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ORIGINAL RESEARCH

Sexual Reorientation Therapy Interventions: Perspectives of Ex-Ex-Gay Individuals

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While the topic of sexual reorientation therapy, that is, therapy intended to change one's sexual orientation from lesbian, gay, or bisexual (LGB) to heterosexual, is not a new one, there is renewed interest in reorientation therapy. While most of the debate surrounding this controversial practice has focused on whether or not it should be banned, relatively few studies exist that detail what the process of reorientation therapy entails. The purpose of this investigation was to find out more about the typical modalities and interventions of reorientation therapy. Participants were 38 individuals who had gone through at least one episode of reorientation therapy and later reclaimed a LGB identity (113 total episodes). Participants’ open-ended responses to questions about their therapy experiences were coded into broader themes, and participants selected from a list of possible treatment methods that were used in their most recent intervention experience. Results indicated that

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Recently used reorientation interventions had a strong emphasis on religious practices, often included negative messages about LGB individuals, and had a greater emphasis on change than on validation techniques. Some participants recounted practices that are inconsistent with the ethical guidelines for mental health professionals. Implications for policy and practice are discussed.

KEYWORDS reorientation therapy, conversion therapy, ex-gay, ex-ex-gay, ethical, mental health

Reorientation therapy, or therapeutic practices intended to change a person’s sexual orientation from lesbian, gay, or bisexual (LGB) to heterosexual, remains a topic of interest in multiple domains of our society. Reorientation therapy has been the focus of numerous policy statements from major mental health organizations, all of which condemn its use (American Psychiatric Association, 2000; National Association of Social Workers, 2000). The American Psychological Association (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) suggests that there is inadequate evidence to support the effectiveness of reorientation therapy, and that there is some evidence of its harmfulness. Yet media reports pertaining to sexual reorientation therapy demonstrate that networks of sexual reorientation therapists, many of whom maintain religious affiliations, continue to thrive in our nation (Luo, 2007). There are also new public policy efforts to restrict mental health professionals from providing reorientation therapy to minors; for instance, California became the first state to ban the use of reorientation therapy with minor children (Eckholm, 2012). Reorientation therapy can be a particularly controversial and polarizing topic because the idea that LGB people can change their sexual orientation has been tied to the question of whether or not LGB people deserve the same civil rights afforded to heterosexual individuals (Drescher, 2003). Clearly, the topic of reorientation therapy continues to exist in the greater collective consciousness of our society.

The debate regarding reorientation therapy continues, with some researchers supporting reorientation therapy (Jones & Yarhouse, 2011). Sexual reorientation therapies have not been manualized, and interventions that are used by practitioners of reorientation therapy are often quite varied (Serovich et al., 2008). Therefore, many mental health professionals and laypersons alike may ask themselves, “What types of therapeutic interventions or what types of activities are implemented when an individual undergoes reorientation therapy?” In this study, one of our aims is to answer this question.

EARLY REORIENTATION THERAPY INTERVENTIONS

Homosexuality was removed as a mental disorder from the second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in
1973 (American Psychiatric Association, 1974). In 1975, the American Psychiological Association followed suit by affirming the American Psychiatric Association’s action and encouraging civil rights for gay, lesbian, and bisexual individuals (Conger, 1975). Despite this policy shift at the organizational level, behavioral and psychoanalytic sexual reorientation interventions continued to be delineated and researched (e.g., Bieber, 1976; Conrad & Wincze, 1976; McConaghy, Armstrong, & Blaszcynski, 1981; Socarides, 1978, 1979).

The literature in this area recounts the use of a variety of different behavioral interventions. Aversive conditioning, involving the pairing of electric shock with images of males, was used in the attempts to change the sexual orientation of gay men. Tanner (1974) found that erection strength, self-reported arousal to homosexual images, and scores on Scale 5 of the Minnesota Multiphasic Personality Inventory (a controversial scale which produces scores that are higher or “deviant when they reflect femininity in men and masculinity in women”; Greene, 2000, p. 151) decreased in the context of an aversive conditioning paradigm. Feldman and MacCulloch (1965) utilized a negative reinforcement-based procedure that allowed participants to avoid an electric shock by pressing a switch that turned off pictures of attractive males while also exposing participants to images of females, in an effort to change the sexual orientation of gay men. Cautela (1967) reported preliminary success of a covert sensitization technique with two patients who were asked to imagine a homoerotic situation, and then imagine unpleasant images such as vomit or body sores.

Participants reported favorable results when practicing orgasmic reconditioning, whereby participants were asked to masturbate to homosexual images then to switch to heterosexual images when they were close to orgasm; however, patterns of physiological arousal to homosexual images did not change as a result of the treatment (Conrad & Wincze, 1976). McConaghy et al. (1981) utilized aversive conditioning, covert sensitization techniques, and sexual surrogates in their sexual orientation change efforts. Some participants in their study reported that homosexual desire and behavior was reduced and that heterosexual desire and relations were increased; however, objective measurements of arousal were not incorporated into the study design (McConaghy et al.).

Some practitioners and theorists employed a more psychoanalytic approach to reorientation interventions. Socarides (1978, 1979) and Bieber (1976) outlined a psychoanalytic perspective to explain the development of homosexuality; their writings specify that homosexuality is the result of pathology within parent-child relationships. Socarides and Bieber both indicate that sexual reorientation efforts with homosexual males call for intensive long-term analysis; Socarides (1979) reports that he treated 63 homosexual patients between 1966 and 1977, and the average length of therapy was 42 months, with sessions occurring three to five times each week. Psychoanalytic treatment of homosexuality involves interpreting therapeutic
resistance, helping the client gain insight into the origins of his pathology, and resolving anxiety, anger, and guilt that stems from failed psychosexual development (Socarides, 1979). Socarides (1979) identified subtypes of homosexuality and provided subtype-specific considerations for psychoanalytic treatment that centered primarily on transference-related challenges, enhancing ego strength, and developing a consolidated sense of self. It is important to note that more contemporary psychoanalytic views discourage the provider from trying to change a patient’s sexual orientation (American Psychoanalytic Association, 2012). Instead, the position of the American Psychoanalytic Association (2012) emphasizes “understanding” (Reparative Therapy section, para. 3) and indicates that same-sex attractions are not indicative of “a deficit in personality development or the expression of psychopathology” (Reparative Therapy section, para. 1).

MODERN REORIENTATION THERAPY INTERVENTIONS

Interestingly, although reorientation therapy interventions were closely linked to either behavioral or psychodynamic theory in the 1960s and 1970s, the limited data that are available regarding more modern reorientation therapy approaches do not indicate a close connection to existing psychological theories. Few recent studies have examined the types of interventions and activities used by practitioners of reorientation therapy. Throckmorton and Welton (2005) presented 28 individuals who had previously sought sexual reorientation therapy with a list of 20 therapist practices in an effort to identify helpful components of reorientation therapy. The most common therapy practices reported by participants in this study were not specific to reorientation therapy and included “your therapist never made an issue of your sexual orientation when it was not relevant” and “your therapist was not afraid to deal with your sexual orientation when it was relevant” (Throckmorton & Welton, 2005, p. 334). Commonly used reorientation therapy practices included, from most used to least used: helping the client to feel positive about his/her ex-gay status; working to comprehend reasons for same-sex attraction; therapist making it known that attractions to individuals of the same-sex were not equal to identification as lesbian, gay, or bisexual; encouragement of nonsexual friendships with people of the same sex; offering ideas about ways to avoid same-sex sexual behaviors, and offering ideas about ways to increase opposite-sex attraction (Throckmorton & Welton, 2005). In general, participants tended to rate therapy as more helpful if therapists thought negatively of identifying as gay or lesbian, did not support or acknowledge the importance of gay or lesbian relationships, knew about gay and lesbian communities, and used the aforementioned therapy practices and reorientation techniques (Throckmorton & Welton, 2005). In addition, Throckmorton and Welton classified certain interventions as active (e.g., journaling, prayer, and repairing family relationships), as
cognitive (Bible reading, enhancing gender identification, and modifying nighttime sexual fantasies), and as social support (group therapy, non-sexual touch). Although the findings do provide some context for understanding the interventions and practices used in conversion therapy, a lack of specificity and systematic categorization of therapist interventions is evident.

Spitzer (2003) conducted telephone interviews with 200 predominantly Caucasian (95%) and male (71.5%) individuals who experienced some form of reorientation therapy and reported some degree of sexual orientation shift toward heterosexuality. Spitzer asked his participants to provide descriptions of their therapy experiences, and he found that 90% reported using more than one type of therapy and 47% reported that therapy with a mental health professional was the only or most beneficial form of the treatment. Spitzer’s participants commonly reported that the most important topics discussed in therapy involved dysfunctional family relationships and childhood trauma, while only five percent mentioned topics involving religion. Participants also reported that gaining insight into associations between childhood or family experiences and the development of their sexual feelings, developing nonsexual relationships with members of the same sex, engaging in thought stopping, and avoiding triggers that might elicit same-sex sexual feelings were all methods for translating therapy into sexual orientation change. More recently, Spitzer reassessed the methods used in his study, determined that his study does not support sexual orientation change, and apologized for the study (Besen, 2012).

Between 1995 and 2000, Shidlo and Schroeder (2002) conducted structured interviews with 202 individuals who had engaged in six or more sessions of conversion therapy and reported pretreatment ratings of 5 (more homosexual than heterosexual) to 7 (exclusively homosexual) with respect to their sexual desires, attractions, and feelings. Data were collected regarding types of clinical interventions used in conversion therapy, with the most common type being “individual psychotherapy–type not specified” (p. 250), followed by behavioral or cognitive behavioral therapy, psychoanalysis, aversive conditioning, clinical/religious individual therapy, group therapy, hypnosis, couples therapy, psychotropic, clinical/religious group therapy, and inpatient treatment. The unspecified type of individual therapy was coded far more frequently (132 times) than the second most frequent type of therapy (27 times), and the average amount of time between termination of the last reorientation therapy episode and the interview was 12 years.

Jones and Yarhouse (2011) reported results from a longitudinal (6–7 years) study of 98 people who had undergone reorientation therapy. Although the purpose of this study was to investigate whether changes in sexual orientation are possible and whether the process of changing one’s sexual orientation is harmful, the authors make a distinction between mental health professionals who offer psychotherapy intended to change one’s sexual orientation and religious organizations that utilize a combination of “spiritual and psychological methods” (p. 407) to accomplish the goal of
sexual orientation change. The authors do not specify the types of spiritual and psychological methods that are used by the religious organizations, and clearly the authors view the spiritual and psychological intervention intended to produce sexual orientation change as distinct from reorientation therapy. However, the possibility exists for persons trained as mental health professionals (e.g., psychologists, social workers, counselors) to be participating in and working for religious organizations who provide services intended to produce sexual orientation change, while also using their professional knowledge and skills. Overall, it is unclear what specific methods were used to promote sexual orientation change in Jones and Yarhouse's study.

The purpose of this study is to augment the existing literature by providing more information about what reorientation interventions consist of, including the length of time spent in reorientation therapy, the cost of these interventions, the intervention methods used, the therapist practices, client practices, and related mental health experiences for the client. This study includes participants who experienced one or more episodes of reorientation therapy, but later came to identify as gay or lesbian.

METHODS

Recruitment of Participants

Participants were recruited via online list-servs for 12 months in 2008 and 2009. These list-servs included an organization comprised of individuals who previously had identified as “ex-gay” and a list-serv for psychologists interested in lesbian, gay, bisexual, and transgender (LGBT) issues. These initial postings were reposted by participants on other list-servs, resulting in re-posting on at least seven other list-servs or websites. Participants were included in this study if they had been through some type of intervention intended to change their sexual orientation from LGB to heterosexual, and currently identified as LGB. The following language was used to describe the study in recruitment materials: “I am conducting a study designed to learn more about the experiences of people who (1) have gone through therapy or an intervention that was meant to change their sexual orientation, and (2) currently identify as gay, lesbian, or bisexual.” Participants contacted the principal investigator and were mailed a paper survey. Participants were given $15 for participation in the study. Forty-two people contacted the principal investigator to indicate they wanted to participate in the study, 40 people provided their address so that the survey materials could be sent to them, and 38 people completed the study by returning survey materials. The first page of the survey provided information about the risks of participation in the survey and notified participants that they could discontinue filling out the survey at any time. Participants were informed that filling out and returning the survey was indicative of consent to participate in the survey. This study was approved by the Institutional Review Board at The University of Montana.
Measures

Sexual Orientation
Participants were asked to identify as one of four categories: gay, lesbian, heterosexual, or bisexual. The Kinsey Scale (Kinsey, Pomeroy, & Martin, 1948), a 7-point scale where individuals rate their sexual orientation from 0 ("exclusively heterosexual") to 6 ("exclusively homosexual"), was also used to measure sexual orientation.

Questions about Therapy Experiences
Several items queried the participants’ experiences with both reorientation therapy and other therapy. These questions asked about the number of episodes of therapy, the length of therapy, the modality of therapy, the designation of the person(s) who provided the therapy, and the setting of the therapy. Additionally, these items asked about the methods used during each episode of therapy to try to change his/her sexual orientation. Respondents were also asked whether or not their most recent reorientation therapist exhibited specific therapy practices. These therapy practices include selected items created by Liddle (1996) denoting ideal and problematic practices of therapists working with lesbian, gay, and bisexual clients, as well as additions to Liddle’s scale created by Throckmorton and Welton (2005) denoting different practices that are commonly used in various modalities of sexual reorientation therapy, including psychoanalytic approaches, separation of identity from attraction, behavioral techniques, and methods used in ministry settings. Two additional items were added: “Your therapist recommended that you increase your participation in activities that are traditional for your gender (for instance: sports for men, or makeup and dressing up for women)” and “Your therapist recommended that you increase your spiritual or religious practices” based on the research of Beckstead and Morrow (2004), who reported that engaging in gender-traditional activities and increasing spiritual practice were often components of reorientation therapy. Respondents were also asked to estimate the financial cost of their reorientation therapy experiences.

Analysis
Participants’ responses to open-ended questions about therapy methods were analyzed using an inductive content analysis strategy (Patton, 2002). Open-ended responses were printed for three research assistants (two PhD candidates in clinical psychology and one individual with experience with religious interventions), who first individually identified intervention strategies present in responses and then shared these identified strategies and
collaborated to develop an open coding system (Strauss & Corbin, 1998). After this, the three researchers used the agreed-upon intervention strategy themes to code each of the responses as to whether or not a specific intervention strategy was present in the response. Fleiss’ Kappa was calculated using the IRR package (Gamer, Lemon, Fellows, & Singh, 2012) of the R Statistical Software Package (R Core Team, 2012) and produced an interrater agreement coefficient of .732 for the raters on these categories. Specific treatment strategies are reported as being present in a response when two out of three of the researchers noted the strategy to be present within the response.

RESULTS

Participants

Thirty-one gay identified males and seven lesbian identified females completed the survey. Participants identified themselves as “exclusively homosexual” (n = 22, 57.9%) or “predominantly homosexual, only incidentally heterosexual” (n = 16, 42.1%) on the Kinsey Scale. Most of the participants identified themselves as Caucasian (n = 33; 86.8%), with the remaining five participants identifying as African American, Latino/Latina, Asian/Pacific Islander, Latino/Asian/Pacific Islander, or Latino/Caucasian. Participants were a mean age of 37.37 (range 20–66, SD = 11.98). Participants (n = 37) reported that they had attained the following levels of education: 1 had attended some college (2.7%), 11 had completed a 4-year college degree (29.7%), 6 had completed some graduate school (16.2%), and 19 had completed a graduate degree (51.4%). Most of the participants identified their current religion as Protestant (n = 26), with other responses reported as follows: no current religion (n = 4), Judaism (n = 2), Greek/Eastern Orthodox (n = 2), Catholic (n = 1), Buddhist (n = 1), and “undecided” religion (n = 1).

Demographics as Related to Reorientation Therapy

AGE

The mean age for the first episode of reorientation therapy was 23.18 (SD = 8.62). The earliest reported reorientation therapy began at age 11 and the latest, at age 52. Six participants (15.8%) had their first episode of reorientation therapy before they were 18 years of age.

RELATIONSHIP AND FAMILY STATUS

More than half (55.3%, n = 21) of the participants reported that they were in romantic relationships with persons of the opposite sex during reorientation
therapy. Of these participants, 19.0% ($n = 4$) were involved with people of the opposite sex who were also in reorientation therapy. Conversely, 47.6% ($n = 10$) of these participants were romantically involved with people who did not know the participant was in reorientation therapy. Fourteen participants (36.8%) reported that they had been married, with 6 participants (15.8%) reporting this was to someone of the opposite sex, 7 participants (18.4%) reporting this was to someone of the same sex, and 1 participant (2.6%) reporting having been married to both a man and a woman. Five participants (13.2%) reported they had children with partners of the opposite sex, and 3 participants (7.9%) reported they had children with same sex partners.

Experiences During Therapy

**TIME IN REORIENTATION THERAPY**

Participants reported a mean of 3.00 different reorientation episodes ($SD = 2.10$), ranging from 1 to 9 different episodes of therapy. Participants reported spending from 12 hours to 3,000 hours ($M = 487.20$, $SD = 639.72$) total in reorientation therapy. Participants reported that the total number of weeks that they spent in reorientation therapy ranged from 8 to 780 ($M = 175.34$, $SD = 176.18$, $Mdn = 120.00$). Participants provided information about multiple episodes of reorientation therapy when they had attended multiple episodes, and thus the 38 participants provided information on 113 different episodes of therapy. Therapy episodes ranged in length from 1 week to 240 weeks ($M = 40.54$, $SD = 42.64$, $Mdn = 26$).

**FINANCIAL COSTS**

When asked the total cost of all of their reorientation therapy episodes, participants reported that they had spent between $0 and $52,000 ($M = \$7,105.28$, $SD = \$11,384.325$, $Mdn = \$2150.00$) on reorientation therapy. Of the 37 respondents for whom a total cost estimate was available, 3 indicated that the total cost of all interventions was $0, 7 respondents indicated the interventions cost $80–500, 17 respondents indicated their total cost to be $1,000–5,000, 3 participants indicated their costs were $10,000–11,000, and 6 participants indicated their total costs were $20,000–52,000. Please note that the researchers took a conservative approach to these estimates, meaning that when participants said they spent “more than $20,000” this was coded as $20,000, and when a range was provided (e.g., $200–300) this was coded as the average of the range ($250). The cost for a single episode of therapy ranged from no cost to $26,000 ($M = \$2,195.45$, $SD = \$5,276.57$, $Mdn = 130$). Out of the 98 responses to this question, 39 episodes were reported
to have been free, 25 episodes cost $25–500, 9 episodes cost $560–1,000, 13 episodes cost $1,300–5,000, 7 episodes cost $5,250–12,700, and 4 episodes were said to cost $20,000–26,000.

TREATMENT SETTINGS AND PROVIDERS

Participants reported that 7.1% of episodes were in an inpatient setting, 50.4% were outpatient, and 42.5% were classified as “other.” Responses to what was meant by “other” varied considerably and included things such as telephone or email therapy, online support groups, conferences, and retreats.

Participants were asked to identify the professional designation of the person who provided their reorientation therapy. Participants could identify multiple professional designations for an individual or individuals who provided their therapy, resulting in 226 total responses to this question. The most frequent responses were that therapy episodes were provided by a religious leader (n = 50, 22.1%) or a religious individual without leadership duties (n = 48, 21.2%). Less frequently reported treatment providers included licensed counselors (n = 38, 16.8%), pastoral counselors (n = 29, 12.8%), peer counselors (n = 21, 9.3%), marriage and family therapists (n = 18, 8.0%), psychologists (n = 11, 4.9%), social workers (n = 6, 2.7%), and psychiatrists (n = 5, 2.2%).

MODALITIES OF INTERVENTIONS

For each episode that participants reported on, they were asked to check boxes indicating if a particular treatment method or modality had been included in the episode. Results are reported in Table 1. In addition, responses to the question “please describe in as much detail as possible what this episode of therapy consisted of” were analyzed as described in the methods section. The methods, theories, and modalities that emerged are documented

<table>
<thead>
<tr>
<th>Treatment method or modality</th>
<th>Number of times endorsed</th>
<th>Percentage used out of 113 episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prayer</td>
<td>89</td>
<td>78.8%</td>
</tr>
<tr>
<td>Educational materials or readings</td>
<td>78</td>
<td>69.0%</td>
</tr>
<tr>
<td>Individual counseling</td>
<td>72</td>
<td>63.7%</td>
</tr>
<tr>
<td>Bible study</td>
<td>71</td>
<td>62.8%</td>
</tr>
<tr>
<td>Group counseling</td>
<td>54</td>
<td>47.8%</td>
</tr>
<tr>
<td>Gender skills training</td>
<td>37</td>
<td>32.7%</td>
</tr>
<tr>
<td>Exposure to heterosexually explicit materials</td>
<td>13</td>
<td>11.5%</td>
</tr>
<tr>
<td>Aversive treatments</td>
<td>8</td>
<td>7.1%</td>
</tr>
</tbody>
</table>
in Table 2. Percentages noted in Table 2 and in subsequent tables referring to reorientation therapy episodes were calculated from the 113 potential responses to this question, as the questions were queried for each episode that participants had experienced. Notably, discussion of heterosexual impulses was only mentioned once (thereby not being counted as a theme).

Almost one-quarter (24.3%, n = 9) of participants indicated that their families participated in their reorientation therapy. For eight of these participants, their families were directly involved by participating in workshops, therapy meetings, or meeting privately with the participant’s individual therapist.

**Therapist Practices**

Participants reported on the practices of their therapist for the most recent episode of reorientation therapy based on items previously used by Liddle (1996), Throckmorton and Welton (2005), and additional items based on previous literature. Complete reporting of the frequency of therapist practices is in Table 3. When examining the modal responses to therapist practice items, the following therapy practices emerge. Therapists tended to believe an LGB identify was sick or inferior, discounted identification as LGB, blamed problems on sexual orientation, lacked basic knowledge of LGB issues, did not recognize or support LGB relationships, were not knowledgeable about LGB communities, made an issue of sexual orientation when it was not relevant, dealt with sexual orientation when it was relevant, did not make the participant feel good about themselves as LGB individuals, helped the participants look for causes of same-sex attractions, indicated same sex attractions did not indicate participants were LGB, suggested strategies to minimize same sex attractions and behavior, suggested strategies to enhance heterosexual attractions, suggested nonsexual friendships with same-sex peers, recommended an increase in participation in activities that are gender typical, recommended increasing spiritual or religious practices, and did not use aversion therapy.

**Ethically Questionable Practices**

In open-ended questions about therapy experiences, 13 different therapy episodes (11.5% of all therapy episodes) reported by 10 different participants (26.3% of all participants) were flagged by raters as containing interventions that may be ethically problematic. Nine of these 13 episodes included a licensed or licensable professional as one of the providers of therapy. Specific practices are described here in the participants’ own words.

Some episodes involved aversive therapies or covert desensitization techniques. For example, while not the only one to report covert desensitization techniques, one participant described his daily exercises as follows:
**TABLE 2** Treatment Methods or Modalities Used in Each Episode of Treatment: Coding of Open-Ended Questions

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency of occurrences</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious practice</td>
<td>46 (40.7%)</td>
<td>“Praying for change . . . biblical examples of what happened to homosexuals.”</td>
</tr>
<tr>
<td>(prayer, worship, bible or scripture study)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-gay readings</td>
<td>15 (13.3%)</td>
<td>“Read ex-gay material.”</td>
</tr>
<tr>
<td>Confession of sins, sexual activities, or thoughts</td>
<td>14 (12.4%)</td>
<td>“Confessing my sins, listing my sexual encounters and repenting of them.”</td>
</tr>
<tr>
<td>Targeting gender atypical or typical behaviors</td>
<td>14 (12.4%)</td>
<td>“The guys played football and the girls put on makeup.”</td>
</tr>
<tr>
<td>Online groups</td>
<td>10 (8.8%)</td>
<td>“Online support group. We weren’t allowed to contact each other outside of the forum. What we wrote was moderated.”</td>
</tr>
<tr>
<td>Psychodynamic/psychoanalytical</td>
<td>9 (8.0%)</td>
<td>“My therapist believed homosexuality was not a valid sexual orientation but rather we are all heterosexuals who simply experience homosexual attractions because of our own broken senses of masculinity. My therapist believed attractions were caused when I would see a guy who ‘represented’ a characteristic I supposedly lacked. Because of this theory, most time in therapy was spent discussing any sort of ‘repression’ techniques or heterosexual attractions as it was assumed once I dealt with homosexual attractions my latent heterosexuality would resurface.”</td>
</tr>
<tr>
<td>Same-sex friendship</td>
<td>7 (6.2%)</td>
<td>“If in a session we discussed a guy I was attracted to, my therapist would likely instruct me to ‘get to know him’ in healthy male-friendship sort of way, the results of which I would report back on at our next session.”</td>
</tr>
<tr>
<td>Deliverance, casting out of demons or evil spirits, spiritual warfare</td>
<td>6 (5.3%)</td>
<td>“He was there to cast the evil demons out of us. An ‘expert’ in spiritual warfare. He prayed, spoke in tongues, laid hands, and cast out demons.”</td>
</tr>
<tr>
<td>Addiction or 12-step training</td>
<td>4 (3.5%)</td>
<td>“The group was called ‘homosexuals anonymous.’ Loosely based on AA except there were 14 steps. Each week we met and discussed one of the steps. Members were encouraged to pray, read ex-gay material, read the Bible, attend services at a conservative church. Members shared their experiences related to each step.”</td>
</tr>
<tr>
<td>Aversive conditioning (imaginal or actual)</td>
<td>4 (3.5%)</td>
<td>“At one point I was instructed to wear a rubber band around my wrist and to snap it every time I thought about a man sexually. Another time my therapist had me close my eyes and rub myself to arousal, then he broke an ammonia capsule under my nose. My nose and eyes watered profusely and while the ammonia stung, it was nearly as painful as the betrayal I felt that day”</td>
</tr>
</tbody>
</table>

*(Continued on next page)*
TABLE 2 Treatment Methods or Modalities Used in Each Episode of Treatment: Coding of Open-Ended Questions (Continued)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency of occurrences</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discomfort or possible sexual exploitation</td>
<td>4 (3.5%)</td>
<td>“My pastor referred me to an ex-gay lay person in the church who led a support group. I was 16 years old. I went to the man’s house. I never had any exposure to gay issues. The man shared his testimony with me and told me detailed, explicit stories about his sexual experiences. He told me about circles jerks, glory holes, bathhouses, sex in parks, and prostitutes. Then he asked me to tell him about my fantasies. He was old enough to be my grandpa. I think he used me to get a thrill. It was more like phone sex than therapy.”</td>
</tr>
<tr>
<td>Documentation/journaling</td>
<td>4 (3.5%)</td>
<td>“Journaling.”</td>
</tr>
<tr>
<td>Classical reconditioning</td>
<td>3 (2.7%)</td>
<td>“I also had to masturbate myself while thinking of women. That was an exercise due to be registered in a grid.”</td>
</tr>
<tr>
<td>Family or couples therapy</td>
<td>3 (2.7%)</td>
<td>“Friends and family weekend.”</td>
</tr>
<tr>
<td>Mixed with paraphilias or “sexual brokenness”</td>
<td>3 (2.7%)</td>
<td>“Group counseling involved a mixed group including former child molesters, exhibitionists, voyeurs, and promiscuous people who I felt I had very little in common with, and felt very uncomfortable there.”</td>
</tr>
<tr>
<td>Regressive therapy</td>
<td>3 (2.7%)</td>
<td>“Rebirthing’ to re-do my bonding with my mother.”</td>
</tr>
<tr>
<td>Date opposite sex</td>
<td>2 (1.8%)</td>
<td>“I was told to date women.”</td>
</tr>
<tr>
<td>Hypnosis</td>
<td>2 (1.8%)</td>
<td>“A lot of ‘hypnosis.’”</td>
</tr>
<tr>
<td>Provide testimony</td>
<td>2 (1.8%)</td>
<td>“… give my testimony to various groups and many individuals.”</td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>2 (1.8%)</td>
<td>“It was a psychoeducational group.”</td>
</tr>
<tr>
<td>Trauma focused therapy</td>
<td>2 (1.8%)</td>
<td>“EMDR used to process some of my early traumatic experiences.”</td>
</tr>
</tbody>
</table>

The exercises called ‘image conditioning’ involved fantasizing about a homosexual encounter, then introducing mental pictures of vomit, excrement, and urine. Then I was to envision water washing away that scene and replace it with a mental picture of myself in a pleasant, but nonsexual situation with a female.

More than one participant described the use of a rubber band:

I had to do some homework, which consisted of wearing a rubber band around my arm and punishing myself every time I was thinking of a homoerotic image by pulling it and releasing it, so that the rubber band would hit my skin and hurt me.
### TABLE 3  Treatment Methods Used in Most Recent Episode of Reorientation Therapy

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Very Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your therapist indicated that he or she believed that a gay, lesbian, or bisexual identity is bad, sick, or inferior.</td>
<td>17 (45.9)</td>
<td>5 (13.5)</td>
<td>6 (16.2)</td>
<td>3 (8.1)</td>
<td>6 (16.2)</td>
</tr>
<tr>
<td>Your therapist discounted, argued against, or pushed you to renounce your self-identification as a lesbian, gay man, or bisexual man or woman.</td>
<td>13 (36.1)</td>
<td>10 (27.8)</td>
<td>2 (5.6)</td>
<td>5 (13.9)</td>
<td>6 (16.7)</td>
</tr>
<tr>
<td>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.</td>
<td>9 (24.3)</td>
<td>10 (27.0)</td>
<td>5 (13.5)</td>
<td>6 (16.2)</td>
<td>7 (18.9)</td>
</tr>
<tr>
<td>Your therapist lacked the basic knowledge of gay, lesbian, or bisexual issues necessary to be an effective therapist for you and/or you had to be constantly educating him or her about these issues.</td>
<td>4 (10.5)</td>
<td>6 (16.2)</td>
<td>4 (10.8)</td>
<td>7 (18.9)</td>
<td>16 (43.2)</td>
</tr>
<tr>
<td>Your therapist did not recognize the importance of lesbian, gay, or bisexual relationships and/or did not support these relationships.</td>
<td>24 (64.9)</td>
<td>4 (10.8)</td>
<td>3 (8.1)</td>
<td>2 (5.4)</td>
<td>4 (10.8)</td>
</tr>
<tr>
<td>Your therapist was quite knowledgeable about the lesbian, gay, and bisexual communities and other resources (so that he or she could have put you in touch with useful books or important resources).</td>
<td>4 (11.1)</td>
<td>3 (8.3)</td>
<td>6 (16.7)</td>
<td>11 (30.6)</td>
<td>12 (33.3)</td>
</tr>
<tr>
<td>Your therapist never made an issue of your sexual orientation when it was not relevant.</td>
<td>4 (10.8)</td>
<td>6 (16.2)</td>
<td>10 (27.0)</td>
<td>5 (13.5)</td>
<td>12 (32.4)</td>
</tr>
<tr>
<td>Your therapist was not afraid to deal with your sexual orientation when it was relevant.</td>
<td>15 (41.7)</td>
<td>8 (22.2)</td>
<td>7 (19.4)</td>
<td>3 (8.3)</td>
<td>3 (8.3)</td>
</tr>
<tr>
<td>Your therapist made you feel good about yourself as a gay man, lesbian, or bisexual man or woman.</td>
<td>2 (5.6)</td>
<td>2 (5.6)</td>
<td>3 (8.3)</td>
<td>4 (11.1)</td>
<td>25 (69.4)</td>
</tr>
<tr>
<td>Your therapist helped you look for and understand causes of same-sex attractions in your life.</td>
<td>12 (33.3)</td>
<td>11 (30.6)</td>
<td>6 (16.7)</td>
<td>1 (2.8)</td>
<td>6 (16.7)</td>
</tr>
</tbody>
</table>

(Continued on next page)
TABLE 3 Treatment Methods Used in Most Recent Episode of Reorientation Therapy (Continued)

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Very Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your therapist indicated that having same-sex attractions did not necessarily mean you were gay, lesbian, or bisexual in orientation.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>10 (27.8)</td>
<td>10 (27.8)</td>
<td>4 (11.1)</td>
<td>2 (5.6)</td>
<td>10 (27.8)</td>
</tr>
<tr>
<td>Your therapist suggested strategies to minimize same-sex attractions and behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22 (59.5)</td>
<td>11 (29.7)</td>
<td>2 (5.4)</td>
<td>2 (5.4)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Your therapist suggested strategies to enhance heterosexual attractions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11 (29.7)</td>
<td>12 (32.4)</td>
<td>3 (8.1)</td>
<td>5 (13.5)</td>
<td>6 (16.2)</td>
</tr>
<tr>
<td>Your therapist referred you to an ex-gay support group.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 (35.3)</td>
<td>6 (17.6)</td>
<td>3 (8.8)</td>
<td>1 (2.9)</td>
<td>12 (35.3)</td>
</tr>
<tr>
<td>Your therapist helped you feel good about yourself as an ex-gay man or ex-lesbian.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 (27.8)</td>
<td>8 (22.2)</td>
<td>10 (27.8)</td>
<td>1 (2.8)</td>
<td>7 (19.4)</td>
</tr>
<tr>
<td>Your therapist suggested that you should develop non-sexual friendships with same-sex peers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20 (54.1)</td>
<td>13 (35.1)</td>
<td>2 (5.4)</td>
<td>1 (2.7)</td>
<td>1 (2.7)</td>
</tr>
<tr>
<td>Your therapist recommended that you increase your participation in activities that are traditional for your gender (for instance: sports for men or makeup and dressing up for women).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13 (35.1)</td>
<td>6 (16.2)</td>
<td>10 (27.0)</td>
<td>3 (8.1)</td>
<td>5 (13.5)</td>
</tr>
<tr>
<td>Your therapist recommended that you increase your spiritual or religious practices.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21 (56.8)</td>
<td>6 (16.2)</td>
<td>6 (16.2)</td>
<td>1 (2.7)</td>
<td>3 (8.1)</td>
</tr>
<tr>
<td>Your therapist used some sort of aversive therapy (e.g. “shock therapy,” medications intended to make you sick, or other means of causing you pain or discomfort while thinking about same sex behavior)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 (8.1)</td>
<td>2 (5.4)</td>
<td>1 (2.7)</td>
<td>2 (5.4)</td>
<td>29 (78.4)</td>
</tr>
</tbody>
</table>

Another participant reported difficulty with an aversion therapy intervention:

Another time my therapist had me close my eyes and rub myself to arousal, then he broke an ammonia capsule under my nose. My nose and eyes watered profusely and while the ammonia stung it was not nearly as painful as the betrayal I felt that day.

Participants also reported potential ethical problems around procedural issues during reorientation interventions. Some participants described episodes where there was a lack of client choice about reorientation therapists or therapy: “we did not choose this therapist, we were forced to go by the pastor
of the church we were on staff with” and “I was basically required to see a counselor because I had been suspended from a Christian college for homosexual behavior and one stipulation for me returning to that school was to see a counselor for a semester.” One participant discussed an abrupt therapy termination with a therapist who had self-disclosed his own same-sex attraction: “After four months he ‘had a fall’ and vanished.” Another participant described a significant breach of confidentiality in a situation where his counselor was discovered “sleeping with female prostitutes,” was “told to leave the church,” and “as he was leaving, he told the people there all we had counseled about.” Another participant described what appeared to be an inaccurate diagnosis from his licensed counselor “he said I might have obsessive compulsive disorder. My obsession was male genitalia and my compulsion was to masturbate while fantasizing.”

Two episodes included situations that made a participant, who was adolescent at the time, feel uncomfortable by pairing him with unlicensed ex-gay adults as part of the intervention. One such episode included “holding therapy,’ an ex-gay man volunteered to rock me in his arms. I was in my early teens and it made me uncomfortable.” An additional episode involved another potential exploitation of a minor by an unlicensed person:

My pastor referred me to an ex-gay lay person in the church who led a support group. I was 16 years old. I went to the man’s house. I never had any exposure to gay issues. The man shared his testimony with me and told me detailed, explicit stories about his sexual experiences. He told me about circle jerks, glory holes, bath houses, sex in parks, and prostitutes. Then he asked me to tell him about my fantasies. He was old enough to be my grandpa. I think he used me to get a thrill. It was more like phone sex than therapy.

CLIENT PRACTICES

When asked if they were always completely honest with their therapist for a particular episode of therapy, participants indicated that they were honest in 58.4% of the episodes and not honest in the remaining 41.6% of episodes. Participants were then allowed to indicate what they were dishonest about, and could indicate multiple response options for a single episode. Participants indicated that they were dishonest about same-sex sexual behaviors during 25.7% of therapy episodes, same-sex fantasies during 24.8% of therapy episodes, and same-sex attractions during 22.1% of therapy episodes. Participants indicated that they were dishonest about heterosexual attractions during 3.5% of therapy episodes, heterosexual fantasies during 2.7% of therapy episodes, and heterosexual sexual behaviors during 1.8% of therapy episodes.
CONCURRENT MENTAL HEALTH EXPERIENCES

Three participants reported being hospitalized for psychiatric reasons. Two of these hospitalizations were during reorientation therapy: one for panic attacks and one for depression with severe suicidal ideation. The remaining hospitalization took place after reorientation therapy and the participant indicated that this 90-day hospitalization was due to his/her experience of “reliving” a specific reorientation therapy experience.

Ten participants (27.0%) reported attempting suicide. Of these 10 participants, 6 participants reported a single suicide attempt prior to reorientation therapy, 7 participants reported 1 or 2 suicide attempts during reorientation therapy, and 1 participant reported 2 suicide attempts after reorientation therapy.

DISCUSSION

The primary purpose of this study was to report on the reorientation therapy experiences of 38 ex-ex-gay individuals; specifically, the types of interventions used, and the context in which these interventions occurred were investigated. The results present a rather heterogeneous collection of experiences in regards to reorientation interventions.

On average, participants reported multiple episodes of therapy interventions, but in some cases this was extreme (up to nine different episodes). Some participants appear to have discontinued reorientation therapy after a short time (only eight weeks), while others continued different interventions for up to 15 years.

Regarding treatment modalities, the majority of reorientation therapy experiences involved prayer, reading educational materials or other literature, individual counseling, and Bible study. Participants reported relatively infrequent (but present) experiences with aversive therapy, and exposure to heterosexually explicit materials was also relatively uncommon. Notably, gender skills training such as sports activities or makeup application, which lacks clear theoretical foundations or documentation in previous literature, was used in almost one third of all therapy episodes.

Participants’ descriptions of interventions at times involved practices that could be considered ethically questionable. Notably, most of the episodes of treatment that involved ethically questionable practices involved a licensed or licensable treatment provider.

Examination of the specific treatment methods used in reorientation therapy clarifies the nature of the different modes of therapy that participants experienced. Not surprisingly, most of the treatments used were focused on change rather than acceptance of the individual in therapy. In contrast to modern, evidence-based treatment approaches (e.g., acceptance
and commitment therapy, Hayes, Strosahl, & Wilson 1999; functional analytic psychotherapy, Tsai et al., 2008) that have been designed to reduce general psychological distress across an array of diagnostic categories, while increasing psychological flexibility and mindfulness, most of the methods used in the reorientation interventions were invalidating of same-sex relationships, devaluing of gay or lesbian identities, and failed to make people feel good about themselves as gay or lesbian individuals.

Reorientation therapy interventions have been poorly documented in the literature. This study adds to the knowledge base by categorizing the actual experiences of individuals who have sought these interventions in their communities. While their experiences are diverse, one commonality that exists is a lack of empirical support or research base for the specific interventions that they are describing.

Limitations

Our data were drawn from a sample of individuals who were recruited into the study because they claimed or reclaimed a gay or lesbian identity after undergoing reorientation therapy; thus, the interventions specified herein are uniquely linked to episodes of reorientation therapy that failed to produce lasting sexual orientation change. As a result, it is possible that the interventions identified in this study may not be representative of the broader body of reorientation therapy interventions.

Next, the participants in this study were self-selected and were reporting retrospectively on their experiences in reorientation therapy. As a result, it is unclear whether the results generalize to persons who were exposed to the recruitment materials but elected not to partake in the study. Additionally, it unclear to what extent the retrospective nature of the study impacted the accuracy of participant reports. Similarly, the paper-and-pencil survey methodology limits the depth of data collected via open-ended questions, as follow up questions may have elicited additional information. At the same time, our coding schematic was quite broad and reliable, thus, the results paint a descriptive picture of the interventions used episodes of reorientation therapy.

Implications

As states and mental health organizations continue to debate the policies surrounding reorientation therapy, data regarding the specific interventions to which clients are exposed are limited. Thus, this study provides the viewpoint of participants who experienced one or more of these interventions, which may help to inform policy developments in this controversial area. Recently, California passed legislation (SB 1172) declaring the practice of
reorientation therapy with clients under 18 years of age, as provided by mental health professionals, unprofessional conduct subject to disciplinary action by the professional’s licensing entity. Cited within this legislation are statements from eight major medical/mental health professional organizations, each denouncing the practice of reorientation therapy. The potential for reorientation therapies to result in harm to the client is highlighted in the statements of five such organizations. Most recently, the Pan American Health Organization (2012) indicated that “[reorientation therapies] violate the dignity and human rights of the affected persons, independently of the fact that their ‘therapeutic’ effect is nil or even counterproductive” (p. 2). In the face of national and international condemnation and a growing consensus regarding an absence of effectiveness and a potential for harm, proponents of reorientation therapies continue to argue that more sophisticated research is necessary to determine whether these therapies are effective and/or harmful (Rosik, Jones, & Byrd, 2012).

Within our sample of 38 ex-ex-gay and lesbian adults, a number of ethically questionable practices emerged. Most relevant to SB1172 are one participant’s descriptions of two reorientation therapy episodes, one that caused discomfort and another that appeared to constitute sexual abuse, which occurred prior to his 18th birthday. Although both of these episodes involved unlicensed paraprofessionals, other ethically questionable accounts were attributable to licensed or licensable professionals. Legislation such as SB1172 exists because some LGB youth have been and may continue to be subjected to a treatment for which no evidence of effectiveness exists and some potential for harm has been documented. For such legislation to be effective, mental health professionals should take a more active role in promoting social justice and advocating for this vulnerable population.

Given that many of the participants in this and previous studies (Shidlo & Schroeder, 2002; Spitzer, 2003) engaged in multiple therapy episodes, it is imperative that mental health professionals who work with LGB clients inquire about possible prior reorientation therapy experiences. If such experiences are reported, mental health professionals may inquire about the provider of the service and advise the client as to whether any ethical principles, codes of conduct, or laws were violated. Regardless of state legislation and the client’s age at the time of the reorientation therapy experience, if ethically questionable or unethical behavior on the part of a licensed provider is identified, clients could be informed of and supported in their rights to report such behaviors to state licensing boards. Supporting the client and clarifying ethical principles such as beneficence and nonmalfeasance (as specified by the American Psychological Association, 2010) may help the client to engage in a future trusting therapeutic relationship.

The results of the current investigation have implications for psychotherapy research and add to the growing body of literature documenting
possible harmful effects attributable to reorientation therapy. As Lilienfeld (2007) notes:

Treatments that are by themselves ineffective but innocuous can produce harm indirectly, most notably by exacting “opportunity costs” such as lost time and the energy and effort expended in seeking out interventions that are not beneficial (Lilienfeld, 2002). Moreover, opportunity costs may preclude clients from obtaining efficacious interventions. (p. 57)

The participants in the present investigation paid an average of $7,105 and spent an average of 487.20 hours on unsuccessful efforts to change their sexual orientations. As the American Psychological Association Task Force (2009) points out, any potential benefits of reorientation therapies can be achieved using LGB-affirmative interventions. Future research should examine whether treatments that emphasize acceptance over change, mindfulness, and cognitive distancing can reduce psychological distress associated with sexual minority status and perceptions of incongruence between sexual and religious/spiritual identities. If these treatments are effective and cause neither direct nor indirect harm, such treatments should be promoted as sound alternatives to reorientation therapy.

It is also naïve to think that changing the therapies that are offered is enough to ameliorate the conflict experienced by those who seek reorientation interventions. Reorientation therapies exist due to a primary conflict between an individual’s culture or cultural beliefs and the individual’s same sex attractions. As long as cultures hold or promote beliefs and policies that marginalize or condemn people with same-sex attractions, individuals will be compelled to change in order to fit into social and cultural norms. For some individuals, discarding one’s religion or cultural beliefs may be as painful as neglecting aspects of one’s sexual orientation (Haldeman, 2004). Even promoting alternatives to reorientation therapy will likely not stop the demand for the therapy as long as cultural and religious systems continue to marginalize lesbian, gay, and bisexual individuals.

REFERENCES


