Summary Narrative

This treatise is a historical review of more than a century of clinical and research reports. Both earlier, less methodologically sophisticated studies were included, as well as more recent, methodologically sounder studies to show how the older and newer findings parallel one another. The older, methodologically weaker studies and the newer, more methodologically rigorous studies all support the same conclusions.

Researchers have shown that homosexuals—notably homosexual men, but in some areas homosexual women—have greater prevalence of pathology than the general population. This is supported by studies that demonstrate the suicidal risk-taking of unprotected sex (van Kesteren et al., 2007), violence (Owen & Burke, 2004), antisocial behavior (Fergusson et al., 1999), higher levels of substance abuse (Sandfort et al., 2001), general suicidality (de Graaf et al., 2006), higher levels of promiscuity and of nonmonogamous primary relationships (Laumann et al., 1994), higher levels of paraphilias (such as fisting) (Crosby & Mettey, 2004), sexual addiction (Dodge et al., 2004), personality disorders (Zubenko, George, Soloff, & Schulz, 1987), and overall pathology (Cochran & Mays, 2007; Sandfort et al., 2001).

As a rule of thumb, many of these problematic behaviors and psychological dysfunctions are experienced among homosexuals at about three times the prevalence found in the general population—and sometimes much more. The preceding material shows that many different pathological traits are more prevalent in homosexual than in heterosexual groups. We believe that no other group of comparable size in society experiences such intense and widespread pathology.

The usual hypothesis is that societal discrimination toward homosexuals is solely or primarily responsible for the development of this pathology. However, the alternative possibility—that these conditions may somehow be inherent in the psychic structure of a homosexual orientation—has not been disconfirmed. Indeed, several cross-cultural studies suggest that this higher rate of psychological disturbance is in fact independent of a culture's tolerance of—or hostility toward—homosexual behavior. We believe that further research that is uncompromised by politics should be carried out to evaluate this issue.

While some anecdotal accounts claim that interventions aimed at changing sexual orientation can be harmful, the body of empirical literature to support these claims is lacking. No study using a random survey concludes that reorientation therapy is likely to be harmful.

A strong argument exists to hold a place at the clinical table for those who seek change in their sexual orientation. We cannot deny the call for such help, as long as that help is autonomous to the client rather than externally driven, and as long as the client remains free to change direction in therapy and to instead claim a homosexual identity.

Those who have received help from reorientation therapists have collectively stood up to be counted—as once did their openly gay counterparts in the 1970s. On May 22, 1994, in Philadelphia, the American Psychiatric Association was protested against for the first time in history—not by pro-gay activists, but by a group of people reporting that they had substantially changed their sexual orientation and that change is possible for others (Davis, 1994). The same thing happened at the 2000 Psychiatric Association convention in Chicago (Gorner, 2000), and again at the 2006 APA convention in New Orleans (Foust, 2006).

The APA cannot ethically deny treatment for unwanted homosexuality as long as there are patients who seek it and therapists who are competent and willing to provide this service after offering proper informed consent procedures. It would contradict the APA's own code of ethics to deny such treatment. The APA states, "Mental health organizations call on their members to respect a person's [client's] right to self-determination" (2008, p. 3).

By the same token, a client who is not distressed about his sexual orientation should not be directed to change, and therapy affirming homosexuality should be available for any client who seeks it.

Client self-determination is one of the cornerstones of any form of psychological care. We uphold the right to psychological care for those who have a persistent and marked distress with their homosexual attractions and behaviors and who wish to be helped in diminishing them and in discovering and developing their heterosexual potential.