Claim 59

Psychological treatments like “conversion therapy” can change a person’s same-sex orientation to a heterosexual orientation.

Alan was concerned about his 14-year-old son, Aaron. Aaron’s interests had always been what his father thought of as “girly,” and now that he was in his teens he was attracting the attention of older boys who seemed to identify as gay. Alan was very uncomfortable with this situation. He was genuinely worried about the prospect of a homosexual life for his son. He felt that such a life would be dangerous in terms of sexually transmitted disease as well as because of possible “gay-bashing” attackers. He also felt that people in same-sex relationships were likely to miss some aspects of community and family life that he thought very valuable. In addition, Alan’s religious beliefs clearly categorized same-sex attraction and sexual activity as sinful, which gave him real concerns for his son’s spiritual future. When a friend told Alan about the practice of “conversion” or “reparative” therapy, he began to think that such treatment might be the best thing he could do for Aaron.

Was Alan right in thinking that Aaron’s sexual orientation could be altered by a psychological treatment like conversion therapy?
Before discussing this claim, some background needs to be provided. First, you need to understand that homosexuality was at one time “officially” considered to be a mental illness, as described in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*. By 1980, however, sexual orientation was listed as a psychiatric concern only when it was “ego-dystonic” or uncomfortable with respect to an individual’s perception of himself. In reports from task forces, the American Psychological Association has stated that sexual orientation, in itself, is not a mental health problem and that it is unethical for psychologists to treat it as if it were (APA Task Force, 2009).

Most recently, the American Psychological Association has asserted that there is “no research demonstrating that providing SOCE [sexual orientation change efforts] to children or adolescents has an impact on adult sexual orientation. The few studies of children with gender identity disorder found no evidence that psychotherapy provided to those children had an impact on adult sexual orientation. There is currently no evidence that teaching or reinforcing stereotyped gender-normative behavior in childhood or adolescence can alter sexual orientation. We have concerns that such interventions may increase self-stigma and minority stress and ultimately increase the stress of children and adolescents” (APA Task Force, 2009, p. 4).

An additional background fact is that calling a treatment a “therapy” does not, in itself, mean that it is beneficial. Lilienfeld (2007) pointed to the possible harm done by some well-intentioned treatment methods and referred to these as “potentially harmful treatments” (PHTs). The idea of the PHT reminds us that it is not enough to ask whether a treatment like conversion therapy is or is not effective; we also need to ask whether it may be harmful. This is a concern about psychotherapies for people of any age, but it is especially important when we are talking about children and adolescents. Young therapy clients are vulnerable because of their need for continuing healthy development and also because they usually are not allowed to make their own decisions about their treatment. Attempts to alter sexual orientation have included the use of electric shock and other less dangerous but painful and frightening physical intrusions (Clair, 2013; Cohen, 2007).

There is little systematic research on the effect of conversion therapy on sexual orientation; certainly, there are none of the randomized controlled trials that are considered the “gold standard” for evidence-based therapies. There are many anecdotal reports of distress caused by the treatment. One study (Flentje, Heck, & Cochran, 2014) interviewed 38 “ex-ex-gay” people—individuals who had considered themselves “cured” of their same-sex orientation but then had realized that they continued to feel attracted to people of the same sex. These adult participants were asked about both
short- and long-term helpful and harmful effects of conversion therapy. Some reported that the therapy was helpful in terms of their understanding that their same-sex orientation was not something to be “overcome.” A few stated that they met a first gay partner or lover as a result of the treatment. Others reported harmful effects: “It was fear-inducing—horrible. Almost like an exorcism performed on me. I had panic attacks and anxiety.” “It . . . led me to start blaming my parents for things they were not responsible for.” “In spite of the therapist’s efforts, my depression grew worse under his care rather than growing better. I began cutting, secured a gun license in my state, and almost killed myself” (Flentje et al., 2014, pp. 1258–1259).

In the absence of systematic evidence of benefits or harm from conversion therapy, it can be helpful to consider whether the treatment is plausible—that is, does it make sense in terms of other things we know about the development of sexuality? Treatment efforts that use reward or punishment to try to change sexual orientation are implausible with respect to the evidence that sexual orientation is probably primarily genetically determined rather than strongly influenced by experience (Dawood, Bailey, & Martin, 2009). Some authors, like Cohen (2007), attribute same-sex attractions to “hetero-emotional wounds” stemming from experiences with dominating mothers and disengaged fathers, which leave boys seeking other males who will supply the missing paternal love. To remedy these problems, Cohen advises a method that he believes intensifies the attachment relationship with the father; this treatment involves “holding therapy” as formulated by the psychiatrist Martha Welch (1989), in which the father embraces the son face-to-face and will not release him for an hour or more. There is no evidence that homosexuality is related to attachment, or that holding affects attachment, or that holding influences same-sex orientations.

Conversion therapy is almost unique among psychotherapies in that mental health professionals have been prohibited by law from using it for minors in two states, California and New Jersey (see Clair, 2013). The treatment is not prohibited for adults, and members of the clergy can legally do it.

When these legislative prohibitions were under consideration and hearings were held to discuss evidence for and against allowing the treatment, it was notable that most of the testimony turned on two kinds of personal experiences and beliefs. One kind came from witnesses with same-sex orientations, who told of their distress as they underwent conversion therapy and their concern that their families could not accept them as they were. The other type of testimony came from members of religious bodies that regard homosexuality as a sinful condition that needs to be corrected by any means possible. Only a few witnesses testified about the lack of evidence to support the effectiveness of conversion therapy, about
its potential for harm to clients, or about its implausibility with respect to established understanding of child development. The legal prohibition of conversion therapy probably has more to do with the political power of persons with same-sex orientations and their friends and families than it does with systematic research evidence.

Conclusion

If Alan and Aaron live in California or New Jersey, it is illegal for Aaron to be given conversion therapy by a mental health professional as long as he is a minor. It would be possible for Alan to seek a member of the clergy to do this treatment, but it seems likely that the therapy would be frightening and uncomfortable for Aaron and would not culminate in any change in his adult sexual orientation. If either Alan or Aaron is unhappy with the situation, it is possible for them to seek affirmative treatment that will help them come to terms with each other and with the reality of Aaron’s apparent sexual orientation (APA Task Force, 2009).

Critical Thinking

1. Is it valid to assume that every person who has undergone conversion therapy had harmful effects like those described in the Flentje et al. (2014) study? Why or why not?

2. As of the writing of this book, New York and Maryland were also considering legislation to ban conversion therapy for minors. Use the Internet to find whether those and other states have now passed such legislation and what arguments were used for or against it. The paper by Clair (2013) will give some idea of the kinds of reasoning that may be used.

3. What penalties did the California “conversion therapy” legislation prescribe for mental health professionals who break the law?

4. Which of the problems of critical thinking discussed in the Introduction to this book seem to be involved in the assumption that sexual orientation is influenced by attachment? Explain your answer.

5. Given all the resources you would need, how would you test the hypothesis that dominating fathers and disengaged mothers cause same-sex orientation? Would this hypothesis predict the same outcomes for males and for females?
References


