Sexual Conversion Therapies

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Synopsis

This paper begins with a historical review of mental health attitudes toward homosexuality. Starting in the 19th century, and continuing into the modern era, there have been ongoing scientific, legal and political debates about whether homosexuality is a normal variation of human sexual expression, a psychiatric illness, or a form of psychological immaturity.

The view of homosexuality as a psychiatric disorder first emerged in the late 19th century. In the early 20th century, Freud considered homosexuality a developmental arrest, rather than an illness, but by the 1940s, neo-Freudians reclassified homosexuality as a psychiatric disorder. Their view dominated American psychiatry until it was challenged by sexologists of the same era whose research supported a view that homosexuality is a normal variant of human sexual expression. In 1973, following a process which is reviewed here, the American Psychiatric Association adopted the normal variant view and removed "homosexuality" from its diagnostic manual. By 1992, the World Health Organization followed suit and removed the diagnosis from the International Classification of Disease.

In the ensuing years, what was once a scientific dispute has become a sociopolitcal debate in the "culture wars." The two broad views of homosexuality being debated are the normal/identity model and the illness/behavior model. While the mental health mainstream has rejected the latter and embraced the former, religious social conservatives now pathologize homosexuality. However, because illness arguments are not supported by scientific research, conversion therapists, much like adherents of the intelligent design movement, have argued most of their case before the general public. They have also overstated the likelihood of change in ways that support political arguments and legislation that deny equal civil rights for lesbians and gay men.

This paper then goes on to critically review some clinical, research and ethical issues associated with sexual conversion therapies, including the Spitzer study.

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In 1973, the American Psychiatric Association (APA) removed "homosexuality" from its diagnostic manual (1) and, consequently, the mental health mainstream would eventually give up the historical practice of trying to "cure" homosexuality. These changes are today reflected in training programs of psychiatry, psychology, social work, medicine and nursing. No mainstream mental health training program teaches how to change a person's sexual orientation and the training focus has shifted to affirming the mental health needs of gay, lesbian and bisexual (GLB) patients (2, 3, 4).

What led to these changes? This paper begins with a history of mental health attitudes toward homosexuality from the 19th century to modern times. It then goes on to explain the cultural context in which present debates around sexual conversion therapies are shaped. Finally, the paper reviews some clinical, research and ethical issues surrounding these controversial approaches.

I. History of Mental Health Attitudes Toward Homosexuality

19th Century Medicalization: From Sin to Illness

In 19th century Europe, homosexuality received increased scrutiny from diverse fields: law, medicine, psychiatry, sexology and human rights activism. In 1869, Hungarian journalist Károli Mária Kertbeny coined the terms "homosexual" and "homosexuality" (5), arguing for a normative view of same-sex relationships in response to Prussia's criminalizing male homosexuality,.

While adopting his terminology, Richard von Krafft-Ebing, a neurologist, rejected the Kerbeny's "normal variant" theory and labeled homosexuality a "degenerative" disorder. Kraft-Ebing's 1886 *Psychopathia Sexualis* (6) viewed unconventional sexual behaviors from an emerging Darwinian approach: all nonprocreative sexual behaviors were presumed to be psychiatric disorders.

Two decades later, Freud took issue with Krafft-Ebing's theory in *Three Essays on the Theory of Sexuality* (7). Freud argued that homosexuality is not a "degenerative condition" because, among other reasons, it is "found in people . . . distinguished by specially high intellectual development and ethical culture" (p. 139). Freud argued that homosexuality is a normal phase of heterosexual development and adult homosexual behavior "arrested" psychosexual

development. He later wrote several papers attributing the homosexuality of specific individuals to family dynamics (8, 9).

Freud was pessimistic about efforts to convert homosexuality. In 1920 he wrote, ". . . to undertake to convert a fully developed homosexual into a heterosexual does not offer much more prospect of success than the reverse, except that for good practical reasons the latter is never attempted" (9, p. 151).

Freud's theory of "stunted growth," what I call a "theory of immaturity" (10), is often conflated with illness models, or theories of pathology. Yet Freud maintained toward the end of his life that homosexuality "is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by a certain arrest of sexual development" (11).

Mid 20th Century Psychoanalysis

Following Freud's death in 1939, neo-Freudian views openly pathologized homosexuality. Most influential was Sandor Rado (12), whose "adaptational" theory had a significant impact on psychiatric thought in the mid-twentieth century. Rado claimed there was no "innate bisexuality" or "normal homosexuality." Heterosexuality was biologically normal and homosexuality a "phobic" avoidance of the other sex caused by inadequate parenting.

Following in the footsteps of Rado, Bieber et al. (13) considered homosexuality “a pathologic biosocial, psychosexual adaptation consequent to pervasive fears surrounding the expression of heterosexual impulses” (p. 220). In their study, Bieber and colleagues reported on their treatment of 106 homosexual men. Claiming a 27% “cure” rate with psychoanalysis, when challenged a decade later to produce a “cured” patient, they were unable to do so (14). Socarides (15) labeled homosexuality a “resolution of the separation from the mother by running away from all women” (p. 60) and claimed to have “cured” 35% of his homosexual patients over a 10-year period (1967-1977) (16). Ovesey (17) called homosexuality “a deviant form of sexual adaptation into which the patient is forced by the injection of fear into the normal sexual function” (pp. 20-21). These theories formed a basis for including “homosexuality” in the first two editions of APA’s Diagnostic and Statistical Manual (18, 19).

Mid 20th Century Sexology

While psychiatrists drew conclusions from a self-selected group (patients seeking treatment for their homosexuality) and wrote case reports, sexologists went into the field and studied large numbers of *non-patient* subjects. Their research lent support to a view that homosexuality, like heterosexuality, is a normal variation of human sexual expression.

Among these were the 1948 and 1953 Kinsey reports (20, 21), which surveyed thousands of people, and found homosexuality more common in the general population than was generally believed. Kinsey's now-famous "10%" statistic is today believed to be closer to 1-4% (22). Kinsey's findings contradicted prevailing psychiatric views of his time that claimed homosexuality was rare in the general population. In 1951, Ford and Beach (23) published a cross-cultural and ethological study cofirming Kinsey's view that homosexuality was *not* rare and that it occurred among other species in natural settings. In 1957, Evelyn Hooker (24) demonstrated, through impartially interpreted projective tests that a group of non-patient homosexual men showed no more psychopathology than heterosexual controls.

The 1973 APA Decision: Psychoanalysis and Sexology Clash

American psychiatry, dominated at the time by psychoanalytic "ego psychology," mostly ignored sexology research and its normalizing conclusions. However, in 1970 this research came to the attention of APA when gay activists, convinced that psychiatry's pathologizing of homosexuality contributed to social stigma, disrupted the 1970 and 1971 annual APA meetings (1). In response, APA permitted two panels at the 1971 and 1972 meetings. The first featured nonpatient gay activists explaining to a psychiatric audience the stigma caused by their

"diagnosis." At the 1972 meeting, the activists returned, joined by a psychiatrist. John Fryer, MD, who appeared as "Dr. H Anonymous," disguising his true identity from the audience and who spoke of the discrimination gay psychiatrists faced in their own profession (25). As an openly gay physician could lose his medical license and professional standing, Fryer, wore a rubber mask, a fright wig, and an oversized tuxedo. He spoke as a closeted gay man to heterosexual colleagues, explaining why he could not be open with them.

From 1971-1973, APA also embarked upon an internal process to study the scientific question of whether homosexuality should be considered a psychiatric disorder. APA's Nomenclature Committee reviewed the psychiatric, psychoanalytic and sexology literature. The latter, a subject not usually taught in psychiatric training programs at that time, was unfamiliar to most psychiatrists (26).

Following its extensive review, the Nomenclature Committee recommended removing homosexuality from the DSM. After review and approval by other APA committees and deliberative bodies, in December 1973, APA's Board of Trustees voted to remove homosexuality from the DSM. However, psychiatrists who objected to removal petitioned to have a referendum so the entire APA membership could vote on the issue. In 1974, the decision to remove was upheld by a 58% majority of voting members. Within two years, other professional

organizations, including the American Psychological Association, the National Association of Social Workers, and the Association for Advancement of Behavior Therapy, endorsed the APA decision. In 1992, the World Health Organization accepted American psychiatry's view and removed homosexuality per se from the International Classification of Diseases (ICD-10) (27).

II. Sexual Conversion Therapies in a Cultural Context:

From Clinical Debates to Culture Wars

Following the 1973 decision, cultural attitudes about homosexuality shifted slowly in the US and elsewhere. A new perspective emerged in western societies: (1) if homosexuality is not an illness, and (2) if one does not literally accept biblical prohibitions against homosexuality, and (3) if gay people are able and prepared to function as productive citizens, what is wrong with being gay? Gradually, what had once been a secular view of homosexuality as pathological was replaced by the belief that it was a normal variant of sexual expression.

Some segments of society reject and oppose this acceptance. Where the mental health mainstream has depathologized homosexuality, a small but vocal minority has resurrected old arguments that homosexuality *is* a mental disorder and promotes sexual conversion therapies. As a result, a scientific dispute about

homosexuality once thought to be a settled has been resuscitated in political debates known as the "culture wars" (28).

Opposing Models of Homosexuality in the Culture Wars

In reductionistic terms, there are two positions in the culture wars. What I call the *normal/identity model* (29, 30) regards homosexuality as a normal variation of sexual expression. In general, proponents of this model either believe that homosexuality is biologically inborn or, in religious terms, that gay people are "made that way" by their creator. Thus, for most gay people, homosexuality is fixed and immutable and that like race, one's sexual orientation is intrinsic to one's social identity. Proponents of this model see gay, lesbian or bisexual (GLB) individuals as members of a sexual minority who should not be subject to discrimination for being GLB. If one accepts this model, GLB people facing societal antihomosexual attitudes should have legal protections that allow them to work in any job setting (including the armed forces and the public schools), to form legally recognized, committed relationships (with benefits that accrue from legal recognition), to raise children and to live wherever they choose. In other words, the normal/identity model underlies much of the movement for GLB civil rights.

On the culture war's opposing side is the *illness/behavior model.* This defines any open expressions of homosexuality as symptoms of a psychiatric illness, a moral failing, or a spiritual illness. This model further maintains that homosexuality is harmful since neither psychiatric nor spiritual illness can provide a foundation for creating a normal identity, a normal family life or a stable society. Proponents of this model further argue that homosexuality is not innate; it is a "learned behavior" that can be altered, either through psychotherapy, faith healing, or both. As this model defines homosexuality as "behavior," no one is "born gay" and there is no need to recognize a gay or lesbian identity. It follows from this belief that there can be no substantive basis for enacting civil rights protections for a behavior" and proponents of the illness/behavior model refer to GLB civil rights protections as "special rights." Finally, if an individual can change his or her sexual behavior, and give up a GLB identity, it suggests to believers of this model that homosexuality is not intrinsic to a person's identity.

The Resuscitation of Sexual Conversion Therapy

Although some motives for the resuscitation of conversion therapy are political (see below), in part the movement began with efforts in the 1970s and 80s to temper religious, antihomosexual traditions of condemnation with compassion for homosexual individuals (31, 32). Historically, many religious communities

treated homosexuality as a greater sin than others. However, in this emerging religious perspective, a gay man or woman does not have to be automatically expelled or shunned by their community of faith. Instead they are embraced for renouncing homosexuality and seeking “healing.” This changing environment has led to a growing movement of religiously based self-help groups for individuals who refer to themselves as “ex-gay” (33, 34).

As the APA and other scientific professions adopted a normalizing view, the mental health mainstream grew less receptive to the theories and practices of secular conversion therapists (35). By 1992, even the American Psychoanalytic Association (APsaA), whose members organized the referendum to challenge the APA’s 1973 decision, adopted a position statement opposing sexual orientation discrimination in training and promotion of psychoanalysts (36). That same year, some disaffected APsaA members formed a new group, the National Association for Research and Therapy of Homosexuality (NARTH). NARTH’s membership includes secular and religious therapists who believe homosexuality to be a mental disorder and that “treatment” to “change” should be made available to anyone who wants it.

It should be noted that NARTH’s membership is quite small (1500) when compared to mainstream groups like the American Psychiatric Association (35,000 members) and the American Psychological Association (150,000). Nevertheless,

NARTH spokespersons, speak as "mental health experts" for conservative, religious groups with sophisticated media expertise and are often in the public eye with a frequency that belies their actual influence in the professions.

NARTH's role in debates about sexual conversion therapy parallels that of "creation scientists" or "intelligent design" advocates in media coverage of the teaching of evolution (37, 38). In fact, many political and religious groups that oppose teaching evolution also oppose the cultural normalization of homosexuality. Thus, similarities in the strategies of intelligent design and conversion therapy advocates are not coincidental. These include:

- Present an issue to the general public *as if* it were a debate among professionals
- Create "think-tanks" and promote self-appointed "experts" to the media to make the case *to the general public* for the marginal theory
- Appeal to the public's sense of fair play and claim discrimination in academic quarters against proponents of the marginal theory
- Impugn, to the public, the motives of mainstream organizations and individuals whose scientific work discredits the marginal theory
- Confuse the public by using selective scientific citations and scientific-sounding criticisms to support a marginal theory and criticize the mainstream theory

NARTH spokespersons espouse psychodynamic theories long repudiated by the mental health mainstream (39, 40, 41). They simultaneously dismiss scientific theories supporting a biological basis for sexual orientation. They claim the mental health mainstream has been taken over by "homosexual activists" and that the truth about the possibility of changing one's sexual orientation is being suppressed. Working with socially conservative, religious organizations, NARTH "experts" are invited to speak at conferences aimed at a network of religious audiences throughout the US (42). What they choose to present and what they omit is the subject of the next section.

III. Clinical and Research Issues

In the 1990s, as organized proponents of sexual conversion therapies made their case in the popular media, articles began to appear in professional publications that raised concerns about the efficacy, ethics and possible harm these therapies might cause (35, 43, 44, 45, 46). To date, there are numerous anecdotal reports but little rigorous research evaluating either the efficacy or harm of sexual conversion therapies. There is sparse scientific data about selection criteria, the risks versus benefits of the treatment, or long-term outcomes of such treatments.

However, when reaching out to the public about the benefits of sexual conversion therapies, advocates tend to downplay or omit important clinical issues.

The Majority Who Try Do No Change

Bieber and colleagues (13) reported that 73% of their 106 homosexual patients in psychoanalytic treatment did not change sexual orientation. Socarides (16) reports that 65% of the patients he treated over a ten-year period did not change. Nicolosi (40) acknowledges that conversion therapy "is not a 'cure' in the sense of erasing all homosexual feelings." (p. xviii).

Absence of Selection Criteria

Who is a good candidate for sexual conversion therapy? Lionel Ovesey (47) offered broad guidelines but concluded that " . . . those who seek treatment are candidates for treatment; those who don't are not (p. 118). In what can be gleaned from anecdotal reports, this approach is common and anyone wishing to undergo a sexual conversion therapy, regardless of the likelihood of success, will find an obliging therapist.

No Harm in Trying?

A willingness to take anyone into treatment undoubtedly stems, in part, from the belief that there is no harm trying to change one's sexual orientation. In a review of the sexual conversion therapy literature, or on the NARTH website, claims of benefits are often overstated with no mention of possible adverse side effects. However, there are anecdotal reports of possible harm.

One significant issue is how conversion therapists establish a situation that leads to patient-blaming. Rather than emphasizing the skill of a particular therapist or the efficacy of treatment, patients are frequently told that their own motivation (or faith) is the primary factor leading to change. These therapists often label a patient's difficulties as "resistance" to change. Then, when treatment fails—and based on their own reports, most treatments do not lead to change—even if the therapist does not overtly blame the patient, in many cases patients blame themselves. Again, according to anecdotal reports, after treatment fails, patients feel worse than when they started. In such cases, patients report a worsening of depression, onset of anxiety, and feelings of suicide. Significantly, these results are not reported in any of the published reports or on the websites of sexual conversion therapists.

In an effort to convert, some patients enter heterosexual marriages—often with the encouragement or urging of their therapist. In some cases, a heterosexual

spouse may be aware of the partner's homosexuality, although not always. Often couples have children. While conversion therapists may see marriage and parenthood as markers of therapeutic success, the ability to marry and procreate does not necessarily lead to cessation of homosexual desires. Sometimes marriages fall apart or, in cases where the couples do not believe in divorce, these families live in tragic circumstances (48, 49, 50, 51).

Another reported harm stems from delaying the process of "coming out" as gay and spending years in an ultimately unsuccessful sexual conversion therapy where one is taught to denigrate one's homosexual feelings. In one small study of gay men who came out after failed sexual conversion therapy, the subjects reported difficulties with self-esteem, depression, intimacy problems, social withdrawal, and sexual dysfunction (52).

Anecdotal Evidence and APA Response

In the medical profession, anecdotal reports of a medication's harm would trigger an investigation by the Food and Drug Administration. However, no government regulatory body monitors sexual conversion therapies. Professional organizations can speak out against controversial "therapies" but have no ability to regulate non-members. In 2000, the American Psychiatric Association raised

concerns about possible harm in a position statement by its Commission on Psychotherapy by Psychiatrists (COPP), recommending:

1. Affirmation of APA's 1973 position that homosexuality is not a mental disorder and that APA respond as a scientific organization when claims are made that is.
2. That ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm.
3. That APA should encourage and support research in the National Institute of Mental Health and the academic research community to further determine conversion therapies' risks versus their benefits (53).

The Spitzer Study

In 2001, Robert L. Spitzer, MD, presented preliminary findings of a study designed to determine whether it was possible to change sexual orientation. Thirty years earlier, Spitzer had been on the APA's nomenclature committee and played a significant role in recommending that homosexuality be removed from the DSM (1, 31). The irony of Spitzer's role in the 1973 decision intrigued the media (54). His study, "Can Some Gay Men and Lesbians Change Their Sexual Orientation? 200 Subjects Reporting a Change from Homosexual to Heterosexual Orientation"

was published in 2003 in the *Archives of Sexual Behavior* (55). In lieu of its usual peer review process, however, the journal chose to publish the study with 26 peer review commentaries (56), mostly critical but some laudatory.

Spitzer's subjects were self-selected (143 males, 57 females) and reported some minimal change from homosexual to heterosexual orientation for at least 5 years. They were interviewed by telephone, in a 45-minute structured interview Spitzer devised. The majority reported changing from a predominantly or exclusively homosexual orientation before therapy to a predominantly or exclusively heterosexual orientation in the year before the study. Reports of complete change were uncommon.

Notably, only 47% saw a mental health professional. Thirty four per cent attended ex-gay or other religious support groups. Nineteen per cent reported help from "a heterosexual role model, bibliotherapy (reading the Bible), or rarely, on their own, changing their relationship to God" (p. 407). As it took 16 months to recruit 200 participants, Spitzer speculated that, "the marked change in sexual orientation reported by almost all of the study subjects may be a rare or uncommon outcome of reparative therapy" (p. 413).

Criticisms of the study—many of its limitations were acknowledged by Spitzer himself (pp. 412-413)—included: (1) the interviewer (Spitzer) was not blind to the research hypothesis; (2) one 45-minute telephone interview without

face to face encounters or follow-up; (3) exclusive reliance on self-reports with subjects answering questions about sexual feelings they had "during the year before starting therapy," *which on average was about 12 years before the study;* (4) no clear objective measures of sexual orientation; (5) sample bias: most subjects were recruited through ex-gay networks and NARTH; 19% were either mental health professionals working as conversion therapists themselves or directors of ex-gay ministries (Robert Spitzer, personal communication, October 3, 2006), or as one critic calls them, "ex-gay for pay"—people who earn their living promoting sexual conversion therapies' (67).

IV. Ethical Issues

In 2001, President-Elect Paul Appelbaum, presented an unpublished paper, (cited in an earlier paper with his permission, 30), entitled "Clinical Issues and Ethical Concerns Regarding Attempts to Change Sexual Orientation."

Appelbaum outlined five conditions for a treatment to be ethical:

- reasonable basis to believe treatment may be effective.
- appropriate disclosure of relevant information to the patient.
- absence of illegitimate pressure on the patient.
- a fiduciary devotion by the therapist to the patient's best interests."
- The patient is able to make a competent decision.

Are Sexual Conversion Therapies Effective?

There is no accepted body of research data to support the position that these treatments are effective (63).

Appropriate Disclosure of Relevant Information to Patients

Informed consent is central to ethical practice. It should include sharing scientific, clinical and medical data with the patient as well discussions of the potential benefits and harms of treatment as well as the benefits and harms of declining treatment.

However, consider the question of what causes homosexuality? The truthful response would be that no one knows. A mainstream, scientific view is that biology plays some role (58). Ethically, a clinician, when asked, would present the lack of scientific certainty and the sparse scientific basis supporting the efficacy of sexual conversion therapies. A clinician who disagreed with these interpretations should acknowledge to a patient that hers is not the mainstream view. It is not unethical to have unorthodox views, although informed consent would require a clinician to explain that to the patient.

Using a form of *subjective informed consent,* the sexual conversion literature interprets scientific data in a manner that is at best misguided and at worst

misleading. Nicolosi (40), for example, incorrectly claims that, “Scientific evidence has confirmed that genetic and hormonal factors do not seem to play a determining role in homosexuality.”

In a 2002 study, Shidlo and Schroeder (59) interviewed 200 individuals who underwent sexual conversion therapies. Many had therapists who told them that APA acceptance of a normal variant paradigm was based on politics, not science and that APA’s position notwithstanding, homosexuality is a psychological disorder. Some therapists offer denigrating stereotypes and told subjects that all gay people live unhappy lives.

Another informed consent issue pertains to disclosing risks and benefits of sexual conversion therapies. Other than absence of change, the sexual conversion literature cites no adverse treatment side effects. Instead the literature trumpets therapeutic successes while glossing over treatment failures. As previously mentioned, when no change occurs, blame is attributed—either implicitly or explicitly—to the patient.

Illegitimate Pressure on Patients

Historically, sexual conversion therapists threatened to end treatment if a patient engaged in same-sex activity. Historian Martin Duberman (60) recounts how his analyst told him to give up his relationship with another man or give up

the analysis. His account is consistent with clinical recommendations of the times. Socarides (61) says threatening termination may be suitable for some patients but not others (p. 428).

In the present era, sexual conversion therapists may act as enforcers of social conventions rather than as agents of their patients. Shidlo and Schroeder (59) interviewed individuals enrolled in religious universities who were mandated to seek treatment for their sexual orientation or face expulsion. Some subjects reported that therapists threatened to tell—or actually breached confidentiality and did tell— university officials or parents of a student's homosexual activities. Some subjects saw therapists who refused to accept the patient's decision to end treatment, and would call patients long after termination to encourage a return to therapy.

Fiduciary Devotion to a Patient's Best Interests

A fiduciary devotion to a patient's best interests means the therapist must be willing to tolerate any outcome of treatment, whether it results in a full or partial change in orientation, or in the affirmation of the patient's same-sex orientation. Although most who try do not change, the conversion therapy literature does not recommend the option of accepting a gay identity. No subject in Schroeder and Shidlo's (59) study ever received a referral to gay-affirmative therapists after

treatment failed. Based on anecdotal reports, patients who give up trying to change and are willing to accept celibacy have been abandoned.

Are Patients Seeking Sexual Conversion Capable of Making a Competent Decision?

Yarhouse (62) says psychologists have "an ethical responsibility to allow individuals to pursue treatment aimed at curbing experiences of same-sex attraction or modifying same-sex behaviors" (p. 248). He bases his assertion on the American Psychological Association's ethical principles (63), specifically those requiring therapists to give "respect to the fundamental rights, dignity, and worth of all people" (p. 1599) and affirming a client's right to "privacy, confidentiality, self-determination, and autonomy" (p. 1600). This latter principle, as interpreted by Yarhouse, gives patients "a right to choose" psychotherapies designed to change their sexual feelings.

Yarhouse's assertion, however, is an overly narrow approach that elevates one ethical principle—patient autonomy—above others. In cases of controversial treatments of questionable efficacy, the principle of autonomy may conflict with other ethical principles, such as the admonition to do no harm.

One historic precedent illustrating such a conflict of principles occurred in the Laetrile controversies (64, 65). Laetrile was purported to cure cancer although

scientific studies showed it had no curative effects and the mainstream medical community discouraged its use. Nevertheless, an organized Laetrile movement developed and many patients put off conventional cancer treatment to try Laetrile. The Food and Drug Administration (FDA) banned Laetrile's distribution. In this case, both government and the medical establishment took the position that preventing harm to the public served a greater good than allowing patients the "right to choose" Laetrile.

Conclusion

As in the case of Laetrile, some individuals desperately wish to change their sexual orientation. It is noteworthy that groups that fund the *marketing* of sexual conversion therapies *do not fund studies* to evaluate their efficacy or how to improve outcomes. While psychiatry and other mental health professions could conceivably find a way to take care of patients unhappy about their homosexuality, doing so cannot ethically include exaggerating claims of success, a lack of selection criteria, misinforming patients about basic sex research, or ignoring the possible harm of trying to change. Furthermore, any mental health research in this area should be conducted in conformity with the ethical principles outlined above as well as those of institutional review boards.

Research issues aside, some sexual conversion therapists pursue an antigay political agenda that overshadows important ethical and clinical questions. Until these therapists learn how the importance of "first do no harm," mental health professionals and the public at large should remain wary of their unsubstantiated, therapeutic claims.

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