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Out of Harm's Way:
Working Ethically with Same-Sex Attracted Persons

Questions of harm, evidence and practice

Core Issues Trust

FOREWORD

George Orwell once remarked that some ideas are "so foolish that only intellectuals can believe them". One such extremely irrational belief is the prevailing gay ideology with its basic contention about the 100% equivalence of homosexuality (orientation and relationships) to heterosexuality and the ensuing moral doctrine about the necessity of a revolutionary reformation of Western society. Intellectual, moral, and social resistance to this ideological belief would be an evil that must be eradicated.

Two characteristics that usually go hand in hand with social ideologies are also predominant in this revolutionary gay reform movement: the false claim of being founded in science and totalitarian or despotic aspirations.

Regarding the false appeal to *science*, there is nothing in the way of scientific proof for misleading affirmations such as that same-sex attractions are inborn or otherwise biologically determined; that one is already "gay" in childhood; that gay partnerships are equivalent to heterosexual unions and marriage; that all psychological, social, and medical problems which are unmistakably associated with the homosexual lifestyle are caused by "discrimination"; that children reared by gay couples grow up at least as healthy and happy as children of normally married parents; that it is impossible to overcome homosexual tendencies; and that change-directed counseling or therapies are harmful and dangerous. In reality however research evidence is overwhelmingly on the side of the opposite of every one of these affirmations. Years ago militant lesbian Camille Paglia warned that "we should be aware of the potentially pernicious intermingling of gay activism with science, which produces more propaganda than truth". A nice ideal, but incompatible with the mindset of the gay reformers. In practice, research data are obligatorily interpreted in favor of "gay" positions; unwelcome evidence is slighted or belittled. Only research thought to yield results useful to the ideology is undertaken, financed, and accepted for publication regardless of its quality. For the core academic establishment, prestigious publishing houses, and most professional magazines now serve the gay reform agenda. "In the end it is gay activism which determines what researchers say about gay people", gay historian Bullough said more than 20 years ago. Meanwhile, we have practically arrived there. Bullough's words are indicative of the *despotic* aspirations of the gay ideology. Today it has the status of a State religion preached and

imposed by the media and the Law (Never mind all this lip-service to the Separation of Religion and State). Both the ideology's methods and mentality are anti-democratic and elitist. We have constant indoctrination in the media, in sex education programs; there is a taboo on objective public information and on dissent. Laws concerning homosexuality issues are not the fruit of free and honest democratic debate. Most objective opinion surveys show that the majority of people reject the full social equalization of homosexuality with heterosexuality as to marriage and adoption as well as gay propaganda in their children's schools. Yet these issues are not decided by democratic referenda but imposed from above by a political and social elite that has surrendered to the gay mythology.

The slogans about "discrimination" and "homophobia" are dishonest, though very successful. Gay advocates play the victim or martyr to get what they want. Any disagreement with their theories, to say nothing of the view of homosexuality as a disorder and the mere suggestion of treatment possibilities, is indignantly branded as antiquated discrimination and should be forbidden like a capital sin. Dissenters suffer from the "sickness" of homophobia. The latter concept is complete nonsense: a phobia is a pathological fear. Many people feel aversion when confronted with openly homosexual behavior, but they are not afraid of it, let alone obsessively afraid. Himself a gay activist, the German Hinzpeter (1997) observed that gays are always complaining about being wronged: "If you believe the gay lobbyists and the media, Germany's gays live in a deep, deep valley of tears … under the threat of murder and increasing violence, discriminated upon in all segments of life". In their excessive self-centeredness, they do not want to see however that they themselves unjustly discriminate against same-sex attracted people who do not share their ideology, for instance those who are disillusioned by their gay way of life or those who want understanding, support and guidance so as not to slide into it and overcome their inclinations as far as possible. Several data sources indicate that at least 20% of same-sex attracted people may belong to this group. A suppressed minority indeed.

But this widely propagated gay way of life: is it really so glorious and natural? German fashion designer Wolfgang Joop was not so sure: "This is an addictive sort of behavior and at the same time a kind of frigidity. You are not satisfied, so you increase the dose—with the result that you multiply the frustration". Numerous similar testimonials can be given; promiscuity is inherent in the gay lifestyle. One statistical illustration: according to a large Dutch study, even men in "steady" gay unions had

an average of 8 additional sex partners per year, the average duration of the steady affair being 1.5 years. Other frequent concomitants of the gay lifestyle: various sexually transmitted diseases, HIV (still mainly a "gay disease" in the West), depressions and suicidal tendencies, emotional crises, psychosomatic complaints, a considerably shortened lifespan.
SPEAKING ABOUT HARM…

The detrimental consequences of the gay way of life are well-documented, in stark contrast with the alleged harm of change-directed approaches. The truth is that most clients seeking such guidance improve emotionally as well as sexually while obsessions and depressions decrease or disappear. I even know some who lastingly changed to complete heterosexuality, leading a happy marriage and family now for over 30 years.

Ideologies usually end up collapsing under the increasing weight of their unnaturalness. The gay ideology will be no exception. But must we wait that long before common sense and moral sense wake up to reality, truth, and authentic compassion?

Gerard van den Aardweg PhD
Psychologist, psychotherapist and author
Haarlem, Holland

"….psychology as a field has employed the assimilation acculturation strategy when it comes to LGB training. The field has foreclosed on an LGB-affirmative stance without a complex discussion of how to deal with competing cultural and religious values. We argue that the assimilation approach often results not only in unexamined, shallow affirmation, but also the marginalization and/or silencing of students and psychologists who are struggling to reconcile their personal religious or cultural values with the expectations of the profession"

Bieschke and Dendy (2010)

Dermot O'Callaghan, MA (Cantab) Studied Mechanical Sciences at Cambridge University and, after five years in industry, spent his working career as a management consultant in a variety of sectors, including mental health. In his retirement he has taken an interest in the way that science in recent decades has sought to understand the causes and consequences of same-sex attraction. He has followed with interest the ways in which science has been used (and sometimes misused) in society's debates and in the shaping of social policy, including the increasingly robust actions of mental health professional bodies to prevent even a married man from being helped to reduce his unwanted same-sex attractions in order to save his marriage.

Dermot is married, with one son and two grandchildren. He is a member of the General Synod of the Church of Ireland. He is a Council of Reference member of Core Issues Trust.

Michael Davidson, PhD (Rhodes) is co-director of Core Issues Trust, a Christian charity initiative supporting individuals with unwanted same-sex attractions (SSA) and those who support them. He has worked in higher education for most of his life. He trained for the pastoral ministry, and was ordained in 1984. He also trained as a secondary school teacher. He worked in teacher training for more than a decade, before a career in academic staff and researcher development units in three UK Universities. Most recently he was in training as a psychodrama psychotherapist. In 2012 he was placed under investigation by his professional body for expressing the view on the BBC that individuals wishing to move from homosexuality should be supported by professionals, where possible, and in 2013 was removed from the register.

Having himself moved away from homosexual practice, he advocates the right of individuals to access professional help to minimise such feelings where appropriate. He is actively engaged in various initiatives to raise awareness of the ideological foundations that deny individuals their freedoms in this area. He is married and has raised two children.

PREFACE

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1.1 Introduction – Setting the Scene

There are many reasons why a person might consult a therapist for psychological help. No therapeutic intervention is entirely without risk, and the range of conditions for which therapists offer help may be ranked conceptually in terms of risk of harm, from the least to the most risky. At one end of the spectrum, a man may seek help to overcome his nerves in making a speech at his daughter's wedding. At the other, a man may feel that he is actually a woman 'trapped in a man's body', and may be offered help even to the point of having major surgery and being given hormone treatment to achieve his life goals – with clearly serious potential risks should all not go according to plan.

Between these two extremes lie countless different conditions with varying degrees of therapeutic risk. It is normal for therapies to be offered ethically throughout the range, subject to the twin principles of client autonomy and informed consent.

With one exception. Any therapist in the UK offering to help a client to reduce unwanted same-sex attraction can now expect to be struck off the register of their professional body. Why should this be? The primary reason is that all therapies geared to such a goal are now alleged to be 'harmful'.

There is notable agreement about this among the major mental health professional bodies in the UK. Significant examples include:

> The British Association for Counselling and Psychotherapy "recognises the PAHO/WHO (2012) recent position statement that practices such as conversion or reparative therapies 'have no medical indication and represent a severe threat to the health and human rights of the affected persons'."

> The UK Council for Psychotherapy warns that "There is overwhelming evidence that undergoing such therapy is at considerable emotional and psychological cost."

> The Royal College of Psychiatrists says that therapy to change a client's sexual orientation can be "deeply damaging".

> The British Medical Association's Annual Representative Meeting

> in 2010 affirmed in a majority vote that 'conversion therapy' was "discredited and harmful to those 'treated' ".

Statements such as these leave no room for doubt about the prevailing view: therapies aimed at reducing same-sex attraction are said to be so dangerous that no ethical case could be made for a therapist to engage in them.

Indeed at the time of writing, an 'Early Day Motion against Conversion Therapy' has been lodged in Westminster, calling for the practice to be banned for under-eighteens and for any links between the NHS and conversion therapists to be investigated. And yet, most thinking people will reject the suggestion that the risk of harm from such therapy is greater than the risks from having major surgery and hormone treatment to attempt to turn a man into a woman, or *vice versa*. If a man wishes to reduce unwanted same-sex attractions, is it really plausible that this is more dangerous for him than to try to turn himself into a woman?

Why should therapy for this one condition – unwanted same-sex attraction – be singled out as being unethical? Could it be a matter of ideology rather than science? The following discussion will investigate that question.

1.2 Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts (2009)

The American Psychological Association commissioned a task force on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts (SOCE), which presented its report in 2009. It set out its methodology regarding the assessment of harm as follows:

> Based on Lilienfeld's (2007) comprehensive review of the issue of harm in psychotherapy, our systematic review examines harm in the following ways:
>
> - Negative side effects of treatment (iatrogenic effects)
> - Client reports of perceptions of harm from treatment
> - High drop-out rates
> - Indirect harm such as the costs (time, energy, money) of ineffective intervention

Though criticised for being unbalanced in composition (its membership included only those who subscribed to the view that SOCE were not 'appropriate'), the task force reported as follows:

> We conclude that there is ***a dearth of scientifically sound research*** on the safety of SOCE. Early and recent research studies provide ***no clear indication*** of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because ***no study to date of adequate scientific rigor*** has been explicitly designed to do so. Thus, ***we cannot conclude how likely it is that harm will occur from SOCE***.
>
> However, studies from both periods [1969-78 and 1999-2007] indicate that attempts to change sexual orientation ***may cause or exacerbate distress*** and poor mental health in some individuals, including depression and suicidal thoughts. The ***lack of rigorous research*** on the safety of SOCE represents a serious concern, as do studies that report ***perceptions*** of harm (cf. Lilienfeld, 2007). [Emphasis added]

Thus the APA acknowledges that there is 'no clear indication of the prevalence' of harm, because of a 'lack of rigorous research'. The reader should compare the APA's admitted lack of evidence with the emotive terms used by the various UK organisations quoted above:

- "severe threat to health" [BACP]
- "overwhelming evidence [of] considerable emotional and psychological cost" [UKCP]
- "can be deeply damaging" [RCPsych]
- "is discredited and harmful" [BMA]

Clearly the claims of harm being made by the UK mental health institutions are going far beyond the evidence found (and not found) by the American Psychological Association.

Treatments That Can Cause Harm

The APA's references to Lilienfeld's review are to his influential paper *Psychological Treatments that Cause Harm* . In fact they cite it no fewer than eleven times (though they never actually quote from it). In each case, there is a subliminal suggestion that Lilienfeld's warnings of harm apply to attempts to reduce unwanted same-sex attraction. It is therefore worth looking at his review in more detail to see what it says about the topic.

Lilienfeld identifies two *'Provisional Lists of Potentially Harmful Therapies'*, some twelve therapies in all, as follows:

Intervention	Potential Harm
Level 1 ***(Probably harmful for some individuals)***	
Critical incident stress debriefing	Heightened risk for posttraumatic stress symptoms
Scared Straight interventions	Exacerbation of conduct problems
Facilitated communication	False accusations of child abuse against family members
Attachment therapies (e.g., rebirthing)	Death and serious injury to children
Recovered-memory techniques	Production of false memories of trauma
DID-oriented therapy	Induction of "alter" personalities
Grief counseling for individuals with normal bereavement reactions	Increases in depressive symptoms
Expressive-experiential therapies	Exacerbation of painful emotions
Boot-camp interventions for conduct disorder	Exacerbation of conduct problems
DARE programs	Increased intake of alcohol and other substances (e.g., cigarettes)
Level 2 ***(Possibly harmful for some individuals)***	
Peer-group interventions for conduct disorder	Exacerbation of conduct problems
Relaxation treatments for panic-prone patients	Induction of panic attacks

It is evident that Lilienfeld does not include sexual orientation change efforts in either the more serious or the less serious category of therapies that he considers to be harmful.

1.3 The Shidlo and Schroeder Study

The study cited most frequently to support the claim of harm is Shidlo & Schroeder (2002) . The Royal College of Psychiatrists says that this study found "little effect as well as considerable harm."

The researchers who produced this study had a clearly biased purpose; they recruited participants using an advertisement which read, "HELP US DOCUMENT THE DAMAGE OF HOMOPHOBIC THERAPIES". (When they found that some respondents reported that they had actually been helped by therapy, they moderated their language to be more neutral in tone, but their purpose did not change.)

Even after allowing for this researcher bias, however, the evidence of harm is at first sight quite shocking. Of a total of some two hundred men in the study, no fewer than 23 said they had tried to kill themselves during their therapy. And 11 tried to do so after finishing therapy. *What more proof could be required of the "severe threat to health"*?

But what is lacking is any evidence that the suicide attempts were actually *caused* by the therapy. This may sound like special pleading, but when one discovers that 25 of the study participants had already attempted suicide *before* starting therapy, the importance of establishing causation rather than merely correlation, becomes very clear. The fact is that a significant proportion of these men were psychologically very unstable and the design of the study does not allow any conclusions to be drawn as to the cause of the men's suicidality during or after their therapy. How does one interpret the fact that fewer tried to kill themselves after therapy than before? It is possible that if there had been no therapy at all, even more of these men might have tried to kill themselves; we simply do not know. The one thing we do know is that it is wrong to use this study to imply a causal link between therapy and harm – the study design precludes any such inference.

A careful reading of the study shows that:

- 61% claimed to find some help from their therapy
- 85% claimed to find some harm
- 46% claimed both help and harm

The authors stated, "The goals of this preliminary study were to add to the body of empirical evidence on conversion therapies so that consumers can make an increasingly informed choice about engaging in conversion therapy ..."

But the goalposts have now been moved. The declared intention of the researchers in 2002 to promote informed client choice, has subsequently been pushed aside by a concerted effort to ban therapy aimed at reducing same-sex attraction – on the entirely unproven grounds that it

is inherently harmful. Ideological pressure is distorting science. We must continue to seek out the actual evidence in order to establish scientific truth as best we can.

1.4 The Spitzer Study

Dr Robert Spitzer had been the leading psychiatrist involved in persuading the American Psychiatric Association to stop classifying homosexuality as a mental disorder in its diagnostic manual in 1973. In 2000 he was interviewed by Dr Christl Vonholdt of the German Institute for Youth and Society. She asked him, "What about the issue of the American Psychiatric Association, to make the offering of treatment for change, unethical?" He replied, "I think this is absurd. It is ridiculous."

In 2001 Spitzer caused a sensation when he presented a study claiming that it was possible for some homosexual men and lesbians to change their orientation. It said,

> Position statements of the major mental health organizations in the United States state that there is no scientific evidence that a homosexual sexual orientation can be changed by psychotherapy, often referred to as 'reparative therapy.' This study tested the hypothesis that some individuals whose sexual orientation is predominantly homosexual can, with some form of reparative therapy, become predominantly heterosexual. ... The majority of participants gave reports of change from a predominantly or exclusively homosexual orientation before therapy to a predominantly or exclusively heterosexual orientation ...

In 2003 his study was peer reviewed and published; it put him in the front line of criticism from gay activists. Wikipedia reports that:

In a 2005 interview, Spitzer stated that "[m]any colleagues were outraged" following the publication of the study. Spitzer added that "[w]ithin the gay community, there was initially tremendous anger and feeling that I had betrayed them." When asked whether he would consider a follow-up study, Spitzer said no, and added that he felt "a little battle fatigue."

In 2012 that battle fatigue finally culminated in a half-hearted attempt by Spitzer to retract his study by means of a telephone call to Dr Kenneth Zucker, the editor of the journal that had published it. The events are described by Prof Alice Dreger , who asked Dr Zucker what had happened:

A few months ago, Zucker told me, Spitzer had called Zucker .... During that call, according to Zucker, Spitzer "made some reference to regretting having done or publishing the study, and he said he wanted to retract it. My recollection of the conversation was something like this: I said, 'I'm not sure what you want to retract, Bob. You didn't falsify the data. You didn't commit egregious statistical errors in analyzing the data. You didn't make up the data. There were various commentaries on your paper, some positive, some negative, some in between. So the only thing that you seem to want to retract is your interpretation of the data, and lots of people have already criticized you for interpretation, methodological issues, etc.'"... In other words, Zucker was trying to get Spitzer to articulate exactly what he wanted to say now, publicly, about his 2003 article. "And that was the end of the conversation. Now had Spitzer a week later submitted a letter to the editor saying 'I no longer agree with my own interpretations of the data,' would I have published it? Of course. Why not?" ... Zucker concluded, "If Spitzer wants to submit a letter that says he no longer believes his interpretation of his own data, that's fine. I'll publish it."

But **a retraction?** Well, the problem with that is that Spitzer's change of heart about the interpretation of his data is not normally the kind of thing that causes an editor to expunge the scientific record. Said Zucker to me, "You can retract data incorrectly analyzed; to do that, you publish an erratum. You can retract an article if the data were falsified—or the journal retracts it if the editor knows of it. As I understand it, he's just saying ten years later that he wants to retract his interpretation of the data. Well, we'd probably have to retract hundreds of scientific papers with regard to re-interpretation, and we don't do that."

All Spitzer has to do is put in writing that he no longer believes what he said about the interpretation of his data, and Zucker will publish his revision.

And here's the thing: Spitzer is a real scholar. He ought to know that you don't retract an article, or otherwise formally revise an article, with a casual phone call. If you want to change something in your publication record, you write to the editor to state what you want done, and why.

And Robert Spitzer should now do that.

It is only fair to state that Spitzer no longer interprets his study as he did originally, but he has not put his views in writing. And, sadly, it must also be said that this reinterpretation depends on an assumption that his study participants misled him as to their change in sexual orientation – a possibility that he had considered and rejected at the time of the study itself.

What are we to say about the Spitzer study? First, we need to understand that Spitzer's sample of participants consisted of volunteers who had been on therapeutic programmes and claimed to have experienced at least some movement from homosexuality towards heterosexuality. In other words, they were 'success stories' – their experiences are unlikely to be typical of what the average person might expect from similar therapies. Spitzer was careful to entitle his study, "Can *Some* Gay Men and Lesbians Change Their Sexual Orientation?" (We should similarly note that the Shidlo and Schroeder participants were recruited primarily from among the 'failure stories' and their experiences cannot be generalised either.)

Also, the Spitzer study was carried out retrospectively – that is to say, people were asked to report on their memories of the degree of change that they experienced at some time in the past. This aspect has been much criticised by those who oppose sexual orientation change efforts. How do we know that people were able to make such assessments accurately several years later?

These are legitimate criticisms, but it must be remembered that the social sciences regularly depend on data of this sort; if such data were automatically deemed invalid, a great many studies would have to be discarded as worthless – not least the Shidlo and Schroeder study discussed above.

The Theoretically Ideal Study

So what are the characteristics that a study of 'harm' should have in order to be scientifically compelling? Ideally it should:

- have a large sample of participants, randomly selected from the population
- be 'prospective' – that is to say, it should begin at the commencement of the therapy and follow participants for an extended period of time (perhaps several years) during therapy (and afterwards, to ensure that any change is not merely temporary);

- have a 'control group' of similar people who do not receive therapy;
- use one or more scientifically recognised measures of distress to gauge whether people are experiencing 'harm' as therapy progresses.

(It would be likely that, having gone to such trouble to set up and implement such a study, the researchers would also take the opportunity to measure in some way participants' sexual orientation, since that would usually be their reason for wanting to be in therapy in the first place; but that is not essential to our primary purpose here, which is the question of harm.)

It is really impossible, however, to set up the type of randomised controlled trial that would be used to test the efficacy or harm of a new drug – for the simple reason that the 'double blind' concept cannot work here. With a white pill it is a straightforward matter to have a treatment group who are given the drug, and a control group who receive the placebo, while neither doctors nor patients know who is in which group. It is obvious, however, that people receiving therapy, and those who are not, will know which group they are in.

There is also an ethical difficulty in that people wanting to reduce same-sex attractions are unlikely to want to be put in the group that receives no therapy. This also raises the question of whether ethics committees regulating the use of human subjects in research would approve the use of placebos for individuals thinking they are receiving help for unwanted desires.

So critics who require randomised controlled trials as evidence of the effectiveness and/or harmlessness of 'talking therapies' are being unrealistic in their demands.

1.5 The Jones and Yarhouse Study

The nearest thing that we have to a randomised controlled trial on the question of harm is a study by Jones & Yarhouse, reported in 2007 and updated in 2011 . Its characteristics include:

- prospective design (longitudinal study following participants for several years)
- use of accepted psychometric tests as a measure of possible harm
- (incidentally also use of several measures of sexual orientation,

though this is separate from the question of harm).

Weaknesses include lack of specificity of types of therapy used (therapeutic interventions took place in religiously mediated contexts); also non-randomness and limited size of the sample. The lack of a control group is not a serious issue since the measures of distress used in the study have norms for the general population.

On the question of harm, the researchers found:

> The attempt to change sexual orientation did not appear to be harmful on average for these participants. The only statistically significant trends that emerged for the GSI (global) and PSDI (distress intensity) variables indicated improving psychological symptoms [Time 1 to Time 6].

They were careful not to overstate their case:

> Despite these findings, we cannot conclude that particular individuals in this study were not harmed by their attempt to change. Specific individuals may claim to have experienced harm from the attempt to change, and those claims may be legitimate, but although it may be that the attempt to change orientation caused harm by its very nature, it may also be that the harm was caused by particular intervention methods that were inept, harsh, punitive, or otherwise ill-conceived, and not from the attempt to change itself. Our findings mitigate against any absolute claim that attempted change is likely to be harmful in and of itself.

This finding of 'no harm' resulting from attempted orientation change *per se* is of great importance. And because it clashes so strongly with the statements from the mental health bodies noted earlier, we need to investigate what evidence they offer to justify their position. To this question we now turn.

1.6 Where is the evidence? Trying to engage the UK Council for Psychotherapy

As noted earlier, the UK Council for Psychotherapy asserts that there is "overwhelming evidence that undergoing such [SOCE] therapy is at considerable psychological and emotional cost."

The Silence of Professor Andrew Samuels

In an attempt to find out if this 'overwhelming evidence' had any

substance, in February 2012 I wrote to Professor Andrew Samuels, then Chair of the UKCP. Salient parts of my letter are set out below.

> In considering the UKCP Ethical Principles I have in mind two hypothetical cases which will serve as examples:
>
> 1. A young man has a lady friend whom he loves and would like to marry. He is concerned, however, that he experiences same-sex attractions which he fears might derail the relationship at some time in the future. For as long as these feelings continue, he is unwilling to take the risk of marrying, not least for the sake of the woman he loves, and would like help in reducing his same-sex attractions.
>
> 2. A woman in her thirties is married with two children. She falls in love with another woman and is torn between leaving her family or staying. She would like help to reduce her same-sex attraction to enable her to keep her family intact.
>
> Each of these people seeks the advice of an appropriately qualified therapist and is told that science has shown that "agreeing to the client's request for therapy for the reduction of same sex attraction is not in a client's best interests" (2.1 - 1.1(a)) The man takes this news badly, goes into a deep depression and tries to kill himself. The woman accepts the therapist's explanation and decides to leave her husband and children, to their great distress.
>
> Such client dilemmas are not uncommon and the UKCP has a clear duty of care to avoid harm in its ethical guidance to psychotherapists. A high burden of proof is obviously needed to show that public safety is enhanced by following the UKCP ethical guidance to decline a reasonable client request.
>
> I must question whether research has in fact shown that therapy for the reduction of SSA is generally "not in a client's best interests." The reference to Drescher is non-specific. Which of his works is referred to? Perhaps *Ethical concerns raised when patients seek to change same-sex attractions*, Journal of Gay & Lesbian Psychotherapy, 5(3/4), 181-210. You will know that Shidlo and Schroeder (2002), the second authority referenced, originally recruited participants under the slogan, "Help us document the damage of homophobic therapists". It would appear that

neither of these references is based on a representative sample, which would be necessary in order to substantiate the universal claim that therapy for reduction of SSA is "not in a client's best interests".

May I ask you please to confirm that you think these two documents have "shown that offering, or agreeing to the client's request for, therapy for the reduction of same sex attraction is not in the client's best interests"?

In section 2.1 – 1.1(b) it is stated that "There is overwhelming evidence that undergoing such therapy is at considerable emotional and psychological cost." Where is this "overwhelming evidence"? Dr Stanton Jones in a current commentary on this debate http://www.wheaton.edu/CACE/Hot-Topics says that his research (with Dr Mark Yarhouse) into the question of harm "[did] not prove that no one is harmed by the attempt to change, but rather that the attempt to change does not appear to be harmful on average or inherently harmful. These findings challenge the commonly expressed views of the mental health establishment that change of sexual orientation is impossible or very uncommon, and that the attempt to change is highly likely to produce harm for those who make such an effort." Can you please give me the name of any study that has followed clients prospectively, administered generally accepted psychological tests to measure distress, and proved that, on average, harm is caused by SOCE?

I notice further that 1.3 – (e) says that for a psychotherapist to offer treatment that might 'reduce' same sex attraction would be "exploitative" as "to do so would be offering a treatment for which there is no illness." I would be grateful if you would explain how that logic applies to the two cases I have outlined above. In neither case is the person described as "ill". But the Guidance implies that if a therapist offered treatment to help persons such as these to achieve their life goals, the therapist would thereby be 'exploiting' the client. The error here, I think, is to imagine that 'treatments' can be offered only in the case of 'illness'. But one can have 'treatment' for everything from nervousness in public speaking to weight loss without being declared ill. It seems to me that the people in my examples above are being denied a human right to treatment intended to help them shape their lives as they wish.

Section 1.3 – (g) denies client 'autonomy' as sufficient justification for a therapist attempting to reduce same sex attractions, by wrongly suggesting that clients such as those in my examples are experiencing

"externalised and internalised oppression." Can you explain to me please how the desire to reduce same sex attractions in order to protect one's family is a sign of "oppression" – either external or internal?

Section 3.1(ii) concludes that "Based on the above considerations" offering 'Sexual Orientation Change Efforts' is "incompatible with UKCP's Ethical Principles and Code of Professional Conduct." In the light of the explanations given in the code of conduct, it seems to me rather that the blanket refusal of SOCE is oppressive, and based on political considerations rather than on science.

In order to help you, I summarise below the questions to which I would welcome answers.

1. Would you please confirm (or deny) that requests for client autonomy such as in my two examples are entirely reasonable and based on legitimate life goals?

2. Would you outline the evidence that sustains the proposition that "agreeing to the client's request for therapy for the reduction of same sex attraction is not in a client's best interests" – that is to say, that there are *no cases* in which such a client request should be honoured and that in *no case* would the maxim 'first do no harm' be violated by refusing the client's request.

3. May I ask you also to confirm that you think the two documents you reference have "shown that offering, or agreeing to the client's request for, therapy for the reduction of same sex attraction is not in the client's best interests"?

4. Would you also provide specific references to high quality scientific research which shows "overwhelming evidence that undergoing such therapy is at considerable emotional and psychological cost." Such evidence would need to be better than that of Jones & Yarhouse who found to the contrary. That is to say, one or more studies would need to have followed clients prospectively, administered generally accepted psychological tests to measure distress, and proved that, on average, harm is caused by SOCE.
5. In the context of the two cases I have outlined, can you explain how it would be "exploitative" for a therapist to

offer treatment that might 'reduce' same sex attraction"?

6. Can you confirm that there are no circumstances in which UKCP permits therapists to offer treatments "for which there is no illness".

7. Can you explain how the desire to reduce same sex attractions in order to protect one's family is a sign of "oppression" – either external or internal?

8. Would you affirm that the denial of a client's request to receive help to achieve the type of life goals that I have outlined is based on scientific evidence that is of such a high standard as to warrant denial of this basic human right in the interest of public safety?

I have tried to be as specific as I can, and would appreciate your specific responses to my questions.

Thank you in anticipation.

Professor Samuels did not reply to this letter.

Attempted formal complaint against UKCP

I then decided to write to the UKCP seeking to make a formal complaint against them, through their own internal complaints procedure. I was sufficiently confident of the strength of my arguments that I was willing to allow the UKCP to be judge, jury and executioner – as well as, of course, 'the accused'. I wanted to generate open discussion of the key parts of their ethics document that were so clearly unjustifiable. The main part of my letter is set out below:

O'Callaghan to UKCP (27th April 2012)

I wish to register a formal complaint against the UK Council for Psychotherapy.

By way of introduction, I would point out that the book *Destructive Trends in Mental Health: The well intentioned path to harm*, eds Nicholas Cummings and Rogers Wright (Routledge 2005) and supported by at least three former presidents of the APA, expresses well in an American context the concerns that I have:

> ... gay groups within the American Psychological Association have repeatedly tried to persuade the association to adopt ethical standards that prohibit therapists from offering psychotherapeutic services designed to ameliorate "gayness," on the basis that such efforts are unsuccessful and harmful to the consumer. Psychologists who do not agree with this premise are termed homophobic. Such efforts are especially troubling because they abrogate the patient's right to choose the therapist and determine therapeutic goals. They also deny the reality of data demonstrating that psychotherapy can be effective in changing sexual preferences in patients who have a desire to do so. (p xxx sic)

Chapter 2 (by Cummings and O'Donohue), entitled *Psychology's Surrender to Political Correctness* contains a section entitled, *Is Treating Homosexuality Unethical?* It says,

> Although the APA is reluctant or unable to evaluate questionable practices and has thus avoided addressing the issue of best practices, this did not prevent its Council of Representatives in 2002 from stampeding into a motion to declare the treatment of homosexuality unethical. This was done with the intent of perpetuating homosexuality, even when the homosexual patient willingly and even eagerly seeks treatment. The argument was that because homosexuality is not an illness, its treatment is unnecessary and unethical. Curiously, and rightly so, there was no counterargument against psychological interventions conducted by gay therapists to help patients be gay, such as those over many decades by leading psychologist and personal friend Donald Clark (the author of the best-selling *Living Gay*) and many others. Vigorously pushed by the gay lobby, it was eventually seen by a sufficient number of Council members as runaway political correctness and was defeated by the narrowest of margins. In a series of courageous letters to the various components of APA, former president Robert Perloff referred to the willingness of many psychologists to trample patients' rights to treatment in the interest of political correctness. He pointed out that making such treatment unethical would deprive a patient of a treatment of choice because the

threat of sanctions would eliminate any psychologist who engaged in such treatment. Although the resolution was narrowly defeated, this has not stopped its proponents from deriding colleagues who provide such treatment to patients seeking it. (p 17,18)

The derision referred to above is clearly detectable in a letter written by Prof Andrew Samuels, as Chair of UKCP, to *The Independent* on 5th February 2010:

No responsible psychotherapist will attempt to "convert" a client from homosexuality to heterosexuality. It is clinically and ethically misguided. Any member of the United Kingdom Council for Psychotherapy who tried to do so would have to face the music.

By contrast, Dr Jack Wiggins, another former APA president, says in the opening pages of the book,

The authors provide cogent examples of how in mental health circles today misguided idealism and social sophistry guarantee that good science and practice will not go unpunished.

Dr. Perloff, also contrasting with Prof Samuels, emphasises the importance of client self-determination. At a conference in 2004 he said,

I am here as the champion of one's right to choose ... It is my fervent belief that freedom of choice should govern one's sexual orientation ... If homosexuals choose to transform their sexuality into heterosexuality, that resolve and decision is theirs and theirs alone, and should not be tampered with by any special interest group -- including the gay community..." http://narth.com/docs/perloff.html

My complaint against the UKCP is that the prohibition of a client's right to choose a therapeutic approach in the context of informed consent, a prohibition clearly set out in its Ethical Principles and Codes of Professional Conduct guidance document relating to therapies that seek to reduce same-sex attraction, contravenes a cornerstone principle held by all of the mental health professions. That document http://www.psychotherapy.org.uk/code_of_ethics.html should be radically modified

without delay in the light of my arguments set out below. The detail of my criticism of the guidance document is set out in a letter that I sent by email to Prof Samuels on 8th February 2012.

[I then added the text of my letter to Prof Samuels as above, and requested answers to my questions.]

UKCP to O'Callaghan (30th April)

In reply I received a letter as follows:

> I trust that you have read our guidance relating to reparative therapy on our website, which states that UKCP does not consider homosexuality, bisexuality, or transsexual and transgendered states to be pathologies, mental disorders or indicative of developmental arrest. UKCP respects sexual diversity and believes it is exploitative for a psychotherapist to offer treatment that might 'cure' or 'reduce' same sex attraction as to do so would be offering a treatment for which there is no illness.
>
> A request for reparative therapy is often a mask for other important issues. In attempting to perform reparative therapy, a psychotherapist risks causing further emotional and psychological issues.
>
> UKCP's position on reparative therapy is the same as many other professional organisations such as the British Association for Counselling and Psychotherapy, Royal College of Psychiatrists, the American Psychiatric Association, the American Medical Association, and the American Psychological Association.
>
> UKCP will continue to stand by its Ethical Principles and Codes of Professional Conduct paper on reparative therapy. As this issue is a matter of opinion and not a complaint or human rights issue, and because you are not a UKCP member, we will not be taking this any further.

O'Callaghan to UKCP (15th May)

I responded:

> Your para 2 reiterates the UKCP position that "it is exploitative for a psychotherapist to offer treatment that might 'cure' or 'reduce' same sex attraction as to do so would be offering a treatment for which there is no illness." But it fails to address my point: Given

that a married woman with children who experiences unwanted same sex attraction which is threatening her marriage is not 'ill', that does not of itself mean that no therapy should be offered to her, still less that the offer of such therapy must always be 'exploitative'.

You say that "this issue is a matter of opinion and not a complaint or human rights issue". But if the UKCP is not able to back up its 'opinion' by reference to evidence, the matter becomes one of ideology (put forward by the UKCP) versus science (put forward by me). And I want to argue that it *is* a matter of human rights as far as the woman in my example goes – she is denied the human right to be helped to reduce her unwanted same sex attractions insofar as such reduction may be possible in her particular case.

It is not acceptable that you should decline to address my complaint – unless the fact that I am not a UKCP member invalidates such complaints automatically. I would be glad if you would confirm that this is the sole reason for your rejection of my complaint; otherwise I wish to make clear that my complaint still stands, and would be glad to have confirmation of your acceptance of this.

UKCP to O'Callaghan (24th May)

I received a reply saying:

In reference to your most recent letter, I must reaffirm our position, which is fully set out on our website. You have a different view. I assure you that the reason we are not taking your complaint any further is not because you are not a member of UKCP but because your different opinion does not constitute grounds for complaint.

This clearly brought the correspondence (which had involved two UKCP heads of function) to a close.

Where is the evidence? No reply.

In a final attempt to persuade the UKCP to engage in the issues I was raising, I wrote (17th July) to the Chief Executive, Mr David Pink:

I hope you will recognise the genuine concerns that underlie my complaint as stated in my previous correspondence:

My complaint against the UKCP is that the prohibition of a client's right to choose a therapeutic approach in the context of informed consent, a prohibition clearly set out in its Ethical Principles and Codes of Professional Conduct guidance document relating to therapies that seek to reduce same-sex attraction, contravenes a cornerstone principle held by all of the mental health professions. That document http://www.psychotherapy.org.uk/code_of_ethics.html should be radically modified without delay.

I do hope that you will take my representations seriously and not brush them aside as a 'difference of opinion'. Any organisation that insulates itself from reasonable criticism offered in a reasoned way is at risk of becoming driven by ideology rather than science.

UKCP CEO David Pink responded (18th July):

I understand that you do not agree with UKCP's Ethical Principles and Codes of Professional Conduct guidance, and you have already written to us a number of times on this subject. You are free to criticise us and our guidance, and you have done so. I am satisfied that the arguments you have put were adequately addressed in the drawing up of our guidance.

As you say, it would not be appropriate for a professional body to engage in wider societal matters of ideology or religious doctrine. But if there were any new points or issues relating to professional psychotherapy that you wish to raise, then I would be happy to address them. But otherwise, I can add little to the previous correspondence.

O'Callaghan replied (18th July)

You say, "I am satisfied that the arguments you have put were adequately addressed in the drawing up of our guidance." But my arguments were mainly in the form of *questions,* which are *not* addressed by your guidance document. For example,

Would you also provide specific references to high quality scientific research which shows "overwhelming evidence that undergoing such therapy is at considerable emotional and psychological cost." Such evidence would need to be better than that of Jones & Yarhouse who found to the contrary. That is to say, one or more studies would need to have followed clients prospectively, administered generally accepted psychological tests to measure distress, and proved that, on average, harm is caused by SOCE.

I would be glad if you would respond even to that one question. It is clearly of great importance in the overall issue.

Mr Pink did not reply. The UKCP thus declined my repeated requests for any evidence in support of their claim of the 'overwhelming evidence' that it is harmful for a client to seek to reduce unwanted same-sex attractions.

Where then is the evidence?

The foregoing discussion demonstrates an unwillingness or inability on the part of the UKCP, a major mental health institution, to present any evidence in support of its contention that, "There is overwhelming evidence that undergoing such therapy is at considerable emotional and psychological cost."

The 'overwhelming evidence' has not been allowed to see the light of day. This is particularly intriguing because a study by King *et al* (2004) of the views of professional therapists found that "only a small minority believed that current practice [in the UK] denied people distressed by their homosexuality an effective means to change their sexual orientation." Thus it is clear that the 'overwhelming evidence' of the UKCP and the 'severe threat to health' pronounced today by the BACP were not apparent to leading psychiatrists just a few years previously. Once again the question presents itself: is this science or ideology?

It is rightly said that 'absence of evidence is not evidence of absence', but it is also true that if a party claims to have 'overwhelming evidence' of something, then failure to produce that evidence in response to a reasonable request leaves that party open to suspicion that the evidence does not actually exist at all.

This suspicion was dramatically confirmed on the BBC Radio 4 Sunday programme, (3 Feb 2013) when Dr Di Hodgson, Chair of the Diversity, Equalities and Social Responsibility Committee of UKCP said in relation to reparative therapy, "I think there is very conflicting evidence. But in some ways, to me, that's really not the right question to ask, if I may say, because whether or not something works doesn't mean that it is ethical or in the public interest or the right thing to do for someone. So we have taken a view in a way which is regardless of the scientific findings. We still believe that it is unethical to seek to agree or to work towards changing someone's sexual orientation through psychotherapy."

This at last is hard evidence that the UKCP has "taken the view" that even if reparative therapy "works", it is not "the right thing to do for someone", simply because the UKCP says so. The "scientific findings" have been replaced by the UKCP's ideology. When one can take a view regardless of the scientific findings, evidence becomes unnecessary and one simply needs to give the general public an assurance that "the evidence is overwhelming". No accountability is required.

This is a tragic turn of events for people who have unwanted same-sex attractions, for the therapists who are struck off for helping them, and – most fundamental of all – for science itself. To suggest that it is "unethical" to use a therapy that "works" in order to help a person achieve a legitimate life goal such as holding one's family together, is bizarre. It is clear that the world of real ethics has been abandoned and replaced by a pseudo-ethical environment in which personal client autonomy is surrendered to a higher authority.

This ideological worldview, being contrary to science, dare not allow itself to be open to scientific scrutiny. Dr Cummings found this out to his cost when he co-authored the aforementioned book *Destructive Trends in Mental Health*. Though he is a former president of the APA, that organisation sent an instruction to the editors of all 28 journals that it controls, instructing them not to review the book .

Dr Cummings has also recently filed an affidavit with a New Jersey court affirming that he has seen hundreds of clients succeed in their desire to change their sexual orientation. He is very critical of the politically charged atmosphere that surrounds this whole area.

Directly contradicting the position of the UKCP as articulated above by Dr Hodgson, he asserts that "it is unethical for ... a professional organisation ... to prevent a patient from seeking help to change his or her sexual orientation if that is the psychotherapeutic treatment the patient desires after being informed of the difficulty of the work, the chances of success and the possibility of recidivism."

That too is the position of the authors of this publication.

2. Working Ethically with Unwanted Same-Sex Attraction A Way Forward. Mike Davidson, PhD

2.1 Introduction

Having worked for more than a decade with individuals conflicted in sexual identity relating to homosexuality, I find myself at odds with "mainstream" thinking now determined to normalise homosexual practices. Ironically my attempt to work within the context of a broadly acceptable ethical framework has been denied me, and I have been expelled by my professional body (The British Psychodrama Association, or BPA). This expulsion was because of views I have expressed publicly - that sexuality is fluid and may change, with or without the help of professional psychotherapy; that "orientation" is a construction rather than a category (like male or female), and that individuals have the right to receive help in reducing homosexual feelings, where this is possible.

The problem

The major UK psychotherapeutic bodies (BACP and UKCP) have followed the Royal College of Psychiatrists and have banned their members from participating in such therapeutic initiatives. O'Callaghan has identified that this is on a "me too basis", neither organisation presenting any scientific substantiation of their own. These trajectories follow in the style of the 1973 decision taken by the American Psychiatric Association (APA-2) to remove homosexuality from their Diagnostic and Statistical Manual. The International Statistical Classification of Diseases and Related Health Problems (ICD) (1992), a medical classification list by the World Health Organisation followed suit, but has retained the category "ego-dystonic sexual orientation" thus indicating that there should be space for individuals with conflicted sexual identity to receive professional help.

My experience of expulsion

In 2009 I entered into training as a psychodrama psychotherapist with the Birmingham Institute for Psychodrama having clearly indicated that I was interested in supporting individuals voluntarily moving out of same-sex attraction. I was open about my own journey in this area. When the UKCP produced a statement on 'reparative' therapies in 2010 I brought this to the attention of my trainers, and was encouraged by them to dialogue with the UKCP, the accrediting body of the British Psychodrama Association (BPA). I approached the then Chair Professor Andrew Samuels who invited me to write to him. In June 2011, I presented largely the material which follows in an attempt to interact with the UKCP statement. Professor Samuels responded:

From: Andrew Samuels
To: Michael Davidson
Cc: David Pink
Sent: Wednesday, July 27, 2011 7:22 PM
Subject: Re: Re-send: M.R. Davidson - 'reparative therapy of members of sexual minorities - Feb 2010'

Dear Dr Davidson,

I am afraid this will be a rather short response as I am presently off on summer holiday. I have read your material carefully.

I would like to focus this. I think you need to share these thoughts with your training organisation because they may have adopted an ethical position similar to that of UKCP (and BACP, it would appear). If they have, then you have an ethical responsibility to apprise them of your views.

I am afraid that the balance of argument is not supportive of your position(s). Our policy has been through extensive consultation processes and we have taken advice.

I regret that you hold a different viewpoint. I can see that it is proving difficult for you to align yourself with current best practice in this area, and I always have some sympathy for people who are somehow out of step. But the policy does not seem at all likely to change in the foreseeable future and so you do need to consider your professional orientation.

Yours sincerely,

Andrew Samuels

After debating the issue briefly on an ethics programme (BBC Radio Ulster) I was notified that I was under investigation, suspended immediately from my trainee status, and a long 14 months later permanently removed from the register, after a "hearing".

The BPA at no point made any attempt to refute any argument I offered. They offered no complaint against me from any client, having acted only on inquiries made by the BBC programme presenter.

Before presenting a rationale and approach to my work, there are some

important terms that might usefully be considered.

Unwanted same-sex attractions

The terms "ego-dystonic" and "ego-syntonic" usefully distinguish between an individual's response to an experience or symptom that they find either acceptable (ego-syntonic) or unacceptable (ego-dystonic).

Different pathways

A further distinction between "gay-affirming" and "gender-affirming" approaches may be useful. Neither position is "values neutral"; neither can boast gold standard Randomised Controlled Trials proving effectiveness. Individuals have a basic right to seek either of these options and work should progress on the basis of advanced informed consent, a concept developed further below (page 32).

Examples of three position statements are discussed below. The first is that of the UKCP (which has dictated the removal of my own membership and trainee status); the second is from the Core Issues Trust of which I am co-director. The third is that of the Association Of Christian Counsellors.

Note on "Reparative Therapy"

Before beginning this analysis, it is important to understand the term "Reparative Therapy". Contrary to popular (media) belief, the term was first described by a UK scholar, Dr Elizabeth Moberly who believed that homosexuality involved a 'reparative drive' towards 'repairing' damage caused by some traumatic experience early in life. Dr Joseph Nicolosi , an American clinician, popularised the term and developed a particular variation of it.

The UKCP statement uses the term in a generic sense referring to any initiative that identifies a "pathological" explanation for the homosexual state. The reader should distinguish however between "Reparative Therapy" (Nicolosi) and 'reparative therapy' the generic term.

2.2 Thoughts about the UKCP statement on the 'reparative' therapy of members of sexual minorities – Feb 2010

Analysis of the UKCP's statement might revolve around four areas: (1) the statement's insistence that use of 'reparative' and 'conversion' therapies in relation to the sexual orientation change efforts (SOCE), is categorically 'irresponsible'; (2) the implied assertion that since homosexuality is neither a pathology nor a disorder, the need for therapists to address clients' aspirations for change is therefore obviated,

unless done via gay-affirming approaches; (3) the implication that these therapies are harmful and therefore should be prohibited (4) the UKCP's preferred methods for dealing with 'egodystonic sexual orientation'.

The statement also appears to conflate the terms 'reparative' and 'conversion' therapies, which although often used interchangeably, have distinct etymologies in the literature. 'Reparative Therapy' has emerged from the psychoanalytical school, through the credible work of Anna Freud, Bieber, Hatterer, Socarides and Nicolosi. 'Conversion Therapy' on the other hand, is based on discredited aversion-type behavioural therapies, according to Douglas Haldeman .Reparative therapies should not be confused with Aversion behavioural therapies.

The UKCP statement rejects SOCE in their totality as "irresponsible", and thereby exceeds the American Psychological Association's Resolution (which the statement cites), which rejects neither SOCE nor Reparative Therapy.

Tolerance in professional bodies: the difference between UK and USA

The UKCP statement appears to contradict such leading textbooks in the field as 'Essential Psychopathology and its Treatment' (Maxmen, Ward and Kilgus, 2009:468). This text states: "…homosexual orientation can indeed be therapeutically changed in motivated clients, and that reorientation therapies do not produce emotional harm when attempted…"

It is important to note the difference between North American and UK ways of reconciling these contradictory positions. Tolerance within the American Psychological Association (APA-1) has allowed for variations in practice and perspective in the USA, whereas the UKCP and BACP tolerate no such diversity in the UK.

APA-1 Resolution cites the following principles that should be considered in the decision making process: scientific bases for professional judgments, benefit and harm, justice, and respect for people's rights and dignity. In the Report of the APA-1 Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) , each of these categories is examined. A psychologist who provides sexual orientation change efforts may, depending on the facts and circumstances, be in violation of one or more of the APA-1's Ethical Standards, but the APA-1 does not categorically prohibit therapies that may result in sexual orientation change. By contrast, the UKCP statement clearly does.

Dogmatic position of UK's UKCP and BACP Professional Bodies

It is worth pointing out that, although changes can be expected in this regard, most recently neither the American Psychiatric Association, the American Counseling Association, the American Association for Marriage and Family Therapy, the American Psychoanalytic Association, the International Society of Psychiatric Mental Health Nurses, nor the National Association of Social Workers prohibit, the practice of 'reparative' or 'conversion' therapy as the UKCP does. Neither in fact does the Royal College of Psychiatrists' Position Statement on Sexual Orientation (2010) ban reparative therapy. In citing some of these organisations in this regard, the UKCP and BACP statements are misleading.

The drive towards gender-neutrality in the UK

The UKCP statement makes the uncritical assertion that "to date, the 'causes' of both heterosexuality and homosexuality remain unknown", a statement which of course attempts to characterise 'homosexuality' as an essential category such as 'male or 'female', and one which is without justification. This in essence, is the ideological premise upon which the UKCP's statement is referenced. The implied argument might claim to indicate that there is now sufficient credible scientific evidence indicating that we are born gender-neutral; that gender-role is entirely a social-construct. It follows from this notion of gender-neutrality embedded in the statement that notions of sexual reorientation therapy are disallowed. Those rejecting this view present a very different reading of the science, instead understanding the species' sexual default to be aligned to its reproductive imperative.

The UKCP's statement that "no responsible psychotherapist will attempt to 'convert' a client from homosexuality to heterosexuality" indicates the organisation's dogmatic view that such an intervention is always harmful. UKCP's failure to substantiate their claim of harm has, however, been demonstrated in the earlier part of this booklet.

The pathologisation of individuals with unwanted same-sex attraction

The statement suggests that "psychotherapists, educators and the media need to work more energetically and in partnership to prevent the re-pathologization of LGBT people". Whilst this statement purports to place high priority on inclusiveness, social responsibility, and equality, it is unlikely that any alternative position will be heard. "Diversity" clearly may not participate in this "equality" agenda. Indeed the UKCP appears to ignore the very "re-pathologisation" it warns against, towards

those it purports to defend. Any professionals with a serious interest in appropriate psychological care for those who wish to move away from homosexuality are being excluded from this professional body. They are also ostracised from the benefits of a co-owned ethical framework usually underpinning the contract between client and therapist.

Alternative Models

Attention must now turn to an alternative model for working, presupposing a different ethical framework and set of values from that imposed by the UKCP and like institutions on society.

The Association of Christian Counsellors currently displays an ethical statement in respect of working with individuals. Although clearly a holding statement with no expressed opinion of its own in relation to sexual "reorientation" one key component is worthy of comment here:

> Any client seeking counselling **has the right to indicate their goals and aspirations** within counselling and to be **respected for that choice**. If a client seeks to explore change to their lifestyle or behaviour then using the core conditions **the counsellor needs to respect that desire and work with them to their benefit.** For the counsellor to reject this out of hand implies that they are seeking to **impose their own agenda** on the client and this is unethical (emphasis added).

The CORE ISSUES TRUST 'Change' Statement

The Core Issues Trust "Change Statement" (Appendix) is couched in religious terms but makes a case for its position using the scholarly arguments associated with re-orientation therapy. The statement asserts that sexual preference is neither biological (i.e. innate) nor unchangeable (immutable). It also claims that sexual impulses are not necessarily chosen and asserts that there are options or choices around such impulses. Core Issues Trust is a member in affiliation to the Association of Christian Counsellors. The statement clearly subscribes to the notion of "change" and to the idea that in some instances homosexual preferences, in addition to practices, may change. This is a transformative model.

When identities collide: providing therapeutic support for individuals with sexual and religious incongruence, ethically.

How then does a counsellor or therapist proceed when working with clients wanting to move away from homosexuality? Thinking through a suitable approach might usefully consider the notion of "sexual identity"

and the general goal of "congruity" or "resolution" of conflicting impulses within a person's sense of being. Essentially this is the quest to work ethically.

It is often claimed that the established consensus of mental health professionals is that homosexuality is a normal positive variation of human sexual orientation and not a mental disorder (Kinsey, Pomeroy, & Martin, 1948 ; Kinsey, Pomeroy, Martin, & Gebhard, (APA, 1975) . Since 1974, the American Psychological Association (APA) "has opposed stigma, prejudice, discrimination, and violence on the basis of sexual orientation and has taken a leadership role in supporting the equal rights of lesbian, gay, and bisexual individuals" (APA, 2005) .The UKCP, BACP and other UK organisations, have followed this lead. Clearly such a consensus is opposed by anyone arguing that homosexuality is neither biological nor immutable.

American studies identify a population of individuals who experience serious distress related to same sex sexual attractions .The majority of these subjects report that their religion is extremely important to them (Beckstead and Morrow, 2004 ; Nicolosi, Byrd, & Potts, 2000 ; Shidlo and Schroeder, 2002, Spitzer, 2003). Individuals in this group report seeking support from religious and secular professionals, using a variety of methods: behavioural, cognitive, psychotherapeutic and religious, to change their sexual orientation. According to gay psychotherapist and recent candidate for APA chairman Haldeman (2004:694) "For some, religious identity is so important that it is more realistic to consider changing sexual orientation than abandoning one's religion of origin". He argues that "religious affiliation can serve as a central, organizing aspect of identity that the individual cannot relinquish even at the price of sexual orientation. Psychology is in no position to negate this affiliation…"

Findings of APA Task Force on Appropriate Therapeutic responses to Sexual Orientation:

The APA Task Force document referred to earlier distinguishes between '*telic congruence'* in which some individuals choose to live their lives in accordance with personal or religious values and '*organismic congruence* ' meaning that some individuals choose to live with a sense of wholeness in one's experiential self rather than, primarily, with a valuative goal. Other literature (Yarhouse and Burkett 2002:238) also highlights dimensions of complexity, debated on both "sides" of the argument in terms of what sexual orientation actually is. '*Essentialists'* argue that it is universal reality; '*social constructionists'*

see it as a cultural category constructed by society to explain a person's sexual preferences. The APA's Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts summarises the Task Force findings as:

> (1) There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation. Some individuals appeared to learn how to ignore or limit their attractions.
>
> (2) Although there is insufficient evidence to support the use of psychological interventions to change sexual orientation, some individuals modified their sexual orientation identity (i.e., group membership and affiliation), behaviour, and values. They did so in a variety of ways and with varied and unpredictable outcomes, some of which were temporary.
>
> (3) On the basis of the Task Force's findings, the APA encourages mental health professionals to provide assistance to those who seek sexual orientation change by utilising affirmative multiculturally competent and client-centred approaches that recognize the negative impact of social stigma on sexual minorities and balance ethical principles of beneficence and nonmaleficence, justice, and respect for people's rights and dignity.

Despite the above APA Task Force findings, which affirm the need for therapeutic support for this population, and avoid the condemnation of sexual reorientation treatments per se, the UKCP statement "On the 'reparative' therapy of members of sexual minorities (Feb 2010)" uncritically brands any attempt by therapists to 'convert' clients from homosexuality to heterosexuality, as irresponsible. The UKCP appears to limit SOCE to 'conversion' therapy (a behaviourist approach associated with such things as electric shocks, no longer practised in the UK), which it conflates with 'reparative therapy', (a 'talking therapy' approach).

2.3 Ethical issues in the client autonomy, the "right to choose" and diversity debate

The UKCP's Ethical Principles document helpfully entreats the psychotherapist to treat clients "with respect" , particularly in relation to "their client's autonomy" . Psychotherapists are to "actively consider issues of diversity and equalities" . It reminds them that "no one is

immune from the experience of prejudice, and acknowledges the need for a continuing process of self-enquiry and professional development". Such prejudice, including a client's "religious or cultural beliefs", should not adversely affect the way they relate to the client . The same principles underline the importance of providing information about the whereabouts of alternative psychotherapists and the importance of appropriate referrals.

Yarhouse and Burkett (2002) argue the case for religious affiliation and expression as legitimate forms of diversity. Those advocating LGBT rights insist that therapists with religious connections avoid pathologising this population. Again Haldeman (2004:695) elucidates the dangers of prejudice on both sides: "Gay clinicians may be particularly at risk for negative counter-transferential reactions towards clients with strong conservative religious affiliations, given the issue of conflict between the gay community and the conservative religious world".

Just as therapists need to guard against requests for change because of familial, social or religious pressures, therapists need to be aware that if gay identity is chosen uncritically over other more primary identities, there remains the potential for profound existential loss. Both gay and 'reparative' therapists are vulnerable to prejudicial interventions. Both will have to consider appropriate referrals if they are unable to walk the journey with their clients authentically. There don't, however, appear to be any known instances of gay-affirming therapists referring clients to therapists offering change therapy

Facilitating autonomy and self-determination – the referral

According to Yarhouse and Burkett (2002:238) referrals to a gay-integrative therapist should be considered if the client:

> (a) states this is a goal for treatment; (b) is in his or her normal state of mental health (e.g., has worked through feelings of anger, frustration, or depression following unsuccessful approaches to change orientation or behaviour); (c) has had same –sex experiences (as opposed to fantasy); (d) is motivated by internal factors (e.g., personal values or sense of congruence) or external factors (e.g., peer or subculture pressure); (e) has considered whether he or she has adequate social support and access to friends, family, places of worship, and community services that support such a decision; and (f) is aware of some of the possible benefits of and risks in pursuing gay-integrative

therapy at this time.

Haldeman's (2004:711) position is:

> If a practitioner feels challenged about maintaining a facilitative neutrality in the face of a client choice, consultation is essential. And if one's reactions against their religious or LGB individuals are such that the advancement of the therapist agendas cannot be avoided, a referral should be made.

Beckstead and Morrow (2004) , Haldeman (2004), Throckmorton and Yarhouse (2006) all argue for therapeutic opportunities to step outside of the two polarised positions of 'out-gay' or 'ex-gay' in working with conflicted clients. This is a person-centred approach and aims to reconcile conflict between same sex attraction and other more primary identities such as a religious identity, thus leading clients towards individualised congruent, solutions. Haldeman (2004:692) lists the ethical challenges to those working with sexual minority clients as:

> (1) informed consent about treatment; (2) alternative treatments; (3) disseminating accurate clinical and scientific information about sexual orientation; (4) respect for individual autonomy; and (5) protection from bias on the part of the practitioner.

Conservative scholars Yarhouse and Burkett and gay integrative therapist Haldeman appear to agree that the ethical standards – informed consent, accuracy of information, withholding of prejudicial attitude and respect for autonomy, are crucial in these cases. This position is what Haldeman (2004:712) calls "antidogma" where rather than encouraging either a "coming out", repressing sexuality in the service of religion, or advocating any particular outcome "a treatment framework is offered that enables the client to make decisions himself". This should not preclude the therapist from expressing their own views and understanding but, if offered, this is not with an intention to indoctrinate the client.

Religious belief and the diversity debate

To Professor Samuels, former UKCP Chair, the defence of "conversion therapy" using the grounds of "free speech" is to be rejected as "specious". Clearly the reticence of the UKCP to recognise SOCE for religious clients or clients motivated to seek this help from a position of 'no faith' in any of its documentation represents a position that differs from the trajectory of the APA. The discussion by Bieschke and Dendy

(2010: 430) about trainee therapists having to navigate between their personal values and expectations of the professions is worth noting:

> We argue that psychology as a field has employed the assimilation acculturation strategy when it comes to LGB training. The field has foreclosed on an LGB-affirmative stance without a complex discussion of how to deal with competing cultural and religious values. We argue that the assimilation approach often results not only in unexamined, shallow affirmation, but also the marginalization and/or silencing of students and psychologists who are struggling to reconcile their personal religious or cultural values with the expectations of the profession.

A way forward

I wish to make the case for the silenced minority who experience same sex attractions and seek to change their behaviour, impulses or orientation or who seek to live rich and fulfilling lives and remain celibate. Many wish to do this with the help and support of professionally trained psychotherapists. For these individuals it may be that their religious identity is primary, just as Green (1994:24) reports that for many African American gay men and lesbians their identities as 'African Americans' is primary. Therapists generally do well to be informed about the fact that many homosexual people disagree with the Judeo-Christian teachings about human sexuality, but similarly, that there is a minority of homosexual people who are committed to the orthodox, historical perspectives on the status of same sex attractions and wish to live in conformity to the teachings of their religious communities.

I submit that the protection of ethical standards and professional conduct in dealing with those conflicted in their religious and sexual identity is best served through appropriate training and professional supervision – and not through the dogmatic refusal of activists, based on ideology, to recognise the fundamental dignity of those who differ from them.

To achieve this it is clear that new associations and distinct ethical frameworks will need to be developed, maintained and protected. In what follows, an approach is offered in respect of working with those conflicted around sexual identity, which aims to respect client autonomy, personal values and goals.

2.4 Supporting individuals conflicted in religious and sexual identities: exploring the possibilities for congruence with religiously motivated clients.

Background

This section offers a *modus operandi* for therapists wishing to work within any ethical framework which truly values client autonomy, and the right to alter lifestyle and behaviour, and seeks to protect sexual minorities from irresponsible therapeutic approaches. The following approach offers neither 'reparative', nor 'conversion' therapy but does support the right of clients to explore "reorientation" pathways.

Often the client population seeking help with these issues requests orientation change, but is unaware of the internalised processes which may have both led them into such conflict, and driven them to seek reorientation. Uncritical acceptance of such requests may lead to collusion between psychotherapist and client on the one hand, and social and religious prejudices on the other.

There is no conclusive scientific evidence, "one way or the other" (APA 2009:23) that sexual orientation change efforts (SOCE) are successful. Neither is there clarity on the nature of 'orientation' nor a consensus on how to measure it. Anecdotal evidence exists claiming both instances of the harm that such efforts may produce and instances where varying degrees of change have been experienced without significant reports of harm.

Approach to psychotherapeutic support for individuals conflicted in sexual identity

Responsible support for individuals who request sexual reorientation and are conflicted in their sexual and religious identity, recognises the need to proceed with caution and to distinguish between a range of possible integrative pathways. These should be suited to client goals, values and worldviews, formulated after appropriate assessment and exploration of presenting issues. Approaches respectful of sexual minority groups are considered in 1-4 below:

(1) Affirmation of the person with the homosexual impulse.

At the most fundamental level, affirmation of individuals with the homosexual impulse, irrespective of whether this is being denied, repressed or acted upon, provides a normative context in which clients can explore personal responses to this part of themselves. This includes the affirmation of the right of

individuals to decide their own pathway, practice and sexual identity, irrespective of the therapist's opinion.

(2) **Exploration of presenting issues and appropriate personal responses.** The therapy objective is therefore clarification of tailored pathways appropriate for future identity integration, consistent with personal values. This clarification may lead to a quest for celibacy, integration to the LGB community or to change. Such work at the initial stages is exploratory; clients are assisted by the therapist to understand, as far as possible, where their feelings have come from, and why such conflicts have emerged. This does not mean the therapist assumes or suggests to the client that their experience of sexuality orientation or 'patterning' is to be understood necessarily as attachment-, development- or trauma-based.

(3) **Advanced informed consent for further work.** Exploratory work with clients may find that they lean towards a certain direction, or are clear about the identity they would like to confirm. In all cases practitioners must provide the client with accurate, up to date information which will support a client's permission for further intervention. Advanced informed consent at the very least clarifies that:

(3.1) homosexuality is not a mental illness needing to be 'cured' according to the mental health organisations, internationally;

(3.2) perspectives on the aetiology of homosexuality and the causes of identity conflict are dependent on the therapist's access to and understanding of up to date research, and the client's own life experiences;

(3.3) clients' values and beliefs may become more easily clarified when clients consider how their view of homosexuality changes in response to different versions of how homosexuality and identity conflict develop;

(3.4) there is no substantial evidence-base for the successful outcome of either gay integrative or re-orientation therapies;

(3.5) some reports suggest that reorientation therapy may be

harmful for some clients, as may affirmative therapy.

(4) Referral and/or psychotherapy. A referral may take place at the beginning of this process, or at any subsequent stage. The outcome of interventions 1-3 above, whilst unlikely to be linear, may mean any of the following requests are made by the client:

(4.1) assistance in management of sexual identity for those unwilling to publicly identify as 'gay' or to integrate with the LGB community, nor to acknowledge to others that such impulses are a personal reality;

(4.2) assistance to achieve the personal goal of celibacy and chastity;

A practitioner with conservative religious values may refer on clients requesting either:

(4.3) integration into the LGB community through referral to a suitable psychotherapist, qualified and willing to facilitate integration into an LGB identity;

(4.4) reorientation therapy through referral to a suitable therapist, qualified and willing to assess the client for work around sexual reorientation.

(5) Conditions for referral to gay-integrative therapists
The conditions for referral to a gay-affirmative therapist as set out by Yarhouse and Burkett above should be followed.

2.5 Some general principles for working with same-sex attracted persons

Offering a model for working in this area is potentially likely to be misconstrued and taken to represent some kind of intended panacea. What follows are some broad-brush strokes that have been helpful as I have worked with such people. The principles are drawn from my own experience as both one moving out of homosexual practice and as a mentor offering support and help.

The work that individuals undertake in this area is about transforming the homosexual impulse, rather than repression and, at best, is about discovering heterosexual potential or finding fulfilment in celibacy. Despite the unpopularity of a "deficit" model, I like what Elizabeth

Moberly (1983:40) said

> To stop being a homosexual means to stop being a person with same-sex psychological deficits. This can only happen through the fulfillment of such needs and the resolution of any barriers to such fulfillment. Conversely it must be understood very clearly that to thwart the fulfilment of such needs implies that the person is forced to remain homosexual. A non-practising homosexual is still a homosexual. Sexual activity may not be appropriate to the outworking of the solution, but sexual abstinence of itself does not begin to meet the problem of the underlying deficits. Only the non-sexual fulfilment of same-sex needs may do this.

Moving away from deeply ingrained habits, or even impulses that have never been acted on, is never easy. Things rarely go to plan, nor are they achieved to a time-frame and they may never be perfectly resolved. The memories of living life at the extreme will be difficult to reduce or eradicate. It will involve hard work, patience and a willingness to explore new ways of relating to individuals, groups, family, friends and those of both the same and opposite sex.

What homosexuality is not...

Given that so many are being encouraged to embrace a 'gay' identity once they identify homosexual feelings, it is probably important to be clear about what homosexuality is not when it comes to how we work with this issue. The "one time sexual encounter" under the influence, or a one-time lark, is not indicative of a suppressed 'true' homosexual identity. Like anything else we can develop an appetite from something, just as sometimes men in prison become homosexual in practice, but revert to heterosexual practice outside of prison.

It's not thoughts or imaginations that we turn into fantasy, which is more to do with the process by which this way of expression becomes imbedded. It's not the genital exploration and the games children often play nor the adolescent experiences in boarding school. It's not the hero worship or the crush you had for the teacher or TV star or the affection you have for members of the same sex. Neither is it about the phobia a person might have for the opposite sex.

It should be of concern that in the effort to provide information to school pupils by which to end bullying against those who embrace a 'gay' or 'transgendered' identity, significant promotion of homosexual practice may be taking place. Having homosexual thoughts and attractions does

not make a child "gay". Most of those who at age 16 think they may be homosexual, have realised by age 17 that they are not.

Sexual 'identity' versus sexual 'orientation'

Many men who have sex with men deny a "gay" identity as do many men married to opposite sex spouses, but they may engage in the same behaviours – some occasionally, others habitually and addictively or compulsively. Probably the key question is "does 'change' refer to 'identity' or/and to 'orientation'?" My own experience has been that the more my behaviour has been modified the more my sense of being has changed.

In the end I believe we are talking about behaviours that for many are unwanted, some of which over time become entrenched, habitual, addictive, compulsive and destructive – all to a greater or lesser extent, depending on the individual.

Choice and options

My own experience has taught me that although I did not choose my homosexual feelings I knew I had choices around what I did with them. Of course if a person sees himself as a "victim" or embraces homosexual feelings as entirely natural, their starting point will be different from mine.

I discovered within myself an emotional template that was more likely to express or indulge homosexual feelings which, once identified, I could adapt. More than one psychotherapist tried to encourage me to embrace homosexuality as my true "gay" identity. At least one encouraged me to end my marriage but none of these suggestions felt true to my sense of identity or purpose. Neither was I content to just see myself as a "homosexual struggler" or even as a "homosexual over-comer". Others will have different experiences, but the desire not to live in homosexual relationship or with homosexual fantasies is a valid pathway.

There are probably other directions available to those who put themselves forward for help around these issues, but the following seem to represent the most common trajectories. UK professional mental health bodies have denied individuals the last two of the following four options:

1. Accept same-sex feelings and practise same-sex relationships
2. Accept same-sex feelings and seek a monogamous/"monogamish" same-sex relationship

3. Accept same-sex feelings and choose to be celibate. Change might happen.
4. Accept same-sex feelings and actively seek change or sexual re-orientation

People may begin and end their journeys at different places, but I believe choice is essential for an individual wanting to explore these deeply personal issues.

The approach Core Issues Trust adopts: general principles

Whatever work is done with individuals wanting to move away from homosexuality, needs to be undertaken in a supportive environment. What follows are (1) general principles for group support and then (2) a basic framework for ongoing individual work with a therapist or experienced individual.

2.6 Support Structures and an approach

Because there is a deep shaming associated with homosexuality, individuals are often wounded by society's inability to work compassionately with them. Church life might be very difficult because often local congregations are unaware of how to support such people. Liberal congregations can be as problematic as conservative ones, and more than one person has told me about the inappropriate approaches individuals within the church have made towards them once they have been open about their struggle. What follows are five broad principles that we think are worthy of consideration:

1. **Homosexuality needs are best resolved through relationship.**
   Often wounding has been received in community, and it is in community that such wounds can be readdressed. This assumes safe, mediated contexts where individuals can be nurtured. The best environment is in "closed-open" groups – meeting for specific purposes of supporting individuals with specific needs. These groups are likely to grow in number but typically require a commitment to attendance, confidentiality, engagement etc. Such spaces provide safe facilitated places for the expression of unmet needs, where unresolved conflicts can be explored. Such groups, run on group psychotherapeutic principles, can be powerful, but well run peer-assisted groups are also valuable. Group work may need to be preceded by one-to-one work, and a commitment by the client to learn how to develop a range of relationships outside of the group or counselling context is essential.

2. **Psychological deficits need to be met completely without sexual activity.** It's no good telling a man or woman caught in emotional dependence or sexual dependence simply to stop such practices. Even if they succeed in doing so, the underlying issues will remain and will resurface if these issues are not resolved. Homosexual feelings are *symptoms* of unmet, legitimate needs. The key to helping such people is to encourage them to seek ways to meet these needs, non-sexually. So many men talk of seeking connection and giving sexual intimacy in the hope of resolving unmet needs for genuine friendship.

3. **Homosexual acts are not essential to the homosexual condition; abstinence is not the ultimate solution.** Sometimes the most difficult person to help is the individual who has never acted on the homosexual impulse, and who deeply fears this side of themselves. It is often important to assess whether or not they are in fact suffering from homosexual obsessive compulsive disorder (HOCD). Understanding the emotional template underlying this condition may require the careful work and input of an experienced therapist. A supportive group, including those who have acted out and are less inclined to romanticise homosexual feelings may also be helpful. Single sex groups as opposed to mixed sex groups, exploring various issues are the most effective in my own experience.

4. **The capacity for same sex love is essentially the love-need of the child for the parent (parenting rather than sexuality is the nub of the issue).** This is not an attempt to blame any parent, but rather acknowledges how individuals learn to take care of their own emotional needs. Of course exploring family background, parenting and sibling relationships is controversial but the attachment needs of an individual's emotional template may be helpfully understood and can unlock what an individual experiences in repeated attempts to explore homosexual relationships, or desire for homosexual 'love'.

5. **Until restoration is seen to involve fulfilment of unmet 'homosexual' needs, and not just holding them back, we shall constantly be hindering rather than cooperating with the individual's drive to resolve the issue.** Whatever we think, a person's needs are going to be met – one way or another. This is why repression is not likely to resolve an individual's difficulties. The task at hand is to find ways of meeting such unmet needs in

legitimate ways that are consistent with the client's value system.

The work we do in this area requires a great deal of patience, love and respect.

2.7 A framework for ongoing work with individuals moving out of homosexual practice.

A survey of the practice-based literature about working in a therapeutic way with those invested in walking away from homosexual practice will show a range of approaches that have been used. The table below represents a simplified approach that might be generally adaptable to a range of modalities and initiatives. What is clear is that a single approach is unlikely to resolve all the issues of this complex condition. Within this framework there are numerous opportunities for different approaches and techniques.

Behavioural Therapy	Cognitive Therapy
'Re-booting' and 're-wiring' the brain Sexual abstinence; checking pornography addictions	Relationship building: assertiveness and confidence; self-esteem issues; improving communication
Psychodynamic Therapy	
Exploring homo- and hetero-sexual wounding Self-regulation and management Developing new relationships	

A word about the pornography epidemic

Practitioners and therapists would do well to explore with clients how pornography is shaping sexual appetites. It is clear, despite the ignorance of governments who claim there is little or no harm done in viewing of pornography, that increasing numbers of consumers are recognising within themselves the consequences of over-stimulation and the "morphing" of sexual appetites. The instantaneous availability of high-speed pornographic images means that the "dopamine" effect is likely to be sustained by pursuing increasing varieties of pornography, (to overcome a numbing and achieve the same effect) all of which contributes to changing sexual preferences and appetites and risking internet pornography addictions. Several individuals report changing sexual appetites and orientations.

Interested readers are encouraged to explore the range of materials and related forum from sites such as www.yourbrainonporn.com evidencing the strength of such movements. This site is an important contribution to a popular understanding of brain malleability or plasticity. All of this is indicative of a growing realisation of just how vulnerable we are to the modification of our brains by unscrupulous social experiments that seem to want to introduce the values and practices of pan-sexuality which seeks to welcome any and all sexual proclivities.

Conclusion

This study has highlighted the fact that despite consistent efforts by mental health institutions to insist that therapeutic support for individuals seeking to reduce homosexual feelings and fantasies is necessarily harmful, this is not supported in scientific studies – from a range of perspectives. The Shidlo and Schroeder (2002), Spitzer (2001/3) and Jones and Yarhouse (2007/11) studies have been examined together with the impression of harmfulness that the APA (2009) Task Force study gives, but fails to substantiate in anything but an ideological way.

Differences in levels of tolerance within professional bodies, in respect of being able to discuss these issues, have been referred to. In the UK therapists have been denied, on ideological grounds, the opportunity to share the regulatory and ethical frameworks of the professional bodies which might otherwise regulate and safely manage therapeutic work in this area. Therapists in this position have generally refused to accept the idea that homosexuality is an innate and immutable condition or have supported the once-universally accepted principle that individuals have a right to choose the sexual identity they apply to themselves. They believe that change is possible, to varying degrees, and that individuals who choose to move away from homosexual feelings and practice need to be respected and supported professionally. They may also accept that a religious identity may be more important for some individuals than a sexual identity.

Core Issues Trust exists to advocate for such beliefs and for safe practices that support individuals to achieve the legitimate goal of moving away from homosexual practice and feelings, where possible. The challenges before us are considerable. As professional training is denied to those who reject the idea of the biological innateness and immutability of homosexuality, so too are the supervisory structures and professional insurance safeguards. The actions of the UK professional bodies thus ensure that safe regulation of activities in this area in matters of training and professional practice, is now jeopardised; *ad hoc* service providers

are likely increasingly to work 'under the radar' in a range of contexts.

What is needed above all is an honest admission that the likelihood of harm resulting from ethical therapies has been grossly exaggerated, to the detriment of those who have the legitimate life goal of seeking to reduce same-sex attraction, for whatever reason.

Simply abandoning the small population of those who seek change, and thereby encouraging them to make use of *ad hoc* service providers or to seek professional 'remote' counselling services outside the UK is no solution.

Appendix

UKCP statement on the 'reparative' therapy of members of sexual minorities - Feb 2010

UKCP does not consider homosexuality or bisexuality, or transsexual and transgendered states to be pathologies, mental disorders or indicative of developmental arrest. These are not symptoms to be treated by psychotherapists, in the sense of attempting to change or remove them.

It follows that no responsible psychotherapist will attempt to 'convert' a client from homosexuality to heterosexuality ('reparative' therapy). Hence, the UKCP notes with concern research (Bartlett, Smith, King, 2009) indicating that as many as one in six therapists surveyed were willing to contract to reduce 'same sex attraction'. These therapists were not working on a religious basis; many were members of the main professional organisations.

To the contrary, UKCP honours and respects sexual diversity as part of our approach to diversity, equalities and social responsibility. In this regard, our position is the same as that of many other professional organisations such as the British Association for Counselling and Psychotherapy, Royal College of Psychiatrists, the American Psychiatric Association (2000), the American Medical Association, and the American Psychological Association (2009).

UKCP considers that more work is needed to refine the clinical theories utilized by psychotherapists of all modalities. For example, practitioners should be careful when faced with male or female clients/patients who ask for conversion therapy as such requests often mask other pressing issues. Or, to give a further instance, there is evidence that uncritical acceptance by some psychotherapists that there is a specific kind of pathological family background to male homosexuality - 'possessive mother/ distant father', or 'faulty attachments' - is being used to justify 'reparative' therapy. UKCP rejects this argument. To date, the 'causes' of both heterosexuality and homosexuality remain unknown.

Psychotherapists, educators and the media need to work more

energetically and in partnership to prevent the re-pathologization of LGBT people. We call on our colleagues in other professional organisations of psychotherapists and counsellors to indicate their support for this statement.

United Kingdom Council for Psychotherapy
February 2010

REFERENCES

American Psychiatric Association (2000). Commission on Psychotherapy by Psychiatrists (COPP): Position statement on therapies focused on attempts to change sexual orientation (Reparative or conversion therapies). American J. Psychiatry, 157:1719-1721.

American Psychological Association, Task Force on the Appropriate Therapeutic Response to Sexual Orientation. (2009). Report of the Task Force on the Appropriate Therapeutic Response to Sexual Orientation. Washington, DC.

Bartlett, A., Smith, G., King, M. (2009) 'The response of mental health professionals to clients seeking help to change or redirect same-sex sexual orientation'. Division of Mental Health, St George's Hospital, University of London; Department of Mental Health Sciences, University College Hospital, University of London

The Core Issues Trust Statement

All human sexuality is fallen and is in need of the sanctifying work of God to restore it to its intended wholeness and divine purpose. There is a growing body of research evidence indicating that sexual preference is neither immutable, innate nor chosen. As a consequence of our basic sinfulness we all have desires that we do not choose to have but we do have choices with respect to what we do about them. As a consequence our sexual identity can be reinforced or altered by either gender-affirming or gay-affirming lifestyles or therapies. CORE works with people who voluntarily seek to change from a "gay" lifestyle to a gender-affirming one. This is sometimes referred to as a "sexual re-orientation" process.

CORE recognizes that homosexuality is not exclusively a spiritual problem. The homosexual impulse may develop because of early wounding that has remained unhealed; it may also find its roots in legitimate physical and emotional needs that have not been met and have become distorted.

The Church of Christ has a responsibility to support, with patience, understanding, sensitivity and respect, individuals who choose to work through those issues that have led to the homosexual impulse. The process of change is often exceedingly painful and requires the support of skilful mentors and a loving

community in order to promote wholeness and restoration.

Merely abstaining from homosexual activity, although admirable, cannot be regarded as healing. Heterosexual preference is the goal of gender-affirming therapy and this may lead to marriage. However there will always be those who choose to remain celibate and single. Such singleness should be valued and respected.

Last modified: Thursday, 19 August 2010, 08:07 AM

List of References

1 http://www.itsgoodtotalk.org.uk/assets/docs/BACP-Ethical-Framework-for-Good-Practice-in-Counselling-and-Psychotherapy_1360076878.pdf

2 http://www.psychotherapy.org.uk/code_of_ethics.html

3 http://www.rcpsych.ac.uk/workinpsychiatry/specialinterestgroups/gaylesbian/submissiontothecofe/psychiatryandlgbpeople.aspx

4 http://web2.bma.org.uk/bmapolicies.nsf/searchresults?OpenForm&Q=conversion+therapy~8~50~Y

5 Lilienfeld, S. O. (2007). Psychological treatments that cause harm. Perspectives on Psychological Science, 2, 53-70

6 Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. (3), 249-259.

7 www.rcpsych.ac.uk/rollofhonour/specialinterestgroups/gaylesbian/submissiontothecofe/psychiatryandlgbpeople.aspx#therapy

8 http://www.dijg.de/english/homosexuality-reality-of-change/

9 Archives of Sexual Behavior, Vol. 32, No. 5, October 2003, pp. 403–417

10 http://www.psychologytoday.com/blog/fetishes-i-dont-get/201204/how-ex-ex-gay-study

11 http://www.tandfonline.com/doi/abs/10.1080/0092623X.2011.607052#.Ub3jkPm1HlU

12 This and similarly numbered references are to ''Guidance on the Practice of Psychological Therapies that Pathologise and/or Seek to Eliminate or Reduce Same Sex Attraction' http://www.psychotherapy.org.uk/ukcp_standards_and_policy_statements.html

13 Treatments of homosexuality in Britain since the 1950s—an oral history: the experience of professionals BMJ 2004;328:429

14 http://www.christianconcern.com/media/bbc-radio-4-report-on-sexual-orientation-therapy-featuring-mike-davidson-and-dr-peter-saunders

15 http://www.youtube.com/watch?v=BKxYBch2LVM

16 http://www.peter-ould.net/wp-content/uploads/Nicholas_Cummings_Declaration.pdf

17 http://www.psychotherapy.org.uk/article1260.html
http://www.acc-uk.org/pdfs/BoardStatementDec2012.pdf
http://learning.core-issues.org/mod/resource/view.php?id=58

18 Moberly, E. Homosexuality: A New Christian Ethic. Lutterworth Press; Reprint edition

19 Nicolosi, J (1997) Reparative Therapy of Male Homosexuality: A New Clinical Approach. Publisher: Jason Aronson.

20 UKCP statement on the 'reparative' therapy of members of sexual minorities – February 2010. http://www.psychotherapy.org.uk/article1260.html <17 June, 2011>

21 "Gay Rights, Patient Rights: The Implications of Sexual Orientation Conversion Therapy" doi 10.1037//0735-7028.33.3.260

22 Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts http://www.apa.org/about/governance/council/policy/sexual-orientation.aspx <17 June, 2011>

23 Maxmen,J.S., Ward,N.G., Kilgus, M (2009) Essential Psychopathology and its Treatment.
Full quote: "While many mental health care providers and professional associations have expressed considerable scepticism that sexual orientation could be changed with psychotherapy and also assumed that therapeutic attempts at orientation would produce harm, recent empirical evidence demonstrates that homosexual orientation can indeed be therapeutically changed in motivated clients, and that reorientation therapies do not produce emotional harm when attempted (eg Byrd and Nicolsi, 2002: Byrd et al., 2008; Shaeffer et al., 1999; spitzer, 2003)."

24 Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009)
http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf

25 Royal College of Psychiatrists Position Statement on Sexual Orientation (2010)
http://www.rcpsych.ac.uk/pdf/PS01_2010x.pdf

26 http://www.acc-uk.org/pdfs/BoardStatementDec2012.pdf

[27] Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). Sexual behavior in the human male. Philadelphia: W.B. Saunders.

[28] Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. (1953). Sexual behavior in the human female. Philadelphia: Saunders.

[29] American Psychological Association. (2005). APA policy statements on lesbian, gay, and bisexual concerns. Retrieved July 4, 2008.

[30] Most recently, "Ex Gays? An Extended Longitudinal Study of Attempted Religiously
Mediated Change in Sexual Orientation" APA Sexual Orientation and Faith Symposium. (2009).
http://wthrockmorton.com/wp-content/uploads/2009/08/Jones-and-Yarhouse-Final.pdf

[31] Beckstead, A. Lee, and Morrow, Susan, L. (2004).Conversion Therapies for Same-Sex attracted Clients in Religious Conflict: Context, Predisposing Factors, Experiences, and Implications for Therapy. The Counseling Psychologist 2004 32: 641-650

[32] Nicolosi, J., Byrd, A. D., & Potts, R. W. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. Psychological Reports, 86, 1071-1088.

[33] Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? Two Hundred participants reporting a change from homosexual to heterosexual orientation. Archives of Sexual Behavior, 32, 403-417.

[34] Haldeman, Douglas, C (2010). Reflections of a Gay Male Psychotherapist. Psychotherapy Theory, Research, Practice, Training. American Psychological Association, 2010, Vol. 47, No. 2, 177–185

[35] Doug Haldeman for APA President http://president.drdoughaldeman.com/news/ <6 September 2011>

[36] Haldeman, Douglas .C., (2004). When Sexual and Religious Orientation Collide: Considerations in Working with Conflicted Same-Sex Attracted Male Clients The Counseling Psychologist 2004 32: 691.

[37] Report of the American Psychological Association on Appropriate Therapeutic Responses to Sexual Orientation (2009) :18 http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf

[38] Yarhouse, Mark A.; Burkett, Lori A.(2002). An inclusive response to LGB

and conservative religious persons: The case of same-sex attraction and Behavior. Professional Psychology: Research and Practice, Vol 33(3), Jun 2002, 235-241.

39 Report of the American Psychological Association on Appropriate Therapeutic Responses to Sexual Orientation (2009) :18 http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf

40 UK Council for Psychotherapy,(2009) Ethical Principles and Code of Professional Conduct. General Ethical Principles 1.2., p 3.

41 UK Council for Psychotherapy,(2009) Ethical Principles and Code of Professional Conduct. GeneralEthical Principles 1.7., p 3.

42 UK Council for Psychotherapy, (2009) Ethical Principles and Code of Professional Conduct. Diversity and Equality. 2.1; 2.2 p. 4.

43 UK Council for Psychotherapy, (2009) Ethical Principles and Code of Professional Conduct. Diversity and Equality. 2.1; p. 4.

44 Yarhouse, Mark A.; Burkett, Lori A.(2002). An inclusive response to LGB and conservative religious persons: The case of same-sex attraction and Behavior. Professional Psychology: Research and Practice, Vol 33(3), Jun 2002, 235-241.

45 Beckstead, A. Lee, and Morrow, Susan, L. (2004).Conversion Therapies for Same-Sex attracted Clients in Religious Conflict: Context, Predisposing Factors, Experiences, and Implications for Therapy. The Counseling Psychologist 2004 32: 641-650

46 Throckmorton, W and Yarhouse Mark, A (2006). Sexual Identity Therapy: Practice Framework for Managing Sexual Identity Conflicts. http://sitframework.com/wp-content/uploads/2009/07/sexualidentitytherapyframeworkfinal.pdf <23

47 Haldeman, Douglas .C., (2004). When Sexual and Religious Orientation Collide: Considerations in Working with Conflicted Same-Sex Attracted Male Clients The Counseling Psychologist 2004 32: 691.

48 Bieschke, K. J., and Dendy, A. "Using the Ethical Acculturation Model as a Framework for Attaining Competence To Work With Clients Who Identify as Sexual Minorities", in Focus on Ethics, Barnett, J

49 Greene, B. (1994) Ethnic Minority Lesbians and gay men: Mental Health and Treatment issues. Journal of Consulting and Clinical Psychology, 62(2), 243-251.

[50] UKCP statement on the 'reparative' therapy of members of sexual minorities – February 2010. http://www.psychotherapy.org.uk/article1260.html <17 June, 2011>

[51] Moberly, E. Homosexuality: A New Christian Ethic. Lutterworth Press; Reprint edition