	10-25	25-50	50-100	100-200	200+
24. Psychologist	1-10	10-25	25-50	50-100	100-200	200+
25. Social worker	1-10	10-25	25-50	50-100	100-200	200+
26. Mental health, family or marriage counselor	1-10	10-25	25-50	50-100	100-200	200+
27. Pastoral Counselor	1-10	10-25	25-50	50-100	100-200	200+
28. Ex-gay or other religious support group	1-10	10-25	25-50	50-100	100-200	200+
29. Non-religious peer support group	1-10	10-25	25-50	50-100	100-200	200+
30. Same gender retreat	1-10	10-25	25-50	50-100	100-200	200+
31. A mentoring relationship with an individual	1 month	1-6 months	6-11 months	1-2 years	2+ years	
32. Intense individual study of books, papers, media info. to change your same sex attraction/ behavior.	1 month	1-6 months	6-11 months	1-2 years	2+ years	

THERAPEUTIC INTERVENTIONS

Please circle the helpfulness of each intervention in your change efforts:

	none	**slightly**	**moderately**	**markedly**	**extremely so**	**not applicable**
33. Psychiatrist (MD)	1	2	3	4	5	0
34. Psychologist	1	2	3	4	5	0
35. Social Worker	1	2	3	4	5	0
36. Mental Health, family/ marriage counselor	1	2	3	4	5	0
37. Pastoral counselor	1	2	3	4	5	0
38. Ex-gay or other religious support group	1	2	3	4	5	0
39. Non-religious peer support group	1	2	3	4	5	0
40. Same gender weekend/ retreat	1	2	3	4	5	0
41. A mentoring relationship/ the purpose of changing same-sex sexual attraction/ behavior	1	2	3	4	5	0
42. Intense individual study (books, papers, tapes, videos, internet, conference presentations) to change same-sex sexual attraction/ behavior	1	2	3	4	5	0

43. If you checked off more than one of the above ten kinds of help, circle the question number that was most helpful.

33 34 35 36 37 38 39 40 41 42

THERAPEUTIC TECHNIQUES

Please circle the <u>helpfulness</u> or the <u>harmfulness</u> of each technique in your change effort:

1=extremely helpful; **2**=markedly helpful; **3**=moderately helpful; **4**=slightly helpful; **5**= not helpful or harmful
6= slightly harmful; **7=** moderately harmful; **8=** markedly harmful; **9=** extremely harmful; **0**=not applicable

	<u>Helpful</u>					**<u>Harmful</u>**				**<u>N/A</u>**
44. Getting healthy non-sexual touch from someone of the same gender.	1	2	3	4	5	6	7	8	9	0
45. Doing things that made you feel more masculine (for men) or more feminine (for women).	1	2	3	4	5	6	7	8	9	0
46. Meditation and spiritual work (e.g, scripture study, praying, confession to spiritual leader, faith in God, experiencing God's love, acceptance, and forgiveness)	1	2	3	4	5	6	7	8	9	0
47. Exploring linkages between your childhood and family experiences & your same-sex sexual attraction &/or behavior	1	2	3	4	5	6	7	8	9	0
48. Understanding better the causes of your homosexuality and your emotional needs and issues	1	2	3	4	5	6	7	8	9	0
49. Learning to maintain appropriate boundaries	1	2	3	4	5	6	7	8	9	0
50. Thought stopping (e.g. stopping homosexual thoughts)	1	2	3	4	5	6	7	8	9	0
51. Avoiding situations that trigger homosexual feelings	1	2	3	4	5	6	7	8	9	0
52. Developing nonsexual relationships with same-sex peers mentors, family members & friends	1	2	3	4	5	6	7	8	9	0
53. Developing a stronger desire to change	1	2	3	4	5	6	7	8	9	0
54. The cognitive reframing of homosexual desire as a symptom of emotional distress in order to explain away such desire while lessening fear and guilt	1	2	3	4	5	6	7	8	9	0
55. Imagining getting AIDS or another aversion image when aroused by the same sex (covert desensitization)	1	2	3	4	5	6	7	8	9	0
56. Abstaining from masturbation	1	2	3	4	5	6	7	8	9	0
57. Using heterosexual surrogates	1	2	3	4	5	6	7	8	9	0
58. Playing team sports	1	2	3	4	5	6	7	8	9	0
59. Going to the gym	1	2	3	4	5	6	7	8	9	0
60. Exercise alone or with others who provide no sexual temptation	1	2	3	4	5	6	7	8	9	0

61. Which therapeutic re-orientation approach did you find most helpful used by the clinician?

Cognitive Behavioral Rogerian Psychoanalysis Gestalt Humanistic Existential None listed Don't know

62. Which therapeutic re-orientation approach did you find most harmful used by the clinician?

Cognitive Behavioral Rogerian Psychoanalysis Gestalt Humanistic Existential None listed Don't know

As a result of your change efforts, circle the <u>positive</u> changes you have noticed in the following areas.

	none	slightly	moderately	markedly	extremely so	not applicable
63. Self-esteem	1	2	3	4	5	0
64. Depression	1	2	3	4	5	0
65. Self-harmful behavior	1	2	3	4	5	0
66. Thoughts /attempts of suicide	1	2	3	4	5	0
67. Social functioning	1	2	3	4	5	0
68. Alcohol and substance abuse	1	2	3	4	5	0

As a result of your change efforts, circle the <u>negative</u> changes you have noticed in the following areas.

	none	slightly	moderately	markedly	extremely so	not applicable
69. Self-esteem	1	2	3	4	5	0
70. Depression	1	2	3	4	5	0
71. Self-harmful behavior	1	2	3	4	5	0
72. Thoughts /attempts of suicide	1	2	3	4	5	0
73. Social functioning	1	2	3	4	5	0
74. Alcohol and substance abuse	1	2	3	4	5	0

75. Are you currently in therapy for your same sex attraction? Yes No

76. If not currently in therapy for your same sex attraction, how long ago did you stop therapy?
Less than 1 month 1 month to 1year More than 1 year to 2 years
More than 2 years to 5 years More than 5 years Not applicable

77. Why did you decide to try to change your same sex thoughts, feelings and behaviors?
1. Religious beliefs 2. Desire to have biological children 3. Desire to marry a person of the opposite sex.
4. Cultural pressure/ acceptance 5. Family pressure/ acceptance 6. Strengthen a current marriage
7. Other _____

BACKGROUND INFORMATION

78. Gender: Male Female

79. Where do you live in the USA now?
West coast Mid West Central Mid East East Coast North East South South East Other_____

80. If presently married, how many years? 1-5 5-10 10-25 25-50 50+

81. How many children do you have? 1 2 3 4 5+

82. Regardless of employment, what is your occupation? _____

83. Your Age: 18-25 26-35 36-45 46-55 55-65 66+

84. Ethnicity:
African American/Black Asian/Pacific islander Native American Hispanic
Caucasian/White Arabic Multi racial Other (please specify)_____

85. Annual <u>household</u> income before taxes:
$0 - $10,000 $10,001 - $25,000 $25,001 - $50,000 $50,001 - $75,000
$75,001 - $100,000 $100,000 - $150,000 $150,001+

86. Your Highest level of education:
Grade school High School Trade School Some College (including Associates Degree) Bachelors Degree
Masters Degree Doctoral Degree

87. How often do you attend religious services?
Daily Few times a week Once a week A few times a month Major holidays Rarely or Never

88. Faith/Denomination:
Baptist Roman Catholic Episcopal Lutheran Methodist
Other Christian Non-Denominational Christian Jewish Buddhist
Muslim Agnostic Atheist Other (please specify) _____