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Counseling Practices as They Relate to Ratings of Helpfulness by Consumers of Sexual Reorientation Therapy

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Twenty-eight individuals who sought sexual reorientation counseling reported on their experiences with 80 therapists, providing information concerning the therapist's use of various practices and the perceived helpfulness of each therapist. Thirteen of the practices were taken from prior studies of gay and lesbian clients and seven were derived from counseling literature regarding sexual reorientation therapy. Participants preferred counselors who were knowledgeable about gay and lesbian issues, did not overfocus on sexual orientation, helped affirm an ex-gay identity, helped clients examine their development for possible reasons relating to the emergence of same-sex attractions, reframed the meaning of the emergence of same-sex attractions for identity, and suggested techniques to minimize same-sex attractions and enhance opposite-sex attractions. They did not judge as helpful counselors who attempted to affirm a gay identity. This is the first study designed to examine the helpfulness of particular therapist practices with clients seeking sexual reorientation.

The mental health professions continue to wrestle with the controversial issue of how to respond to individuals experiencing same-sex attraction who want to affirm a heterosexual identity. Recent reports in peer-reviewed journals have advocated the availability of interventions designed to assist clients change their sexual attractions, often called sexual reorientation therapy, either via professional psychotherapy or religious ministry (Throckmorton, 2002; Yarhouse & Throckmorton, 2002). Other writers assert that such interventions are harmful to homosexually oriented clients and therefore should be discouraged or discarded (Tozer & McClanahan, 1999; Shidlo & Schroeder, 2002).

The human context of this debate is a large number of current and former consumers of counseling services on both sides of the issue. Some clients seeking sexual reorientation counseling report benefit from such counseling (Spitzer, 2003) and some report feeling harmed (Shidlo & Schroeder, 2002). However, there is no research examining specific interventions that are associated with perceptions of harm or benefit.

Past research has addressed how best to match client need with therapist demographics and theoretical technical interventions (Beutler, Machado, & Neufeldt, 1994). However, few studies have examined interventions that lead to positive outcomes for clients who identify as gay, lesbian, or bisexual. No research has systematically examined the interventions associated with perceptions of helpfulness by clients who seek sexual reorientation.

Subsequent to the removal of homosexuality from the *Diagnostic and Statistical Manual* of the American Psychiatric Association in 1973, research designed to investigate methods of sexual reorientation all but disappeared. Behaviorally oriented practitioners continued to report studies of methods to change same-sex orientation, but by the 1980s, such reports were rare. Most research since the 1980s has focused on whether such counseling objectives could be ethically supported by clinicians. Many writers have called for therapists to abstain from efforts to alter sexual orientation (Haldeman, 1994; Tozer & McClanahan, 1999) while others have advanced ethical arguments against such bans (Throckmorton, 1998; Yarhouse & Throckmorton, 2002). Given that professional associations have not expressly banned therapy designed to effect changes in sexual feelings, research examining factors that maximize the well being of clients seeking sexual reorientation therapy is appropriate and necessary.

Liddle (1996) first investigated the relationship of therapist practices to ratings of therapist helpfulness with a sample of gay and lesbian clients. The therapist practices she investigated were derived from research conducted by Garnets, Hancock, Cochran, Goodchilds, and Peplau (1991). Garnets et al. derived these practices

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from surveys of psychotherapists regarding helpful and inappropriate interventions with GLB clients. The interventions were divided into 9 negative and 4 positive practices. Liddle used a convenience sample of 392 self-reported gays and lesbians providing ratings on 923 therapists to explore the perceptions of these practices by GLB clients. Liddle (1996) found that therapists were at increased risk of being rated unhelpful if they engaged in the negative practices (see Table 1, Practices 1-9). They were more likely to be considered helpful if they engaged in the positive practices (see Table 1, Practices 10-13). Liddle did not identify any clients who sought reorientation counseling in her study.

Shidlo and Schroeder (2002) examined the accounts of 202 people who had been involved in some kind of sexual orientation change efforts. Originally, the investigators solicited participants to document negative effects from conversion therapies. The original project title was "Homophobic Therapies: Documenting the Damage." After finding some participants that reported being helped by conversion therapies, they changed the focus of the study to include both those who felt harmed and helped by their experiences in conversion therapy.

Of the 202 participants, Shidlo and Schroeder (2002) reported that 87% perceived failure in their change efforts with the remaining 13% feeling successful. Of those 13%, the authors noted that 12 participants were still struggling somewhat with their sexual feelings, six still had some level of same-sex desire but did not struggle with it, and eight described a heterosexual shift in orientation. The majority of the eight were involved professionally in ex-gay ministries.

Of interest to this report is the description offered by Shidlo and Schroeder of what they termed "homosexual behavior management (HBM)" (p. 254). The authors used this term to identify what they called, "the range of cognitive and behavioral tools taught in conversion therapy to diminish and cope with same-sex desire and behavior and to increase heterosexual desire and behavior" (p. 254).

Shidlo and Schroeder noted 11 "tools" or techniques that were identified by the minority of participants who were helped by conversion therapies. These include: a) cognitive reframing of homosexual desire as a symptom of emotional distress, thereby lessening fear and guilt; b) imagining an aversive consequence of same-sex behavior when experiencing same-sex desire (e.g., getting AIDS); c) abstaining from masturbation; d) using opposite-sex sexual surrogates; e) having an accountability partner; f) forming nonsexual same-sex friendships with heterosexuals; g) playing team sports; h) going to the gym; i) reading the Bible; and k) praying. Cognitive reframing was the most frequent technique described. However, the authors conducted no systematic exploration of client perceptions of these techniques.

Shidlo and Schroeder's participants reported various types of harm and benefit. The authors noted increased levels of depression, suicidal and self-esteem difficulties. However, the frequency of these experiences was not recorded, nor were the authors able to distinguish between effects of the conversion therapy and pre-existing or co-morbid psychological disturbance. In other words, there is no way to tell if the conversion therapy contributed to the negative therapeutic effects or whether these negative outcomes would have occurred anyway.

Jones, Botsko and Gorman (2003) examined predictors of benefit from psychotherapy for gay, lesbian, and bisexual clients. They surveyed 600 participants covering nearly 2000 episodes of psychotherapy. Thirteen of those episodes involved clients who described conversion therapy. The clients involved gave their experiences an average helpfulness rating of 2.2 out 10 (most helpful). Clearly, these respondents did not perceive benefit from their reorientation experiences. The authors did not report any specific interventions or approaches that were associated with these negative perceptions.

Beckstead and Morrow (2004) followed 50 Latter Day Saint men through their experience in conversion therapy. Despite the fact that same-sex attractions were diminished for some participants, they reported no significant changes in sexual orientation but reported mixed benefits on other dimensions of outcome. Some clients felt that they had achieved a greater congruence with their religious beliefs and were happier as a result. The authors suggest that models of therapy be considered that do not polarize a client's objectives into sexual orientation change versus no change. They submit that certain elements of conversion therapies can provide benefit as a means of assisting religious clients to integrate their sexuality and their faith. This study did not report specific interventions that participants perceived as helpful or harmful.

Table 1
Listing of 20 Therapist Practices

Liddle's (1996) Inappropriate practices:	
Practice 1	Your therapist gave some indication that he/she had automatically assumed you were heterosexual before you indicated your sexual orientation.
Practice 2	Your therapist indicated that he/she believed that a gay or lesbian identity is bad, sick, or inferior.
Practice 3	Your therapist discounted, argued against, or pushed you to renounce your self-identification as a lesbian or gay man.
Practice 4	Your therapist blamed your problems on your sexual orientation or insisted on focusing on sexual orientation without evidence that your sexual orientation was relevant to your problems.
Practice 5	Your therapist suddenly refused to see you any more after you disclosed your sexual orientation. (Do not include cases where the therapist made a sensitive and appropriate referral to a therapist who was especially skilled in your expressed areas of concern).
Practice 6	Your therapist lacked the basic knowledge of gay and lesbian issues necessary to be an effective therapist for you and/or you had to be constantly educating him/her about these issues.
Practice 7	Your therapist pressured or advised you to come out to someone in spite of the fact that you believed it was too risky.
Practice 8	Your therapist did not recognize the importance of lesbian and gay relationships and/or did not appropriately support these relationships.
Practice 9	Your therapist apparently did not understand the problems of societal prejudice against gay men and lesbians and/or internalized homophobia.
Liddle's Exemplary practices:	
Practice 10	Your therapist was quite knowledgeable about the lesbian and gay communities and other resources (so that he/she could have put you in touch with useful books or important community resources).
Practice 11	Your therapist never made an issue of your sexual orientation when it was not relevant.
Practice 12	Your therapist was not afraid to deal with your sexual orientation when it was relevant.
Practice 13	Your therapist tried to help you feel good about yourself as a gay man or lesbian.
Seven additional items:	
Practice 14	Your therapist helped you look for and understand causes of same-sex attractions in your life.
Practice 15	Your therapist indicated that having same-sex attractions did not necessarily mean you were gay, lesbian or bisexual in orientation.
Practice 16	Your therapist suggested strategies to minimize same-sex attractions and behavior.
Practice 17	Your therapist suggested strategies to enhance heterosexual attractions.
Practice 18	Your therapist referred you to an ex-gay support group.
Practice 19	Your therapist helped you feel good about yourself as an ex-gay man or ex-lesbian.
Practice 20	Your therapist suggested that you should develop non-sexual friendships with same-sex peers.

The review above presents a picture of minimal change with maximal risk. Although reorientation counseling was perceived negatively in general ways, no specific interventions have been identified as associated with perceptions of harm. Relying solely on these studies, one might conclude that the pursuit of sexual reorientation is always harmful. However, other reports suggest that some clients have benefited from such therapies (Spitzer, 2003; Throckmorton, 1998, 2002). We now review studies that have reported various benefits of sexual reorientation therapies.

Nicolosi, Byrd, and Potts (2000) reported the results of a survey of 882 individuals who had tried conversion therapy. Surveys were distributed to therapists, ex-gay groups, and ex-gay conferences (e.g., Exodus International). Nearly 23% reported no perceived change in sexual feelings, 42.7% reported some changes, and 34.3% reported much change. Sexual orientation was not defined and so it is difficult to know how each respondent viewed the type of change they experienced.

As a group, respondents rated their therapy or change experience as being helpful on a range of variables, including self-acceptance, trust of the opposite-sex, self-esteem, emotional stability, relationship with God, and depression. However the authors also noted that 7.1% of survey respondents said that they were doing worse after intervention than before. Concerning these results, the authors noted that "conversion therapy is not appropriate for all clients. Clients who have decided they wish to affirm a gay identity could feel shamed and emotionally hurt if therapists attempted to impose conversion therapy on them" (Nicolosi et al., 2000, p. 1084). Specific interventions associated with either benefit or harm were not identified.

Schaeffer and colleagues have conducted three studies of ex-gay ministry participants. These studies all surveyed Exodus International participants (Nottebaum, Schaeffer, Rood, & Leffler, 2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Schaeffer, Nottebaum, Smith, Dech, & Krawczyk, 1999).

Schaeffer et al. (2000) surveyed 184 men and 64 women who were attempting to change sexual orientation with the assistance of an Exodus International ministry and found that Exodus participants were significantly more heterosexually oriented at the time of the study than they remembered being at age 18. The changes reported were positively associated with religious motivation to change and positive mental health.

In a follow-up study of 140 of the original participants, Schaeffer et al. (1999) 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. The researchers found that change was positively associated with religious motivation and emotional well-being.

Nottebaum et al. (2000) extended these two studies by comparing 105 participants who accepted a gay male/lesbian identity with a matched sample of Exodus participants who were attempting to change their sexual orientation. Current sexual orientation and orientation at age 18 were examined, along with the role of emotional well-being, therapy, religion, and childhood experiences. Although the two groups did not differ concerning sexual orientation at age 18 (both reported similar same-sex identities), the Exodus group reported more current heterosexual identification. Both groups reported good mental health. These reports did not identify specific interventions that were associated with benefit or harm but rather global assessments of their experiences in pursuing reorientation.

Spitzer (2003) surveyed 200 participants (143 men and 57 women) by telephone. One of the criteria for being in the sample was that the participants had been successfully involved in a sustained effort of at least 5 years' duration to change their sexual orientation. Spitzer examined self-reports of sexual attraction, sexual thoughts, same-sex fantasies during sexual activity, emotional attachments, and same-sex sexual behavior. On all dimensions, the year prior to the interview was compared with recollection of the year prior to the efforts to change. He reported that 33 of the men and 6 of the women assessed themselves as extreme on indicators of homosexual orientation in the year prior to change. Spitzer defined extreme homosexual orientation as having those who reported no heterosexual sex, no teenage opposite-sex attraction, a rating of at least 95 out of 100% homosexual attraction and no heterosexual masturbatory fantasies prior to therapy to effect change in sexual orientation.

Concerning the 33 men in this category (he did not provide analysis of the small number of women), Spitzer reported that 67% had achieved "good heterosexual functioning" defined as being involved in a loving heterosexual relationship, satisfaction from the emotional relationship with their partner rated as at least seven on a 10 point scale where 10 is as good as it can be and 1 is as bad as it can be, heterosexual sex at least monthly, physical satisfaction from heterosexual sex rated at least seven on the same 10 point scale, and never or rarely (<20%) thinking of the same-sex during heterosexual sex.

There were perceived changes on other dimensions as well. During the year prior to initiating change, 99% of the total male sample and 88% of the female sample affirmed that they had same-sex sexual fantasies, whereas after they experienced change, only 32% of the men and 5% of the women reported the same type of fantasies. A desire for emotional involvement with same-sex individuals went from 78% of the men and 81% of the women to 8% of the men and 4% of the women post change (Spitzer, 2003). Spitzer concluded that the majority of participants made substantial changes from predominantly or exclusively homosexual to a predominant heterosexual adjustment. Although he noted that complete change was uncommon, he further reported that most of those who made lesser changes felt that those changes were beneficial.

All studies reported here suffer from a lack of control groups, a reliance on self-report and participant recollections, and sampling bias. This review reveals widely divergent findings regarding those who have pursued sexual reorientation. Clearly, research has identified some who feel harmed while other research has identified some who have perceived benefit. In the most recent research, the dimension of perceived harm versus benefit has become the focus. No research to date has examined the associations of specific interventions with perceptions of harm or benefit. Shidlo and Schroeder (2002) come the closest to identifying specific reorientation therapy techniques but it is not clear from their report how their participants regarded these or other techniques.

To address this gap in the research, we investigated for the first time the perceptions of those who seek reorientation counseling regarding the helpfulness of interventions offered them. Prior research has globally examined whether participation in efforts to change sexual orientation was helpful or harmful. The present study investigates a variety of interventions regarding their helpfulness to clients engaged in efforts to reorient sexual feelings.

We do this in part by adapting the methodology of Liddle (1996) with a group of participants who sought reorientation counseling. Liddle identified 13 interventions considered relevant to gay and lesbian clients. She then asked participants whether or not their counselors used the various interventions and sought a global helpfulness rating of those counselors. She was able to determine that certain practices were associated with therapist ratings.

We individually interviewed each participant in our research using structured interviews. We wanted to know which, if any, practices were associated with perceptions of benefit and/or harm. We included the 13 practices from Liddle as well as seven additional practices often associated with clinicians who work with clients pursuing sexual reorientation. Practices 14 and 20 were derived from psychoanalytic approaches (e.g., Moberly, 1983; Nicolosi, 1991); practice 15 from Yarhouse and Burkett (2002, 2003) and their emphasis on distinguishing between the experience of same-sex attraction and the development of a gay identity; practices 16 and 17 were drawn from behavioral approaches to sexuality (e.g., Greenspoon & Lamal, 1987); practice 18 is associated with ministry based approaches as studied by Schaeffer and colleagues (Schaeffer, et al., 1999; Schaeffer, et al., 2000) and practice 19 is generically an aspect of all approaches to sexual reorientation therapy (Throckmorton, 1998). Note that these seven practices correspond closely to some of the practices identified by Shidlo and Schroeder (2002) as making up homosexual behavior management.

Method

Participants

Participants for the study had been in reorientation counseling with a professional therapist and currently viewed themselves as having reoriented or as being in the process of reorienting. Thirty-two interviews were conducted but 4 participants were excluded because their therapists were not professionally trained or credentialed or their change experience did not include counseling. The 28 participants reported on their experiences with 80 mental health professionals for a mean of 2.9 therapists per participant. The number of therapists ranged from one to nine. Mean

Table 2
Kinsey Ratings of Participants, Before Therapy and At Time of Study

Kinsey Rating	% Before Therapy	% At Present
Exclusively heterosexual	0.0%	21.4%
Almost entirely heterosexual	0.0%	50.0%
More heterosexual than homosexual	0.0%	10.7%
Equally heterosexual and homosexual	0.0%	7.1%
More homosexual than heterosexual	14.3%	10.7%
Almost entirely homosexual	14.3%	0.0%
Entirely homosexual	71.4%	0.0%

number of sessions per episode was 47.6 with a median of 20 sessions per episode. The range was extreme, between one and 575 sessions.

The participants were predominantly white, very religious, and well educated. The average age of the participants was 39 with 96% being Caucasian. The participants were 79% Protestant, 7.1% Catholic, 10.7% Latter Day Saint, and 3.1% Buddhist. All participants agreed that religion was either "extremely important" (89%) or "important" (11%). Most were or had been married (54.6%) with the remainder not married (46.4%). All participants had at least a bachelors degree, with 43% having an advanced degree.

Concerning their sexual feelings, the mean age of onset of same-sex attractions was 13.5 with a range from age 5 to 30. The participants started their change process an average of 10.6 years prior to the survey with a range of 1 to 30 years. Table 2 reports the aggregated sexual orientation ratings before initiating therapy efforts and at present. At the time of the study, 6 (30%) of the 20 participants who declared themselves exclusively homosexual (Kinsey 6) before entering therapy rated themselves exclusively heterosexual (Kinsey 0). Eight (40%) of the participants with an initial Kinsey 6 rating viewed themselves as almost completely heterosexual (Kinsey 1) at the time of the study. The remaining six Kinsey 6 participants were equally divided in their change to Kinsey ratings of 2-4 (two participants for each rating), representing a bisexual adjustment.

Procedure

This convenience sample was derived from calls for participants on ex-gay Internet list servs and discussion groups. Data were collected via a 90 minute phone interview with the first author. In some cases, participants completed the survey first and the first author confirmed the data via a follow up phone interview. Data were collected from October 2001 to October 2002.

Instrument

As a model we used the survey of Liddle (1996). However, we reworded some of the items for clarity and added the 7 items derived from the literature on counseling clients seeking change in sexual orientation. See Table 1 for practices used in the survey instrument.

The survey asked respondents to describe all therapeutic contacts that were undertaken with an objective to address discomfort with sexual identity and/or sexual feelings in some manner. Each therapist description was represented by a separate column in the survey. For each therapist, participants reported the following concerning the therapist: gender, sexual orientation, professional affiliation, and the number of sessions they worked together. The dependent measure of Brooks (1981) and Liddle (1996) was asked: "How helpful was this therapist?" using the following options (1) destructive, (2) not helpful, (3) sometimes helpful, sometimes not helpful, (4) helpful, and (5) very helpful. Finally, the respondent also reported whether or not the therapist exhibited 20 specific interventions. For each therapist, respondents were asked if each practice was present during that therapeutic episode.

Results

Respondent ratings of therapist helpfulness were generally positive (M = 3.85, SD = 1.10), and included some ratings at both extremes. Respondents also indicated whether the therapist had used each of the various 20 therapist practices. The helpfulness ratings were then correlated with the reported usage of each of the 20 therapist practices (see Table 3) to determine

Table 3
Correlations of Rated Therapist Helpfulness with 20 Therapist Practices

Therapist Practices	Frequency of Use $N = 80$	Frequency of Non-use $N = 80$	Correlation of Rated Helpfulness with Use v. Non-use of Therapist Practice, $r =$	$p <$
1.	24	56	.02	n.s.
2.	36	44	.24	.05
3.	13	67	.15	n.s.
4.	3	77		
5.	1	79		
6.	26	54	-.47	.001
7.	11	69	-.28	.05
8.	50	30	.27	.05
9.	10	70	-.22	.05
10.	36	44	.31	.01
11.	72	8	.41	.001
12.	71	9	.20	n.s.
13.	13	67	-.37	.001
14.	56	24	.48	.001
15.	51	29	.51	.001
16.	48	32	.40	.001
17.	47	33	.23	.05
18.	22	58	.16	n.s.
19.	58	22	.53	.001
20.	50	30	.27	.05

NOTE: Statistical tests are not provided when frequency of use was less than 5.

whether the presence or absence of each of the 20 therapist practices would predict whether or not the therapy was reported as being helpful. Two of these 20 practices were used so rarely as to call into question the stability of the results. Hence, the correlations for Therapist Practices 4 and 5 are not reported.

The first nine Therapist Practices, identified by Liddle (1996) as being inappropriate, showed weak and inconsistent results. Two of these, just noted, were rarely seen. Two others did not show significant results (Practices 1 and 3). The other five showed significant results, but two were positively associated with helpfulness (Practices 2 and 8). Only three were perceived as being unhelpful (Practices 6, 7, and 9). It was indeed unhelpful when the therapist was seen to lack the basic knowledge of gay and lesbian issues necessary to be an effective therapist (Practice 6), when the therapist pressured or advised to come out to someone in spite of the fact that the client believed it was too risky (Practice 7), and when the therapist apparently did not understand the problems of societal prejudice against gay men and lesbians and/or internalized homophobia. However, it was seen as being helpful when the therapist indicated that he/she believed that a gay or lesbian identity is

bad, sick, or inferior (Practice 2) and when the therapist failed to recognize the importance of lesbian and gay relationships and/or did not appropriately support these relationships.

The next four Therapist Practices, identified by Liddle (1996) as being exemplary, also showed mixed results, but were generally positive. One of the practices showed no effect (Practice 12). Two practices showed a positive effect. It was indeed helpful when the therapist was quite knowledgeable about the lesbian and gay communities and other resources (Practice 10), and when therapists never made an issue of sexual orientation when it was not relevant (Practice 11). It was unhelpful; however, when therapists tried to help these respondents feel good about themselves as gay or lesbian (Practice 13).

The seven additional Therapist Practices were generally seen as being helpful by the respondents. Although one of the seven did not show significant results (Practice 18), the other six were all positively correlated with perceived helpfulness. It was seen as being helpful when therapists helped look for and understand causes of same-sex attraction (Practice 14), when therapists indicated that having same-sex attractions did not necessarily mean that one was gay or lesbian (Practice 15), when therapists suggested strategies to minimize same-sex attractions (Practice 16), when therapists suggested strategies to enhance heterosexual attractions (Practice 17), when therapists helped one feel good as an ex-gay or ex-lesbian (Practice 19), and when therapists suggested that one should develop non-sexual friendships with same-sex peers.

During the phone survey, the first author asked the participants if there were any techniques not mentioned that were either helpful or harmful. A variety of additional interventions were mentioned. Intentionally changing same-sex pre-sleep sexual fantasies, overcoming same-sex peer rejection and severing ties to a gay identity were mentioned four times by participants. Bible reading and prayer, journaling, visualizing positive outcomes, repairing broken family relationships, enhancing gender identification were each mentioned three times. Non-sexual physical touch from same-sex friends and group therapy were mentioned twice and resolving sexual abuse was mentioned once as helpful interventions.

Five participants said that it was unhelpful when therapists prescribed adherence to rigid gender stereotypes as a part of therapy. Two said suggestions to date heterosexually early in therapy were harmful. Suggestions to engage in non-sexual physical contact with same-sex friends and encouragement to masturbate to opposite-sex imagery were mentioned once as unhelpful.

We tabulated the prevalence of each practice and report these in Table 3. As noted above, practices 4 and 5 were rarely used. Practice 1 (your therapist gave some indication that he/she had automatically assumed you were heterosexual before you indicated your sexual orientation), 3 (your therapist discounted, argued against, or pushed you to renounce your self-identification as a lesbian or gay man), 7 (your therapist pressured or advised you to come out to someone in spite of the fact that you believed it was too risky), 9 (your therapist apparently did not understand the problems of societal prejudice against gay men and lesbians and/or internalized homophobia), 13 (your therapist tried to help you feel good about yourself as a gay man or lesbian), and 18 (your therapist referred you to an ex-gay support group) were described as occurring infrequently (30% or less) among the therapists rated. On the other hand, practices 11 (your therapist never made an issue of your sexual orientation when it was not relevant), 12 (your therapist was not afraid to deal with your sexual orientation when it was relevant), 14 (your therapist helped you look for and understand causes of same-sex attractions in your life), and 19 (your therapist helped you feel good about yourself as an ex-gay man or ex-lesbian) were perceived to have been done by more than 70% of the therapists rated.

Finally, we asked the participants if they felt any pressure from their therapists to enter reorientation therapy. We also asked if the participants felt any pressure from therapists not to enter sexual reorientation. None of the participants reported pressure from therapists to become involved in reorientation therapy, whereas 11 (39.2%) perceived pressured from therapists not to enter such therapy.

Discussion

In general, these participants perceived benefit from their experiences in counseling that supported their desire to affirm a heterosexual identity and mixed results from those interventions identified by Liddle (1996). Participants did not prefer professionals who were not knowledgeable about gay and lesbian issues, who

pressured or advised one to come out to someone in spite of the belief that it was too risky, who did not understand the problems of societal prejudice against gay men and lesbians, and who sought to help participants feel good about themselves as gay or lesbian.

On the other hand, participants preferred therapists who indicated that they believed that a gay or lesbian identity is negative, who did not support maintenance of lesbian and gay relationships, who was quite knowledgeable about the lesbian and gay communities, who never made an issue of sexual orientation when it was not relevant, who helped clients look for and understand causes of same-sex attraction, who indicated that having same-sex attractions did not necessarily signal a necessity to identify as gay or lesbian, who suggested strategies to minimize same-sex attractions, who suggested strategies to enhance heterosexual attractions, who helped clients feel good about themselves as an ex-gay or ex-lesbian, and who suggested that you should develop non-sexual friendships with same-sex peers.

In examining the seven additional interventions, we found that, in general, participants viewed therapists employing these techniques as helpful. The only one of the practices not significantly related to benefit was Practice 18 (your therapist referred you to an ex-gay support group).

When given the chance to identify therapist practices in addition to those in the survey, the participants did not congregate on any dominant trend. Some preferences for active interventions (journaling, prayer, severing ties to a gay identity, repairing family disruptions), cognitive approaches (Bible reading, visualization, enhancing gender identification, modifying pre-sleep sexual fantasies) and social support (group therapy, non-sexual touch) were expressed. Regarding additional harmful interventions, some participants expressed strong dislike for approaches that advocated adherence to rigid gender stereotypes. Additional research could investigate these practices in the same way we have examined the practices in our survey.

On balance, these results provide support for the recommendations of Throckmorton (2002) and Yarhouse and Burkett (2003) that clients experiencing same-sex attraction but who wish to affirm a heterosexual identity can be referred to counselors who can support their counseling objectives. This study could also call into question strong warnings issued by professional mental health associations condemning reorientation counseling as invariably leading to harm. Such warnings may help explain why 39% of study participants perceived pressure from therapists to avoid reorientation therapy. It appears that professional groups have not fully addressed the situation of those same-sex attracted clients who wish to affirm a heterosexual identity as an aspect of their counseling experience.

Critics of reorientation counseling on the grounds that such therapies stigmatize gays and lesbians may find some support in the finding that 45% of the therapists were perceived as agreeing with practice 2: "your therapist indicated that he/she believed that gay or lesbian identity is bad, sick or inferior." Furthermore, the participants rated therapists who were perceived in this manner as generally helpful. This particular item generated more spontaneous comments and questions from participants than any other item. Some of these comments may help clarify how participants viewed the item. One female participant said, "My therapist never made me feel bad, sick or inferior but I went to him because I did not think my homosexual feelings were right." A male respondent said, "My therapist never really said what he thought, but he never disagreed with my view that homosexuality was immoral." It is possible that therapists could have been neutral on this issue but were perceived as having negative views.

Did the perceived negative or neutral views of the therapists influence the self-image of the clients? All we can say from this investigation is that among those clients who perceived negative therapist attitudes, there was a general rating of helpfulness. One explanation could be that the perceived agreement in attitude had some relationship to perceived overall benefit. Given the religious nature of these participants, it may seem natural for them to experience a "love the sinner, hate the sin" dichotomy. This dichotomy could allow them to feel benefit and support from a therapist who may convey neutral or negative attitudes toward homosexuality. It is important to note that a majority of reorientation episodes did not occur with therapists who were perceived as agreeing with this attitude. Given the exploratory nature of this investigation, such an attitude cannot be viewed as a necessary condition for being considered a helpful therapist by those seeking sexual reorientation. This finding makes it important to caution therapists involved in reorientation interventions to make clear to

clients that collaboration in exploring a heterosexual identity synthesis does not of necessity convey disrespect for sexual orientation diversity. More research into the role of perceived therapist attitudes and its impact upon perceptions of benefit would help to clarify this matter.

Certainly this study should be replicated with a larger sample size and via more representative sampling techniques. However, for reasons not completely clear, it is difficult to secure sizable numbers of people who have sought reorientation counseling willing to discuss their lives and experiences in counseling. Many of these participants of this study expressed caution in agreeing to participate. Difficulty in attaining adequate samples is characteristic of these kinds of studies. For instance, Spitzer (2003) took two years to find 200 former homosexuals who met his stringent criteria for inclusion. Shidlo and Schroeder (2002) took five years to find the 176 participants for their investigations concerning how some clients were harmed by their experiences. Our study found 32 willing participants over 1 year which is consistent with these prior studies.

We are aware that we investigated only those participants who indicated they were pursuing or had pursued a goal of sexual reorientation. We do not know how many people continue to pursue this goal. If some in the original group have abandoned these efforts, they might currently view their past counseling experiences differently. Of necessity all such surveys are snapshots in time. It is certainly possible that time could indeed change the perceptions of clients depending upon their current life situation.

Longitudinal research is needed to examine the experience of consumers of sexual reorientation therapy over time. There is disagreement about the longevity of the changes described by those who identify as formerly homosexual. Some empirical and anecdotal evidence exists suggesting persistent changes (Throckmorton, 2002; 2004) as well as evidence suggesting the existence of ex-ex-gays, or those who attempt reorientation but then return to a gay identity (Shidlo & Schroeder, 2002). Follow up studies might well identify varying developmental patterns for people who pursue modification of sexual feelings.

References

Beckstead, L., & Morrow, S. (2004). Mormon clients' experiences of conversion therapy: The need for a new treatment approach. *The Counseling Psychologist, 32*, 651-690.

Beutler, L. E., Machado, P. P. P., & Neufeldt, S. A. (1994). Therapist variables. In A. E. Bergin & S. Garfield (Eds.). *Handbook of Psychotherapy and Behavior Change* (4th Ed.). New York: John Wiley & Sons.

Brooks, V. R. (1981). Sex and sexual orientation as variables in therapists' biases and therapy outcomes. *Clinical Social Work Journal, 9*, 198-210.

Garnets, L., Hancock, K. A., Cochran, S. D., Goodchilds, J., & Peplau, L. A. (1991). Issues in psychotherapy with lesbians and gay men. *American Psychologist, 46*, 964-972.

Greenspoon, J., & Lamal, P. (1987) A behavioristic approach. In L. Diamant (Ed.), *Male and female homosexuality: Psychological approaches* (pp. 109-127). New York: Hemisphere Publishing.

Haldeman, D. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Consulting and Clinical Psychology, 62*, 221-227.

Jones, M. A., Botsko, M., & Gorman, B. S. (2003). Predictors of psychotherapeutic benefit of lesbian, gay, and bisexual clients: The effects of sexual orientation matching and other factors. *Psychotherapy: Theory, Research, Practice and Training, 40*, 289-301.

Liddle, B. J. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to ratings of helpfulness by gay and lesbian clients. *Journal of Counseling Psychology, 43*, 394-401.

Moberly, E. R. (1983). *Homosexuality: A new Christian ethic*. Cambridge, MA: James Clarke.

Nicolosi, J. (1991). *Reparative therapy of male homosexuality*. Northvale, NJ: Jason Aronson.

Nicolosi, J., Byrd, A. D., & Potts, R. W. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports, 86*, 1071-1088.

Nottebaum, L. J., Schaeffer, K. W., Rood, J., & Leffler, D. (2000). *Sexual orientationA comparison study* . (Manuscript submitted for publication.) (Available from Kim Schaeffer, Department of Psychology, Point Loma Nazarene University, 3900 Lomaland Drive, San Diego, CA 92106).

Schaeffer, K. W., Hyde, R. A., Kroencke, T., McCormick, B., & Nottebaum, L. (2000). Religiously-motivated sexual orientation change. *Journal of Psychology and Christianity, 19*, 61-70.

Schaeffer, K. W., Nottebaum, L., Smith, P., Dech, K., & Krawczyk, J. (1999). Religiously-motivated sexual orientation change: A follow-up study. *Journal of Psychology and Theology, 27*, 329-337.

Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research and Practice, 33*, 249-259.

Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior, 32*, 403-417.

Throckmorton, W. (1998). Efforts to modify sexual orientation: A review of the outcome literature and ethical issues. *Journal of Mental Health Counseling, 20*, 283-304.

Throckmorton, W. (2002). Initial empirical and clinical findings concerning the change process for ex-gays. *Professional Psychology: Research and Practice, 33*, 242-248.

Throckmorton, W. (2004). Critics ignore the whole truth about ex-gays. AmericanDaily.com, available at http://www.americandaily.com/article/5852.

Tozer, E. E., & McClanahan, M. K. (1999). Treating the purple menace: Ethical considerations of conversion therapy and affirmative alternatives. *Counseling Psychologist, 27*, 722-742.

Yarhouse, M. A., & Burkett, L. A. (2002). An inclusive response to LGB and conservative religious persons: The case of same-sex attraction and behavior. *Professional Psychology: Research and Practice, 33*, 235-241.

Yarhouse, M. A., & Burkett, L. A. (2003). *Sexual identity: A guide to living in the time between the times.* Lanham, MD: University Press of America.

Yarhouse, M. A., & Throckmorton, W. (2002). Ethical issues in attempts to ban reorientation therapies. *Psychotherapy: Theory, Research and Practice, 39*, 66-75.

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