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Sexual Orientation Conversion Therapy for Gay Men and Lesbians: A Scientific Examination

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The American Psychiatric Association's 1973 decision to remove homosexuality from its Diagnostic and Statistical Manual of Mental Disorders marked the official passing of the illness model of homosexuality. The American Psychological Association followed suit with a resolution affirming this anti-illness perspective stating, in part: "the APA urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations" (American Psychological Association, 1975).

Homosexuality was replaced with the confusing "ego-dystonic homosexuality" diagnosis, which itself was dropped in 1988. Despite this now complete official depathologizing of homosexuality, efforts by both mental health professionals and paraprofessionals (e.g., pastoral care providers) to convert lesbians and gay men to heterosexuality have persisted. In fact, such efforts seem to be increasing at present. They span a variety of treatment modalities and are referred to as conversion therapy.

There are two major concerns about the "rehabilitation" of homosexual men and women. First, conversion therapies have long been questioned as to professional ethical standards (see Davison, this volume). These ethical concerns involve the extent to which conversion treatments are in keeping with the American Psychological Association's affirmative policies on homosexuality, as well as larger issues of therapist responsibility and consumer welfare, which are applicable to all areas of mental health practice. Second, empirical studies fail to show any evidence that conversion therapies do what they purport to do: change sexual orientation. The methodological problems with such studies will be shown to be considerable. These examples of poor science have engendered conflict among those emotionally fragile gay men and lesbians who are typical targets of conversion attempts. Many of

these individuals are vulnerable to the idea of repairing in themselves what is actually society's problem: a history of rejection and discrimination based upon socially instituted homophobia. As Bryant Welch (1990), APA's executive director for professional practice, recently stated: "[these] research findings suggest that efforts to 'repair' homosexuals are nothing more than social prejudice garbed in psychological accoutrements."

Davison (1976, 1978, 1982) has detailed many of the ethical objections to conversion therapies. Silverstein (1977b) and Begelman (1975, 1977) have noted that the issues for gay people seeking sexual orientation change are social in nature, not intrinsic to homosexuality. Other relevant discussion is contained in the *Symposium on Homosexuality and the Ethics of Behavioral Intervention* (1977). This chapter, however, will focus on the scientific validity of conversion methodologies.

An examination of the literature shows that not only are conversion therapies unethical and professionally irresponsible, as Davison describes in this volume, but they additionally constitute inadequate and questionable science. Silverstein, in this volume, details similar concerns with biomedical attempts at conversion. Both the ethical and scientific perspectives offer ample and sound justification for abandoning conversion techniques.

A REVIEW OF CONVERSION METHODOLOGIES

Prior to its declassification as a mental illness, a variety of modalities were commonly employed for treating homosexuality. Psychoanalytic tradition posited that homosexual orientation represented an arrest in normal psychosexual development, most often in the context of a particular dysfunctional family constellation. Such a family typically featured a close-binding mother and an absent or distant father. This theory has never been empirically validated, but is based solely upon clinical speculation. Subsequent studies have indicated that etiologic factors in the development of sexual orientation are unclear, but that the traditional psychoanalytic formulations about family dynamics are not viable (Bell, Weinberg, & Hammersmith, 1981).

Psychoanalytic treatment of homosexuality is exemplified by the work of Bieber et al. (1962), who advocate intensive long-term therapy aimed at resolving the unconscious childhood conflicts responsible for homosexuality. Bieber's methodology has been widely criticized on numerous grounds. First, his sample is entirely a clinical one. Second, all outcomes are based upon subjective therapist impression, not externally validated data or even self-report. Last, follow-up data have been poorly

presented and not at all empirical in nature. Nevertheless, Bieber et al. (1962) report a meager 27% success rate in heterosexual shift after long-term therapy. Of these, however, only 18% were exclusively homosexual in the first place; 50% were bisexual. This blending of "apples and oranges" is quite common in conversion studies, and renders misleading these claims of success, which are, in this study, not impressive in the first place.

Other analysts have "treated" homosexuality. One study reported virtually no increase in heterosexual behavior in a group of homosexual males (Curran & Parr, 1957). Other studies report greater success rates: for instance, Mayerson and Lief (1965) indicate that half of 19 subjects reported exclusive heterosexual behavior four and a half years after treatment. However, as in Bieber's study, those subjects reporting such change were bisexual to begin with; exclusively homosexual subjects reported little change. Further, all outcomes were based on patient self-report, with no external validation. Last, the authors incorrectly interpret an expansion of the sexual repertoire toward heterosexuality as equivalent to a shift of sexual orientation.

Group therapies aimed at changing sexual orientation have provided similar contradictory results. One study of 32 subjects reports a 37% shift to heterosexuality (Hadden, 1966), but the results must be viewed with some skepticism, due to the entirely self-report nature of the outcome measures. Persons involved in such group treatments are especially susceptible to social demand influence in their own reporting of "treatment success." Similarly, a study of 10 male homosexuals resulted in therapist impressionistic claims that homosexual patients were able to "increase contact" with heterosexuals (Mintz, 1966). Birk (1980) describes a combination insight-oriented/social learning group format for treating homosexuality. He claims that overall, 38% of his patients achieved "solid heterosexual shifts"; nonetheless, he states:

> It is my belief that these represent shifts in a person's salient sexual adaptation to life, not a metamorphosis. Most, if not all, people who have been homosexual continue to have some homosexual feelings, fantasies and interests. More often than not, they also have occasional, or more than occasional, homosexual outlets, even while being "happily married." (Birk, 1980)

What, then, is the intended goal of treatment? If a "solid heterosexual shift" is defined as one in which a "happily married" person may engage in "more than occasional" homosexual encounters, what does a "soft" heterosexual shift look like? This reiterates one of the major objections to conversion studies: these interventions do not shift sexual

orientation at all. Rather, they instruct or coerce heterosexual activity in a minority of subjects which is not the same as reversing sexual orientation.

Eager to construe heterosexual competence as orientation change, these researchers ignore the complex question of how sexual orientation is assessed in the first place. The chapter by Gonsiorek and Weinrich in this volume discusses the complexities of defining sexual orientation. The studies discussed in this review do not display any such complexity or thoughtfulness. While they claim to change orientation, the outcomes are nearly always defined in terms of heterosexual performance.

Early behavioral work in conversion therapy operated on the rationale that if certain predetermined (homosexual) behaviors could be extinguished, and if "adaptive" (heterosexual) behaviors could be substituted, the individual's sexual orientation would change. Such early behavioral studies primarily employed aversive conditioning techniques, usually involving electric shock or nausea-inducing drugs during presentation of same-sex erotic visual stimuli. Typically, the cessation of the aversive stimuli would be accompanied by the presentation of opposite-sex erotic visual stimuli, to supposedly strengthen heterosexual feelings in the sexual response hierarchy. Some programs attempted to augment aversive conditioning techniques with a social learning component—assertiveness training, how to ask women out on dates, and so on (Feldman & McCulloch, 1965). Later, the same investigators modified their approach, calling it "anticipatory avoidance conditioning," which enabled subjects to avoid electrical shock when viewing slides of same-sex nudes (Feldman, 1966). One wonders how such a stressful situation would permit feelings of sexual responsiveness in any direction; nevertheless, a 58% "cure" rate was claimed. Again, however, the outcome criteria were defined as suppression of homosexuality, and an increased capacity for heterosexual behavior. It is not uncommon for homosexuals who have undergone aversive treatments to notice a temporary sharp decline in their homosexual responsiveness.

As with aversive techniques, the "covert sensitization" method calls for the use of noxious stimuli paired with same-sex erotic imagery. In this procedure, however, the subject does not actually experience the electric shock or induced vomiting, but is instructed to imagine such stimuli (Cautela, 1967). Outcomes here are limited to single-case studies, and are not generalizable.

More recent studies suggest that aversive interventions might extinguish homosexual responsiveness, but do little to promote alternative orientation. One investigator suggests that the poor outcomes of conversion treatments is due to the fact that they "disregard the complex learned repertoire and topography of homosexual behavior" (Faust-

man, 1976). Other recent studies echo the finding that "aversive therapies in homosexuality do not alter subjects' sexual orientation, but serve only to reduce sexual arousal" (McConaghy, 1981). This pattern is reflected in yet another study suggesting that behavioral conditioning decreases homosexual orientation, but does not elevate heterosexual interest (Rangaswami, 1982). In fact, such methods applied to anyone else might be called by another name: torture. Individuals undergoing such treatments do not emerge heterosexually inclined; rather, they become shamed, conflicted, and fearful about their homosexual feelings.

Throughout all the claims of sexual orientation change, not one investigator has ever raised the possibility that such treatment may harm some participants, even in a field where a 30% "success" rate is seen as high. Many conversion investigators ascribe the treatment "failures" to lack of patient motivation or the resistance of sexual orientation to change. While the latter is certainly true, it is unethical practice for researchers not to concern themselves with the potentially harmful effects of their methods.

Gay men and lesbians who are coming out are at particular risk for the harmful effects of conversion treatments. Such individuals are often tempted to hope for sexual orientation change as a panacea during a difficult period; this makes them vulnerable targets for conversionists. One study on gay and lesbian adolescents points to the dangers of identification with the dominant (heterosexual) group as a strategy for coping with homosexuality (Hetrick & Martin, 1987a, 1987b). They state: "Denial of group membership is intimately intertwined with identification with the dominant group and, thus, with self-hatred . . . which can lead, in turn, to aggression against one's own group."

The stages of coming out and gay identity formation have been well described (Malyon, 1982a, and the chapter by Gonsiorek and Rudolph in this volume). It is important, during this process, for the individual to have affirmative support for the natural evolution of her or his identity, and to be encouraged toward self-acceptance, rather than toward a conversion procedure that is likely to fail as well as confuse.

Not all behaviorally based conversion approaches use aversive techniques. Fantasy modification studies seemed initially to yield heterosexual shift in single-case designs and small group studies. However, when more rigorous experimental procedures were applied, physiological measures of sexual arousal remained unchanged (Conrad & Wincze, 1976). And though these results do not suggest conversion, at least these investigators included external, physiological measures in their outcome measures; few conversionists do this, opting instead for less rigorous self-report and subjective impression.

The work of Masters and Johnson on sexual orientation change was published in 1979, in *Homosexuality in Perspective.* Like previous volumes, it addresses, through a behavioral sex therapy format, the resolution of sexual concerns for men and women. However, this volume also includes a study of 54 "dissatisfied" homosexual males. This was unprecedented for the authors, as their previous works on heterosexual dysfunction did not include treatment for dissatisfied heterosexuals. Homosexuality is conceptualized here as the result of blocks in "normal" learning that facilitate heterosexual responsiveness. Masters and Johnson's theoretical basis is a variation on the illness theme of homosexuality: that people become homosexual because of failed or ridiculed attempts at heterosexuality. The researchers do not consider the obvious: that heterosexual "failures" among homosexual people are to be expected, since the behavior in question is outside the individual's normal sexual response pattern. At one point, the authors suggest that male ignorance of women's inherently strong sexual capacity potentiates lesbianism; despite their comments to the contrary, the study is founded upon heterosexist bias.

Gonsiorek (1981) raises a variety of concerns with the Masters and Johnson study. Beginning with selection criteria for inclusion in the sample, the authors indicate that subjects were screened for "major psychopathology or severe neurosis," though they do not explain how such screening was performed. Also missing was an explanation of how "motivation to change" was assessed, since this dimension is considered crucial by the researchers. Nevertheless, 19 of the 54 subjects were described as uncooperative during therapy, and refused to participate in a follow-up assessment. Even so, these 19 were assumed, without justification, to be among the "nonfailure" group.

The presentation of treatment methodology is avoided in the work itself; a description of therapeutic methods was published five years later (Schwartz & Masters, 1984). Still, it would be tremendously difficult to replicate this study; this is important, since the ability of independent researchers to utilize the same procedures in different experiments is fundamental to scientific research. It is of particular concern here, since these authors claim a success rate nearly twice that which is reported elsewhere, and all in two weeks' treatment time!

The confusing manner in which the Masters and Johnson data were reported makes it difficult to determine their actual procedures. They distinguish between "conversion" (leading previously nonheterosexually experienced homosexual men into newfound heterosexual competence) and "reversion" (directing homosexually identified men with a heterosexual history, even if marginal, back to heterosexual activity). The problems with this distinction are obvious, given that history of

heterosexual behavior may have nothing to do with actual sexual orientation, and much to do with fulfillment of social expectations, or with a priori nonhomosexual status.

Masters and Johnson's "homosexual" sample, in fact, may not be "homosexual" in orientation at all. Of 54 subjects, only 9 (17%) identified themselves as Kinsey 5 or 6 (exclusively homosexual). The other 45 subjects (83%) ranged from 2 to 4 on the Kinsey scale (predominantly heterosexual to bisexual). Furthermore, since 30% of the sample was lost to follow-up, it is conceivable that the outcome sample does not include any homosexuals at all. Perhaps this is why such a high success rate is reported after two weeks' treatment. It is likely that rather than "converting" or "reverting" homosexuals to heterosexuality, Masters and Johnson were really strengthening heterosexual responsiveness in people with already established bisexual repertoires.

Masters and Johnson defined their results in terms of "nonfailures," which they distinguished from "successes." In long-term posttreatment follow-up, some 73% of (presumably) homosexual subjects were considered to be "nonfailures" in sexual orientation conversion or reversion. It is not clear what assessment measures were used to establish this. Moreover, the use of heterosexual competence as sole criterion for orientation shift has been criticized (Krajeski, 1984).

The general inconsistencies in this research are significant. This supposedly scientific study has left unclear who is being measured, what is being measured, and how it is being measured. Indeed, its credibility in the eyes of many is simply due to the reputation of the investigators.

The studies reviewed here have one thing in common, in addition to their purported claims to reverse sexual orientation: namely, that they represent inadequate and misleading scientific practice. They are consistently flawed by poor or nonexistent follow-up data, improper classification of subjects ("converting" bisexuals who are not primarily homosexual in the first place), and confusion of heterosexual competence with sexual orientation shift. Pervading all of this is an atmosphere of homophobic researcher bias: that homosexual behaviors are identified as "maladaptive" in the most openly prejudicial cases, and merely "troublesome to the individual" in the most covert. Most "troublesome" to the individual is the social prejudice facing her or him; but either way, such theoretical positions are in direct opposition to the diagnostic nomenclature decisions of both psychiatry and psychology, and the empirical evidence on the lack of inherent psychopathology in homosexuality, as reviewed by Gonsiorek in this volume. California psychologist Joseph Nicolosi, a specialist in "reparative therapy" with what he refers to as "nongay" homosexuals, is reported to have acknowledged that he has never had a client who left his office "cured" of homo-

sexuality and that one of his most "successful" clients, married and the father of three, still reported "homosexual fantasies that lingered 'like a gnat buzzing around your ear'" (Buie, 1990). To promote conversion programs for something that is even acknowledged by its proponents as nearly impossible is hardly in the best interest of the consumer of psychological services.

RELIGION-BASED CONVERSION PROGRAMS

Apart from the efforts of the scientific community, the primary proponents of sexual orientation change have been pastors and religiously-oriented lay persons. This is of concern to psychology because of the unprofessional and unethical nature of some of these "spiritual" treatments. Further, an increasing number of mental health professionals are serving as referral sources to fundamentalist Christian groups promising to change the sexual orientation of many unhappy lesbians and gay men.

The professionalism and ethics of this practice are highly questionable. It has been shown that those gay men most likely to be inclined toward doctrinaire religious practice are also likely to have lower self-concepts, to see homosexuality as more "sinful," to feel a greater sense of apprehension about negative responses from others, and to be more depressed in general (Weinberg & Williams, 1974). Such individuals make vulnerable targets for the "ex-gay" ministries, as they are known. Their testimonials, therefore, are the most suspect relative to the efficacy of the pastoral conversion programs in which they enroll; nevertheless, it is such testimonials that form the basis of most claims for "successful conversion" via religious means.

Fundamentalist Christian groups, such as Homosexuals Anonymous, Metanoia Ministries, Love In Action, Exodus International, and EXIT of Melodyland are the most visible purveyors of conversion therapy. The workings of these groups are well documented by Blair (1982). In this work, agents of sexual orientation change are characterized as nonprofessional individuals, many of whom are themselves intensely troubled by conflicts regarding their own homosexuality. Their programs are understandably reluctant to provide outcome data, simply stating that they have received numerous testimonials from satisfied counselees. Blair states that although many of these practitioners publicly promise "change," they privately acknowledge that celibacy is the realistic goal to which homosexuals must aspire. Furthermore, more than one religious group leader has "fallen from grace" for having sex with clients who are themselves in treatment for conversion of sexual orientation.

Perhaps the most notorious of these is Colin Clark. Clark is a pastor whose counseling program, Quest, led to the development of Homosexuals Anonymous, the largest antigay fundamentalist counseling organization in the world. The work of Clark, his ultimate demise, and the subsequent cover-up by the Seventh Day Adventist church, are described by sociologist Ronald Lawson (1987). Lawson characterizes Clark as a troubled homosexual man who had lost a highly visible pastorate in Manhattan as a result of promiscuous homosexual behavior. Celebrating his lack of professional counseling credentials, he discovered a market for ministering to self-doubting, conflicted, homosexual men. This led to his rapprochement with the Seventh Day Adventist church, and the founding of his Quest Ministries in Reading, Pennsylvania. Through the seven years' operation of his organization, approximately 200 people received "reorientation counseling" from Clark, his wife, and an associate. From this organization sprang Homosexuals Anonymous, a 14-step program based on Alcoholics Anonymous.

Lawson (1987), in attempting to research the efficacy of Clark's program, was denied access to counselees on the basis of confidentiality. Nonetheless, he managed to interview 14 clients, none of whom reported any change in sexual orientation. All but two reported that Clark had had sex with them during "treatment," in the form of nude massage and mutual masturbation. The two clients excluded from this pattern of exploitation were an older male and a man who received only telephone counseling. Even the telephone counselee, however, reported that Clark had masturbated during a telephone counseling session.

When Lawson brought these facts to light, Clark resigned his ministry; the church, however, refused to acknowledge the abuses of Clark's "pastoral care," or to make restitution for the damage done. Now, after what he describes as a period of his own "successful rehabilitation," Clark is attempting to rejuvenate his ministry to homosexuals.

The tradition of conflicted homosexual pastors using their ministries to gain sexual access to vulnerable gay people is as long-standing as the conversion movement itself. Ralph Blair, in his 1982 monograph *Ex-gay*, reports on one of the first "Ex-Gay" programs, Liberation in Jesus Christ. This program was founded by Guy Charles, who had claimed a heterosexual conversion subsequent to his acceptance of Christ; he was assisted in his ministry by a charismatic Episcopal church in Virginia. Charles was promoted through the evangelical world as no longer gay, and that God had removed "the lusts, the desires, and the act" (Blair, 1982, p. 6). Charles's claim that homosexuality is a choice, and his plan to "divest . . . homosexual desires" were called into question, however, when several who had sought the "ex-gay" experience through Liberation in Jesus Christ complained that Charles was having sex with them in the context of the conversion "treatments." Blair states:

> He [Charles] was telling these seekers that the homosexual experiences they were having with him were not "homosexual" but "Jonathan and David" relationships. The seekers, many of whom were "seeking" against their own will because they had been sent to Charles by a church or their parents, were quite cooperative in such "Jonathan and David" relationships. The Episcopal Church, which housed Liberation in Jesus Christ, kicked Charles out, convinced he was a fraud. (Blair, 1982, p. 7)

One of the of the most notable claims for the spiritual "cure" of homosexuality was advanced by Dr. E. Mansell Pattison, a psychiatrist, and his wife Myrna Loy (credentials not specified) (Pattison & Pattison, 1980). They reported that within a "supernatural framework," utilizing "generic methods of change common to folk therapy," some 11 male subjects changed from homosexual to heterosexual. As with almost all other conversion studies, successful outcome was defined as capacity for heterosexual intercourse. This is not equivalent to the Pattisons' claim of "complete orientation reversal."

Nonetheless, the Pattisons have continued to advertise their "method" as a cure for homosexuality, despite the numerous methodological problems with their study. Foremost, the sample of 11 subjects was culled from a group of 30 "ex-gays" who had sought treatment from the charismatic self-help group, EXIT of Melodyland. The 30, however, are but 10% of the 300 total "dissatisfied" homosexuals who had initially requested treatment. The Pattisons do not explain the basis upon which 270 subjects were excluded from the study, but the presumption is that this 90% were not successfully treated. Nor do they explain why 19 others of the 30 presumable "treatment successes" declined interviews. The inherent sampling bias of 11 of 30 (preselected according to indeterminate criteria from 300) renders highly questionable any resulting data. The Pattisons' therapeutic method is inadequately explained; only vague references to spiritual issues and group support describe how their "conversions" took place.

The Pattisons defined "successful treatment" as an exclusive shift in sexual orientation. Nevertheless, despite their own criteria, their data indicate that only 3 of the 11 (of 300) subjects report no current homosexual desires, fantasies, or impulses, and that one of the three is listed as still being "incidentally homosexual." Of the other 8, several indicate ongoing "neurotic conflict" about their homosexual impulses. Though six of these men have married heterosexually, two admit to more than incidental homosexual ideation as an ongoing issue. Blair reports that, when confronted with the apparent inconsistency of claiming exclusive heterosexual shift yet having ongoing homosexual fantasies, Pattison indicated that he thought such fantasies were normal, especially after a fight with one's wife! (Blair, 1982, p. 34). Heterosexual marriage is not

equivalent to sexual orientation change, since it has been reported that some 20% of gay men marry at least once (Bell and Weinberg, 1978). From a religious perspective, Blair (1982) cites other Christian theologians, such as evangelistic psychiatrist Ruth Tiffany Barnhouse, who is skeptical about converting homosexuals. Those who can function heterosexually, according to Barnhouse, simply are demonstrating that "the physiology of their sexual apparatus is in good working order," and that the fundamentalist demand for celibacy in homosexuals is an "unreasonable and cruel" demand. The Pattison data present an unconvincing picture of heterosexual conversion following a treatment program that is poorly described to begin with, and founded upon ill-defined constructs.

Recently, founders of yet another prominent "ex-gay" ministry, Exodus International, denounced their conversion therapy procedures as ineffective. Michael Busse and Gary Cooper, cofounders of Exodus and lovers for 13 years, were involved with the organization from 1976 to 1979. The program was described by these men as "ineffective . . . not one person was healed." They stated that the program often exacerbated already prominent feelings of guilt and personal failure among the counselees; many were driven to suicidal thoughts as a result of the failed "reparative therapy" (*Newswatch Briefs*, 1990).

The fundamentalist Christian approaches to conversion treatments have been characterized by a host of problems, ranging from lack of empirical support to the sexually predatory behavior of some counselors, such as Clark and Charles. To exacerbate the potential harm done to naive, shame-ridden counselees, many of these programs operate under the formidable auspices of the Christian church, and outside the jurisdiction of any professional organization that might impose ethical standards of practice and accountability on them.

CONCLUSION

Psychological ethics mandate that mental health professionals subscribe to methods that support human dignity and are effective in their stated purpose. Conversion therapy qualifies as neither. It reinforces the social stigma associated with homosexuality, and there is no evidence from any of the studies reviewed here to suggest that sexual orientation can be changed. Perhaps conversion therapy seemed viable when homosexuality was still thought to be an illness; at this point, it is an idea whose time has come and gone. At no point has there been empirical support for the idea of conversion; indeed, the methodological flaws in these studies are enormous. It now makes sense to discontinue focusing on conversion attempts and focus instead on healing and educating an

intolerant social context. Some will say that an individual has the "right to choose" conversion treatment. Such a choice, however, is almost always based on the internalized effects of a hostile family and an intolerant society.

As long as we focus on homosexuality itself as the problem, we miss the point. Martin (1984, p. 46) states:

> A clinician's implicit acceptance of the homosexual orientation as the cause of ego-dystonic reactions, and the concomitant agreement to attempt sexual orientation change, exacerbates the ego-dystonic reactions and reinforces and confirms the internalized homophobia that lies at their root.

To view self-negating homosexuals seeking change otherwise is to deny the significant impact of negative social stigma that confronts the gay person at every step. If we attempt to conjure a "cure" for homosexuality, we only reinforce bigotry.

Conversionists skip this issue altogether and promote change methods assuming the pathology of homosexuality because their reasoning is based upon such bigotry, or a certain biblical interpretation. They do not attempt to prove the conceptual underpinnings of their efforts because they cannot, since their theories are entirely nonscientific. Therapy is not value-fee; nor, certainly, is religion. Both do gay people harm by trumpeting false promises of "cure," when it is the caregivers themselves—and society as a whole—that are in need of a "cure."

Mental health and paraprofessional practitioners who engage in conversion therapies may be likely to harm such clients, and in addition may also commit consumer fraud, as this damaging practice simply does not work. Professionals merely "referring" clients for such services also bear responsibility. The violation of client welfare and standards of professional conduct inherent in these practices warrants a response from professional organizations to mandate ethical and professional practice.

The American Psychological Association's "Fact Sheet on Reparative Therapy" opens with the following statement: "No scientific evidence exists to support the effectiveness of any of the conversion therapies that try to change sexual orientation." Bryant Welch (1990), in an APA statement on conversion therapy, said: "The real issue confronting our society today is not why people seek love and understanding as they do, but why some seem so unable to love and understand at all." We do gay men and lesbians, and society as a whole, a disservice by perpetuating the myth that sexual orientation can be changed.