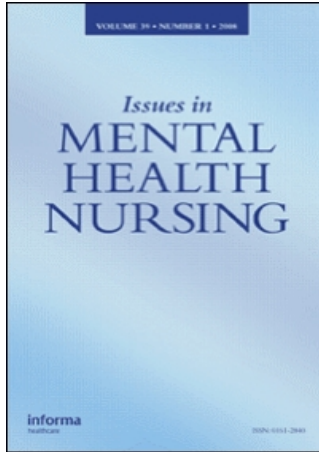


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Nursing Implications in the Application of Conversion Therapies on Gay, Lesbian, Bisexual, and Transgender Clients

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NURSING IMPLICATIONS IN THE APPLICATION OF CONVERSION THERAPIES ON GAY, LESBIAN, BISEXUAL, AND TRANSGENDER CLIENTS

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Conversion therapies, also known as reparative therapies, emphasize homosexual orientations as psychopathology in gay, lesbian, bisexual, and transgender (GLBT) clients and claim these individuals can reverse their sexual orientation through psychiatric counseling and treatment. Although professional medical and nursing organizations have branded psychiatric interventions designed to change an individual's sexual orientation as unethical, an international movement fueled largely by religious organizations promote such therapies for GLBT persons. This article explores the historical perceptions of homosexuality as psychiatric pathology, efficacy of conversion-based therapies in the changing of clients' homosexual orientations to heterosexual, positions of professional medical and nursing organizations regarding the use of conversion therapies, and ethical considerations these types of therapies pose for psychiatric and mental health nurses.

HISTORICAL PERCEPTIONS OF HOMOSEXUALITY AS PSYCHIATRIC PATHOLOGY

While societal homophobia, heterosexism, and homonegativity are well documented in social science literature, defining their precise

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etiologic mechanisms is difficult. Critical inquiries have shown a strong correlation between a Christian religious identification, male gender, belief in the “free choice” model of homosexuality (the thinking that gays and lesbians choose their sexual orientation), and other variables such as lack of association with gays, lower educational levels, and high regard for traditional family ideologies and structures with homonegative attitudes and discrimination (Blackwell & Dziegielewski, 2005; Blackwell, Dziegielewski, & Jacinto, 2006; Blackwell, Ricks, & Dziegielewski, 2004; Crawford, McLeod, Zamboni, & Jordan, 1999; Lim, 2002; Rivers, 2002; Swigonski, 2001).

Research has positively correlated religious association with homophobia (Berkman & Zinberg, 1997; Dennis, 2002; Ellis, Kitzinger, & Wilkinson, 2002; Finlay & Walther, 2003; Herek, 1988, 2000a, 2002a; Herek & Capitanio, 1995; Herek & Glunt, 1993; Lewis, 2003; Petersen & Donnerwerth, 1998; Plugge-Foust & Strickland, 2001; Wilson & Huff, 2001). As Swigonski (2001) indicates, “Hebrew and Christian scriptures have been used to characterize GLBT persons as moral transgressors, as individuals who stand outside the cloak of protection of human rights” (p. 34). Religious conservatism and liberalism play a significant role; support for gay rights varies by religion, with Jews most accepting and born-again Protestants the most disapproving (Lewis, 2003). Heterosexuals self-identifying with a fundamentalist religious denomination typically manifest higher levels of sexual prejudice than do non-religious and members of liberal denominations (Herek, 2000b; Herek & Glunt, 1993).

Perhaps some of the etiology for hatred and homophobia towards gays is rooted in psychological science itself (Morrow, 2001). Freud’s psychoanalytic theory was dominant in the psychological literature well into the 1960s (Morrow, 2001). Psychoanalysis claimed that homosexuals were in arrested development, representing a fixation in the Oedipal stage of psychosexual development. This theoretical viewpoint led to the widely-viewed belief that homosexuality was pathological and resulted from dysfunctional parent-child relationships (Morrow, 2001). More specifically, this postulate proposes that male homosexuals develop their sexual orientation through a perpetual search for a lost male identity (Nicolosi, 1997; Socarides, 1978); gay males form a female gender identity as a result of cold and distant relationships with their fathers (Nicolosi, 1997; Socarides, 1978).

Psychoanalysis places the development of homosexual orientations as primitive ego defense mechanisms that manifest through behavioral, emotional, and psychological sexualization (Nicolosi, 1997; Socarides, 1978). Nicolosi (1997) termed this pathology as gender identity deficit.

Female homosexuality also was classified as pathological in development. Psychoanalytic theories claimed that lesbians developed their homosexual orientation out of dysfunctional parent-child relationships and child sexual abuse (Cianciotto & Cahill, 2006). Homosexuality was listed as a mental illness in the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM)* through edition two (*DSM-II*) (Spitzer, 1981).

Using this social construction of homosexuality as anomalous, many lesbians and gays living in the first half of the twentieth century were afraid to disclose their sexual orientation or "come out," out of a fear of being institutionalized as mentally ill (Morrow, 2001). Popular literature of this era (for example *Time*, *Look*, *News Week*, and *Life*) negatively portrayed gay males (usually ignoring lesbians entirely). In her comprehensive analysis of *Time* and *News Week* between the years of 1947 through 1997, Bennet (2000) found the magazines published just two articles about homosexuals in the 1940s, 21 in the 1950s, and 25 in the 1960s. She concluded that nearly every article was resoundingly critical of gays and lesbians both in language and content. Second-hand sources, such as military, law enforcement, government officials, and psychiatrists largely served as their sources (Bennet, 2000). Gay or lesbian people were rarely quoted—mostly because they were afraid to identify themselves (Bennet, 2000).

The House UnAmerican Activities Committee (in conjunction with McCarthy) persecuted lesbians and gays—tagging them as threats to the stability of the country (Morrow, 2001). At the conclusion of World War II, the United States military began discharging gays and lesbians and openly prevented them from serving. Lesbians and gays were involuntarily released from military services. Their dismissals were classified as "undesirable" discharges which precluded their receiving future military benefits and damaged their reputations for seeking employment in the civilian sector. The military infused mandatory lectures on the pathology of homosexuality in the training of new military troops (Morrow, 2001).

As psychological research regarding human sexuality began to proliferate in the late 1960s and early 1970s, the perceptions of homosexuality as a mental disease began to erode (American Psychiatric Association [APA], 2006a). Emerging literature and experts on human sexuality began to support the notion that a homosexual orientation did not meet criteria to maintain its classification as a mental illness. Consequently, in 1973, the APA removed homosexuality from its list of sexual disorders (APA, 1973, 2006b). The APA contends that no strong evidence exists that point to the etiology of heterosexuality, homosexuality, or bisexuality (APA, 2006b).

Furthermore, it asserts that theories indicating homosexuality as the result of troubled family dynamics or faulty psychological development are currently considered to have been based on misinformation and prejudicial bias (APA, 2006b). No specific psychosocial or family dynamic cause for homosexuality has ever been identified; histories of childhood sexual abuse do not correlate with the development of gay, lesbian, or bisexual identities (APA, 2006b). As Robinson (2006) highlights, if theories supporting faulty son-father relationships as the cause of homosexuality in males were correct, there should have been a large surge in the percentage of homosexual orientations among children born shortly before World War II (1941–1945), as many boys were deprived of their fathers during these formative years.

Second, the incidence of homosexuality should be much higher in African Americans; a much larger percentage of African American children are brought-up in a single-parent family in which a father is absent (Robinson, 2006). No data exist which support either of these phenomena (Robinson, 2006). Current data indicate that development of a homosexual orientation probably has strong biological ties. Differences in postmortem brain morphology between heterosexual and homosexual males, genetic predisposition and genotyping of heterosexual versus homosexual samples, and early considerable differences in associative gender development have all been supported in the literature as at-least partial causative agents (Bailey & Pillard, 1991; Bailey, Pillard, Neale, & Agyei, 1993; Bell, Weinberg, & Hammersmith, 1981; Comperio-Ciani, Corna, & Capiluppi, 2004; LeVay, 1991; Zastrow & Kirst-Ashmon, 1997).

Research supporting an element of socialization in the development of sexual orientation focuses on the scarce data derived from prison samples (Van Wormer, Wells, & Boes, 2000). This data suggests that some homosexual sexual behaviors first learned in the prison environment perpetuate into life outside of prison; males who received anal sex during incarceration were much more likely to continue this sexual activity once returned to the general population than those males who actually penetrated other males (Van Wormer et al., 2000). The current dominant theory of causality in the social science literature is termed interaction theory, which proposes that a homosexual orientation results from both biological and psychosocial input variables (Van Wormer et al., 2000).

So while current psychiatric clinical thought supports that homosexuals do not have pathology in need of treatment, mental health interventions and counseling techniques are still employed by reparative therapists who maintain that homosexuality is a disease in need of

curing (Bright, 2004). Critical analyses of the efficacy of these treatment regimens have yielded no evidence-based effectiveness in the ability of therapy to convert homosexual orientations to heterosexual orientations. In addition, there are data that suggest these clinical interventions may actually cause psychological, social, and interpersonal damage to GLBT clients (APA, 2006b; Bright, 2004; Cianciotto & Cahill, 2006; Drescher, 2006).

EFFICACY OF CONVERSION-BASED THERAPIES

Conversion therapists apply various methods in different combinations (Steigerwald & Janson, 2003), some of which include long-term psychoanalytic therapy in attempt to solve unconscious childhood conflicts believed to be the etiology of one's homosexuality, group social demand treatments, heterosexual responsiveness instruction, aversion conditioning, social learning training, covert sensitization, fantasy modification, capacity for heterosexual intercourse, training for abstinence and celibacy, drug treatment, and fundamental spiritual treatments (Haldeman, 1994; Steigerwald & Janson, 2003). While longitudinal critical assessments of the efficacy of conversion therapies are scarce, perhaps the most exhaustive inquiry was that of Shidlo and Schroeder (2002). These psychologists conducted a seven-year study (Cianciotto & Cahill, 2006) analyzing the overall effectiveness of conversion-based therapies in changing clients' homosexual orientation to heterosexual. With a sample size of 202, participants were asked to gauge their degree of homosexuality using a modified Kinsey Scale, where a score of 1 indicated a complete heterosexual orientation and a 7 indicated a complete homosexual orientation; only those scoring greater than 5 were included in the study. These clients were asked to provide information regarding their sexual orientation (a) before the first conversion intervention, (b) immediately after the intervention (and after the second and third interventions), and (c) at the time of the interview (Shidlo & Schroeder, 2002).

Results indicated that of the 202 participants who had participated in conversion therapy, only 26 (13%) believed they had a self-perceived successful change from a homosexual to heterosexual orientation (Shidlo & Schroeder, 2002). It is important to note, however, that only 8 of these 26 individuals reported they were not experiencing occurrences of "slips" (Cianciotti & Cahill, 2006, p. 5) or not requiring a need for coping mechanisms to control their same-sex behaviors or attractions. Perhaps even more striking, of these eight individuals, seven were

current providers of ex-gay counseling and four out of those seven held paid-positions as ex-gay counselors (Shidlo & Schroeder, 2002). In conclusion, these researchers indicated that only 4% of their sample could be classified as having the self-perception of a complete transformation from homosexual to heterosexual orientation.

Data collected by Spitzer (2003) supported a higher percentage of success rates with conversion therapies. Spitzer assessed participants' same sex attraction, fantasy, yearning, and overt homosexual behavior the year prior to receiving therapy compared to the year before being interviewed. The majority of participants indicated a change from a primarily homosexual orientation pre-therapy to a primarily heterosexual orientation in the past year (Spitzer, 2003). Females reported significantly more change than males. However, Spitzer (2003) concluded that reports of complete change (11% for males and 37% for females) were uncommon.

Perhaps of more significance is the intense scrutiny and inquiry into Spitzer's study following its publication in the *Archives of Sexual Behavior*. Post-analyses by Spitzer's peers revealed significant problems in his study's methodology and his interpretation of the results (Cianciotti & Cahill, 2006; Sandfort, 2004; Silverstein, 2004). Gregory Herek (2003), who has been widely published in the literature pertaining to GLBT psychology and prejudice (Altschiller, 1999), reported four major flaws in Spitzer's (2003) study: "(1) his uncritical reliance on self-reports from a highly select sample of activists from groups whose *raison d'être* is to promote efforts to change homosexuals into heterosexuals; (2) the inability of his method to determine whether changes in sexual orientation—if indeed they occurred in his sample—were due to an intervention, rather than other factors; (3) his inattention to the potential harm inflicted by interventions attempting to change sexual orientation; and (4) his insensitivity to the antigay political agenda of groups promoting such interventions" (Herek, 2006). His final conclusion was that Spitzer's study was methodologically flawed and disturbingly silent about ethical concerns (Herek, 2006).

In summary, the American Psychiatric Association maintains there is no published scientific evidence supporting the efficacy of conversion therapies as a treatment to change sexual orientation. Finally, regarding the safety and efficacy of conversion therapies, Robinson (2006) has found four unifying themes: (1) None are currently accepted by most therapists; (2) None were accepted by most therapists at any time in the past; (3) All are, or have been, widespread forms of therapy by a minority of therapists or clergy; and (4) None have been meaningfully researched and shown to be helpful (Robinson, 2006).

Strong evidence indicates the effects of these therapies on GLBT clients can be harmful and damaging and in fact, result in serious psychological trauma to clients (APA, 2006b; Beckstead & Morrow, 2004a; Bright, 2004; Cianciotto & Cahill, 2006; Phillips, 2004; Shidlo, & Schroeder, 2002; Steigerwald & Janson, 2003; Tozer & Hayes, 2004; Tozer & McClanahan, 1999; Worthington, 2004). As a consequence, many professional organizations have branded conversion therapies as unethical. These organizations include but are not limited to the American Psychiatric Association, American Academy of Pediatrics, American Medical Association, American Counseling Association, National Association of School Psychologists, National Association of Social Workers, and the Royal College of Nursing. Appropriate to this discussion, the position statements of the American Psychiatric Association, American Psychological Association, and Royal College of Nursing are provided.

POSITIONS OF PROFESSIONAL MEDICAL AND NURSING ORGANIZATIONS REGARDING THE USE OF CONVERSION THERAPIES

Due to the ethical implications of conversion therapies, several professional organizations have drafted position policies regarding their use in clinical practice. The American Psychiatric Association (APA) identifies its position as follows:

As a general principle, a therapist should not determine the goal of treatment either coercively or through subtle influence. Psychotherapeutic modalities to convert or “repair” homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of “cures” are counterbalanced by anecdotal claims of psychological harm. In the last four decades, “reparative” therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, APA recommends that ethical practitioners refrain from attempts to change individuals’ sexual orientation, keeping in mind the medical dictum to first, do no harm. (APA, 2006b, para. 7)

Like the APA, the American Psychological Association also brands conversion therapy as unethical. Specifically, the American Psychological Association:

opposes portrayals of lesbian, gay, and bisexual youth and adults as mentally ill due to their sexual orientation and supports the dissemination

of accurate information about sexual orientation, and mental health, and appropriate interventions in order to counteract bias that is based in ignorance or unfounded beliefs about sexual orientation. (American Psychological Association, 1999, p. 6)

In 1999, the American Psychological Association partnered with the American Academy of Pediatrics, American Counseling Association, American Association of School Administrators, American Federation of Teachers, American School Health Association, Interfaith Alliance Foundation, National Association of School Psychologists, National Association of Social Workers, and National Education Association to publish *Just the Facts about Sexual Orientation and Youth: A Primer for Principals, Educators, & School Personnel*. This technical report provides extensive information regarding sexual orientation issues in youth and asserts that conversion therapies are based in outmoded psychological theories and have been soundly rejected by all major health and mental health professions.

Neither the American Nurses Association (ANA) or American Psychiatric Nurses Association currently propose a practice policy position regarding the application of conversion therapies by nurses practicing in mental health. A comprehensive analysis of nursing organization positions regarding conversion therapies yields only one nursing organization with such a position statement policy. The Royal College of Nursing (RCN), “represents nurses and nursing, promotes excellence in practice, and shapes health policies” within England, Northern Ireland, Scotland, and Wales (RCN, 2006, para. 1). RCN has developed practice guidelines for mental health nurses working with gay and lesbian clients and has denounced conversion therapy (Ryan & Rivers, 2003).

RCN partnered with Unison, the trade union for public sector workers, in 2004 to author *Not Just a Friend*, a guideline for nurses treating lesbian, gay and bisexual clients (RCN, 2004). Within this publication, conversion therapy is never given attention while mental health issues for these clients are discussed. Several guidelines support nursing advocacy in mental health services, particularly as it relates to equal access to care and challenging prejudicial treatment in mental health services (RCN, 2004). While educational, psychological, psychiatric, and social work professional bodies have strongly condemned conversion therapies, the dearth of American nursing organization positions suggests the need for progressive evidenced-based policy development within professional nursing organizations, particularly those within the United States.

ETHICAL CONSIDERATIONS FOR THE MENTAL HEALTH/PSYCHIATRIC NURSE

American nursing organizations have remained relatively silent regarding the application of conversion therapies to reverse GLBT clients' sexual orientations, and no data exist that have assessed the number of nurses who may be practicing conversion therapy. Regardless, there are numerous ethical violations this therapy imposes in mental health and psychiatric nursing. Although the American Nurses Association (ANA) Code of Ethics does not explicitly cite ethical considerations regarding clients' sexual orientations, it does specifically outline the responsibility of the nurse in preventing unethical nursing practice (ANA, 2001). Specifically, provision 3 states: "The nurse promotes, advocates for, and strives to protect the health, safety, and the rights of the patient" (ANA, 2006).

The interpretation 3.5 of this provision goes even further in outlining the nurses' responsibility to counter unethical practice:

The nurses' primary commitment is to the health, well-being, and safety of the patient across the life span and in all settings in which health care needs are addressed. As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the health care team or the health care system, or any action in the part of others that places the rights or best interests of the patient in jeopardy. (ANA, 2006, para. 1)

The harms of conversion therapies have been well-documented in the literature (APA, 2006b; Beckstead & Morrow, 2004a; Bright, 2004; Cianciotto & Cahill, 2006; Phillips, 2004; Shidlo, & Schroeder, 2002; Steigerwald & Janson, 2003; Tozer & Hayes, 2004; Tozer & McClanahan, 1999; Worthington, 2004). Critical inquiry into the effects of conversion therapies has revealed several ominous findings of ethical significance (Drescher, 2006). While the efficacy of successful conversion from homosexual to heterosexual orientations in clients has already been scrutinized, a comprehensive literature review conducted by Cianciotto and Cahill (2006) cited several adverse psychological effects in clients who had undergone conversion therapies.

Depression, suicidal ideation, and suicide attempts are often reported in these clients (Drescher, 2006). Shidlo and Schroeder (2003) found in their study that 11 clients attempted suicide after undergoing conversion therapy; only 3 of these clients had previously made such attempts. Feelings of decreased self-esteem and increased feelings of internalized homophobia (self-hatred of one's own homosexual orientation and

homosexuality) also have been found (Drescher, 2006; Shidlo & Schroeder, 2003). The increased prevalence of these emotions arise from repetitive negative false and defamatory information regarding homosexuality conveyed by conversion therapists (Cianciotto & Cahill, 2006).

Clients who undergo conversion therapy also have higher incidences of a distorted perception of homosexuality; some conversion therapists emphasize some, if not all, negative experiences and life events with the client's homosexuality (Cianciotto & Cahill, 2006; Shidlo & Schroeder, 2003). This can lead to the false notion that if a client is able to change his or her sexual orientation, the other problems in his or her life also will disappear (Cianciotto & Cahill, 2006; Shidlo & Schroeder, 2003). Conversion therapies also can cause intrusive imagery and sexual dysfunction in clients (Cianciotto & Cahill, 2006; Shidlo & Schroeder, 2003). Part of conversion therapy is imagining a member of the opposite sex while a client engages in same-sex activities. This can impede later sexual relationships, causing impotence or failure to achieve orgasm, due to traumatic imagery during subsequent same-sex sexual activities (Cianciotto & Cahill, 2006; Drescher, 2006; Shidlo & Schroeder, 2003).

Paranoia resulting from feelings of inadequate gender role expression (overt attempts for males to express highly masculine or females to express highly feminine personality traits) also has been demonstrated in post-conversion therapy clients (Cianciotto & Cahill, 2006; Shidlo & Schroeder, 2003). Clients became overly preoccupied with their speech and mannerisms in an attempt to "pass" as heterosexual (Cianciotto & Cahill, 2006; Shidlo & Schroeder, 2003). Perhaps equally damaging as the psychological harm caused by conversion therapies are the consequent social and interpersonal harms clients experience.

Some conversion therapists place blame on an individual's parents for the development of their homosexual orientation, resulting in significantly strained interpersonal relationships between the son or daughter with his or her mother or father (Cianciotto & Cahill, 2006; Shidlo & Schroeder, 2003). In addition, alienation, loneliness, and social isolation; difficulty in establishing intimate relationships; loss of social supports when entering and leaving the ex-gay community; fear of becoming an eventual pedophile; and interruption of developmental tasks due to delayed acceptance of a homosexual orientation and identity have all been documented in the literature (Cianciotto & Cahill, 2006; Drescher, 2006; Shidlo & Schroeder, 2003).

While no strong scientific data exist which support the longitudinal efficacy of conversion therapies in successfully reversing a client's homosexual orientation to heterosexual (Herek, 2006; Robinson, 2006), much data suggest these therapies cause significant psychological, social, and

interpersonal harms (APA, 2006b; Beckstead & Morrow, 2004a; Bright, 2004; Cianciotto & Cahill, 2006; Phillips, 2004; Shidlo, & Schroeder, 2002; Tozer & Hayes, 2004; Tozer & McClanahan, 1999; Steigerwald & Janson, 2003; Worthington, 2004), resulting in the branding of such therapies as unethical by a multitude of professional organizations.

Because the ANA specifically prohibits the nurse in participating in any unethical practice and stresses the significance of the nurse in remaining alert to and taking appropriate action against any instances of incompetent, unethical, illegal, or impaired practice or action that places the rights or best interests of the patient in jeopardy (ANA, 2006), it can be concluded that nurses who apply conversion therapy principles or who attempt to reorient a client's sexual orientation through psychiatric interventions are, in fact, violating the ethical duties of the profession.

SUMMARY AND CONCLUSION

This article has discussed the historical perceptions of homosexuality as psychiatric pathology, the efficacy of conversion-based therapies in the changing of clients' homosexual orientations to heterosexual, positions of professional medical and nursing organizations regarding the use of conversion therapies, and ethical considerations these types of therapies pose for psychiatric and mental health nurses. As client advocates, nurses need to embrace the diversity of their clients and ensure the self-dignity, uniqueness, and inherent worth of every individual are respected, promoted, and protected (ANA, 2006).

Further research assessing the ethical considerations conversion therapies have in psychiatric and mental health nursing is desperately needed by nursing scholars. In addition, nurses need to be mental health leaders in establishing optimal evidence-based practice guidelines for treatment of GLBT individuals experiencing psychiatric or psychosocial distress. Professional nursing organizations should recognize the role of the nurse in preventing unethical mental health practice and draft strongly worded professional policy statements discouraging the application of conversion therapies on GLBT clients. Nurse educators should reinforce sexual orientation issues in nursing curriculum and promote tolerance and acceptance of GLBT clients in every facet of nursing practice (Blackwell, 2005).

Nurses have a unique opportunity to serve as true client advocates when working with underserved and disparate aggregates of individuals. Most nurses believe GLBT people should have their rights protected and support policies to diminish potential discrimination (Blackwell, 2005). Promoting physical, mental, and spiritual health among clients is a great

responsibility nurses hold close in their daily interactions with clients. Not only does this entail a personal choice and fulfilling duty, but a standard of practice that nurses are ethically accountable for as well.

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