Imagine for a moment that you are an anxious person and that being anxious is against the law. You must try to hide your fears from others. Your own home may be a safe place to feel anxious, but a public display of apprehension can lead to arrest or at least to social ostracism. At work one day an associate looks at you suspiciously and says, "That's funny. For a crazy moment there I thought you were anxious." "Heck no," you exclaim a bit too loudly, "not me!" You begin to wonder if your fellow worker will report his suspicions to your boss. If he does, your boss may inform the police, or will at least change your job to one that requires less contact with customers, especially with those who have children.

There are many parallels between the way an anxious person is treated in this seemingly improbable fantasy and the recent (if still not current) plight of homosexuals. Sexual attraction among members of the same sex has been amply documented throughout recorded history in many different cultures. In many societies homosexual practices have been suppressed by harsh laws; indeed in some states of contemporary America laws exist by which homosexuals can be arrested and imprisoned, although not all these statutes are rigidly enforced. Never have societal sanctions eliminated homosexuality, nor does it seem likely that they could. The widespread prevalence of homosexuality, even though such practices are often threatened by punishment, has led some workers to believe that this aspect of sexuality is, in some important way, part of human nature.

Recent years have seen a growing liberalization of views on adult human sexual conduct. One of the earliest progressive statements was issued in 1974 by the Association for Advancement of Behavior Therapy on my initiative while I was president of the group.

The AABT believes that homosexuality is in itself not a sign of behavioral pathology. The Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been attributed to these patterns of emotion and behavior. While we recognize that this long-standing prejudice will not be easily changed, there is no justification for a delay in formally according these people the basic civil and human rights that other citizens enjoy.

Several other professional groups, including the American Psychological Association and the American Psychiatric Association, also moved away from an illness view of homosexuality. Indeed the third edition of the American Psychiatric Association's official nomenclature, DSM-III (American Psychiatric Association, 1980), included homosexuality only under a special rubric, "ego-dystonic homosexuality," a diagnosis to be applied when a person was troubled by his or her homosexual inclination (note that DSM-III belied its continuing bias by not having an ego-dystonic heterosexuality category). And the current version, DSM-III R, dropped even this residual diagnosis, adding a category that is nonspecific with respect to the gender of the person one is sexually attracted to, namely, Sexually Disorder Not Otherwise Specified. And the current edition of the American Psychiatric Association's official nomenclature, DSM-III R, dropped even this residual diagnosis, adding a category that is nonspecific with respect to the gender of the person one is sexually attracted to, namely, Sexually Disorder Not Otherwise Specified, defined by the presence of "persistent and marked distress about one's sexual orientation" (American Psychiatric Association, 1987, p. 296, revised from 1980). Silverstein, in this volume, describes the historical, social, and political context of diagnosis.

As encouraging as these developments have been to those committed to removing the stigma of homosexuality, a less obvious but perhaps even more important political and ethical issue must be addressed, namely, the availability of therapeutic regimens for shifting sexual orientation from same-sex to opposite-sex partners. The following may illustrate this predicament:

API (Apocryphal Press International). The governor recently signed into law a bill prohibiting discrimination in housing and job opportunities on the basis of membership in a Protestant church. This new law is the result of efforts by militant Protestants, who have lobbied extensively during the past ten years for relief from institutionalized discrimination. In an unusual statement accompanying the signing of the bill, the governor expressed the hope that this legislation would contribute to greater social acceptance of Protestantism as a legitimate, albeit unconventional, religion.

At the same time, the governor authorized funding in the amount of two million dollars for the coming fiscal year to be used to set up within existing mental health centers special units devoted to research into the most effective and humane procedures for helping Protestants convert to Catholicism or Judaism. The governor was quick to point out, however, that these efforts, and the therapy services that will accompany and derive from them, are not to be imposed on Protestants, rather are only to be made available to those who express the voluntary wish to change. "We are not in the business of forcing anything on these people. We want only to help," he said.

THE MYTH OF THERAPEUTIC NEUTRALITY

My basic premise is, to paraphrase Halleck (1971), that therapists never make ethically or politically neutral decisions: "Any type of psychiatric intervention, even when treating a voluntary patient, will have an impact upon the distribution of power within the various social systems in which the patient moves. The radical therapists are absolutely right when they insist that psychiatric neutrality is a myth" (1971, p. 13).

The very naturalness of what therapists agree to do with particular kinds of cases tends to blind them to their prejudices and biases. Surely no ethical issues are worth discussing when one helps a severely disturbed child to stop banging his head against the wall. But this is an extreme case, and I suggest that most of what therapists deal with falls into that important gray area in which biases play a controlling role in what is done. This seems to be particularly the case in the approach to those people who have homosexual behavior or feelings. In spite of the apparent decline in requests for change of sexual orientation (Rosen & Beck, 1988), I would suggest that most therapists by and large still regard homosexual behavior and attitudes to be undesirable, sometimes pathological, and at any rate generally in need of change toward a heterosexual orientation. Indeed, homophobia continues to be prevalent among both lay and professional people (Forstein, 1988). If therapists are less busy trying to discourage people from homosexual practices than they were twenty years ago, I would argue that this is due to fewer people seeking such alteration. Thus, while much has changed since I first set forth these arguments in an address to the Association for Advancement of Behavior Therapy (Davison, 1974), there are issues, some of them not specific to homosexuality, that merit review and analysis.
SOME RELEVANT AND IRRELEVANT ISSUES SURROUNDING HOMOSEXUALITY

Allow me to mention briefly some exclusions that I hope will be obvious. I am not talking about homosexual behavior that is part of a psychotic pattern of existence. For example, the male who has the delusion that he is Marie Antoinette intent on seducing every available 20th-century man would be exhibiting a pattern of sexual behavior that is best viewed as part of an unfortunate psychotic aberration. I would similarly not want to conclude that heterosexuality is sick because there are male schizophrenics who chase female nurses and try to fornicate with them in hospital dayrooms.

There is something else implicit in what I will be saying, so let me make it explicit at this juncture. Though I will often be referring to "homosexuals," I am in agreement with investigators such as Kinsey Pomeroy, and Martin (1948) and Churchill (1967), who construe sexual preference as a continuum on which people can be placed according to the relative frequencies of their homosexual-heterosexual fantasies, feelings, and behavior. Clearly the available survey data strongly indicate that a significant number of human beings lie between the extremes of exclusive homosexuality and exclusive heterosexuality.

In any discussion of homosexuality in therapy, the question of the normality of homosexual preference has often been raised. Many studies have failed to find differences between heterosexuals and homosexuals (see Evans, 1970; Gagnon & Simon, 1973; and Chapter 8 in this volume). However, some point out the oft-cited data of Bieber et al. (1962) and to a conceptual replication by Evans (1969) as evidence supporting a pathology view of homosexuality. There are a number of serious flaws in the Bieber study, not the least of which is that the male homosexuals were all in therapy. However, there is also a major logical error in reasoning, namely, that one has demonstrated pathology of homosexuality by showing that male homosexuals have childhood experiences that are different from those of male heterosexuals. The fact is that one cannot attach a pathogenic label to a pattern of child-rearing unless one a priori labels the adult behavior pattern as pathological. For example, Bieber et al. (1962) found that what they call a "close-binding intimate mother" was present much more often in the life of the analytic patient. In a similar vein, male homosexual patients than among the heterosexual controls.

There is another issue worth discussing. Many people point to problems in homosexual relationships, prompting the conclusion that homosexuality could not possibly be normal. To such objections I would reply that homosexuals who suffer in poor relationships do not have a monopoly on stormy interpersonal functioning. Simply because there is so much marital discord in this country, one seldom hears people concluding that heterosexuality is inherently bad. What I am suggesting is that clinicians might perhaps pay more attention to the quality of human relationships rather than to the particular gender of the adult partners (see Chapter 12 in this volume for elaboration). If one follows this further, we might consider a shift in focus with homosexuals that pays little attention to the fact that the partners are the same sex and more attention to the kind of relationship a person is in and how that relationship might be improved. Naturally, when therapeutic efforts are aimed in this direction, I believe one inevitably ends up having to deal with the considerable legal and social oppression of these groups of people.

NO CURE WITHOUT A DISEASE

I believe that clinicians spend time developing and analyzing procedures only if they are concerned about a problem. It seems very much the case with homosexuality. And yet, consider the rhetoric that typically speaks of social labeling of behavior rather than viewing a given behavior as intrinsically normal or abnormal. Consider also the huge literature on helping homosexuals (at least males) change their sexual preference (reviewed and critiqued in this volume by Haldeman) and the paucity of literature aimed at helping the labelers change their prejudicial biases and encouraging the homosexual to develop as a person without changing orientation. How can therapists honestly speak of nonprejudice when they participate in therapy regimens that by their very existence-and regardless of their efficacy-would seem to condone the current societal prejudice and perhaps also impede social change?

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behavior,” since treatment may be offered for it. As a consequence of this therapeutic stance, as well as a wider system of social and attitudinal pressures, homosexuals tend to seek treatment for being homosexuals. Heterosexuals, on the other hand, can scarcely be expected to seek voluntary treatment for being “heterosexual,” especially since all the social forces arrayed—including the unavailability of behavior therapy for heterosexuality—attest to the acknowledgment of the idea that whatever “problems” heterosexuals experience are not due to their sexual orientation. The upshot of this is that contrary to the disclaimer that behavioral therapy is “not a system of ethics” (Bandura, 1969, p. 87), the very act of providing therapeutic services for homosexual “problems” indicates otherwise. (p. 180)

I suggest further that the availability of a technique encourages its use. For example, many behavior therapists who have good clinical success with systematic desensitization and who are also persuaded by the experimental literature that it is useful for reducing anxiety try to conceptualize client problems in terms of this technique. Thus, social isolation might be viewed at least in part as a consequence of unnecessary sensitivities that themselves could be translated into an anxiety hierarchy. By the same token, I would suggest that the extensive clinical and experimental work in aversion therapy (for example, Feldman & MacCulloch, 1971), or “Playboy therapy” (see Davison, 1968), or heterosexual-heterosexual skills training channel the assessment and problem-solving activities of behavioral clinicians into working to change sexual orientation and to persuade homosexual clients that this is a worthwhile goal. Why else would they be spending so much time working on the techniques?

CLINICAL PROBLEMS
AS CLINICIANS’ CONSTRUCTIONS

This issue can be usefully placed in the context of clinical assessment. As I have argued elsewhere (e.g., Davison & Neale, 1990; Goldfried & Davison, 1976), clients seldom come to mental health clinicians with problems as clearly delineated and independently verifiable as what a patient brings to a physician. The latter practitioner/scientist has better data on which to make a diagnosis (and yet even here reliability is far from perfect). In contrast, a client usually goes to a psychologist or psychiatrist in the way described below by Halleck (1971). That is, the client is unhappy; his life is going badly; nothing seems to be meaningful; she’s depressed more than her life circumstances would seem to warrant; his mind wanders when he tries to concentrate; unwanted images intrude on her consciousness or in her dreams. The clinician transforms these often vague and complex complaints into a diagnosis or assessment, a set of ideas about what is wrong and, usually, what might be done to alleviate what is wrong. I would argue, then, that psychological problems are for the most part constructions of the clinician: our clients come to us in pain, and they leave with more clearly defined problems that we assign to them.

My argument has been that when homosexuals go to a therapist, whatever psychological or physical woe they may have has all too often been construed as being caused entirely or primarily by their sexual orientation. Further, I have suggested that this happens because (a) their sexual orientation is usually the most salient part of their personhood, and/because (b) it is regarded as abnormal-regardless of whatever “liberal” stance the clinician takes overtly. This is not to say that a homosexual orientation may not sometimes cause people distress! Rather, it is to say that this salient feature of their personality—because it is negatively sanctioned, still, even with the advances made in DSM-IIIR and elsewhere in the professional literature—colors the clinician’s perceptions and guides his or her data-gathering activities in a direction that implicates homosexuality and implies the desirability of a change in sexual orientation.

This is of course a very difficult proposition to verify, and it causes an empirical, cognitive-behavioral clinician like myself not a little discomfort, but I believe there is a body of data on clinician bias that presumes what is wrong. In an analogue study conducted some years ago (Davison and Friedman, 1981), we found that descriptions of a hypothetical anxious client elicited judgments of more serious psycho-pathology when it was mentioned (in passing) that the client was homosexual than when he was described as heterosexual. Related findings come from the research of Lopez (Lopez, 1989; Lopez and Hernandez, 1986; Lopez and Nunez, 1987), showing that the stereotypes clinicians have about Hispanics affect their understanding of clinical complaints. The role of subjective factors in perception and problem solving has been acknowledged and demonstrated in experimental psychology since the work of Wundt more than one hundred years ago and confirmed time and again in cognitive psychology, from the “new look” in perception of the 1940s and 1950s (e.g., Bruner & Goodman, 1947) to the schema-oriented work of today in cognitive science (e.g., Neisser, 1976). And in epistemological writings such as Kuhn (1962), paradigms in science are explicitly compared to perceptual biases that affect profoundly the way data are collected and even defined. A generation of thoughtful scientists has been sensitized to the nontrivial influences our often unspoken assumptions have on our organization of the world.
A PROPOSAL ON THERAPY WITH HOMOSEXUALS

These several considerations led me in 1974 to make a proposal that surprised no one more than myself, an idea present for several years in some of the gay activist literature (see especially Silverstein, 1977b): therapists should stop engaging in change-of-orientation therapy programs, whether it was the client requesting it or someone else insisting on it. As Silverstein put it at the 1972 Association for Advancement of Behavior Therapy convention in a discussion of male homosexuality:

To suggest that a person comes voluntarily to change his sexual orientation is to ignore the powerful environmental stress, oppression if you will, that has been telling him for years that he should change. To grow up in a family where the word "homosexual" was whispered, to play in a playground and hear the words "faggot" and "queer," to go to church and hear of "sin" and then to college and hear of "illness," and finally to the counseling center that promises to "cure," is hardly to create an environment of freedom and voluntary choice. The homosexual is expected to want to be changed and his application for treatment is implicitly praised as the first step toward "normal" behavior. What brings them into the counseling center is guilt, shame, and the loneliness that comes from their secret. If you really wish to help them freely choose, I suggest you first desensitize them to their guilt. Allow them to dissolve the shame about their desires and actions and to feel comfortable with their sexuality. After that, let them choose, but not before. I don't know any more than you what would happen, but I think their choice would be more voluntary and free than it is at present. (Silverstein, 1972, p. 4)

In other words, Silverstein suggested that therapists inquire into the determinants of the client asserting that he or she wants to change. He proposed that these determinants may be based on prejudice and ignorance and therefore should not be catered to or even strengthened by an establishment of therapists who offer their services to those clients who "express the wish to change."

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But what, ourld be the consequences of this? Does this not limit the choices available to the person troubled by his sexual orientation? Who is the behavior therapist or psychotherapist to decide for potential clients which options would be available in therapy? To my mind the frankest answer—but one that seems unpalatable to many—has been elaborated by Halleck (1971). Therapists already have made these decisions, perhaps not fully aware of their larger implications. By having worked so diligently and, until recently, exclusively on change techniques, has the mental health establishment not been affirming that the prejudices and laws against certain sexual acts are in fact well founded? What are therapists really saying to clients when, on the one hand, they assure them that they are not abnormal and, on the other hand, present them with an array of techniques, some of them painful, that are aimed at eliminating that set of feelings and behavior that have just been pronounced normal? What is the real range of "free choice" available to homosexually oriented people who are racked with guilt, self-hate, and discrimination? What of the anxieties arising from this discrimination—how have therapists helped them with these problems?

London (1969) suggested that an unappreciated danger in behavior control technology is our increasing ability to engineer what we have regarded as free will. Thus therapists seem to be capable of making people want what is available and what they feel clients should want. Moreover, just because therapists can assert that they are not doing something against the will of their clients does not free them from the responsibility of examining those factors that determine what is considered free expression of intent and desire on the part of our clients.

In a related vein—and this should be familiar not only to therapists but to those who have been clients themselves—Halleck (1971) says:

At first glance, a model of psychiatric practice based on the contention that people should just be helped to learn to do the things they want to do seems uncomplicated and desirable. But it is an unobtainable model. Unlike a technician, a psychiatrist cannot avoid communicating and at times imposing his own values upon his patients. The patient usually has considerable difficulty in finding the way in which he would wish to change his behavior, but as he talks to the psychiatrist his wants and needs become clearer. In the very process of defining his needs in the presence of a figure who is viewed as wise and authoritarian, the patient is profoundly influenced. He ends up wanting some of the things the psychiatrist thinks he should want.

(p. 19)

One might add to Halleck’s caution the fact that clients seldom see a therapist when they are confident of their judgments! The social influence that a therapist wields is all the stronger, given the persuasive, even gullible state most clients would seem to be in.

But is it not harsh and unfeeling to propose that therapists deny a particular client the possibility of losing himself or herself from his or her homosexual attraction and turning him or her on to the other half of the adult population? What about the homosexual client who could conceivably want to switch, not out of societal pressures but out of a sincere desire for those things that in our culture are usually part of the heterosexual package—a spouse and children? Why deny such a person—rare though he or she may be—the opportunity to fulfill such...
desires? Is not the scheme I am proposing a kind of "coercive liberalism," to use London's (1969) phrase? Coercive liberalism goes something like this: I will help you be happier, freer, more fulfilled, etc.—and you will have no choice but to be so according to my standards. By proposing that preference change programs with homosexuals be terminated, I am obviously running this risk. One solution would be simply to accept the risk; this would seem to be consistent with Halleck's views. But another way out of this dilemma is to propose that a concerted program of clinical research be encouraged for the development of maximally effective procedures to help heterosexually oriented people become homosexuality oriented if they really want to. That is, therapists might consider the possibility that many heterosexuals may wish to change, or at least expand, their sexual activities, as some homosexuals may wish to do. Are mental health professionals prepared to devote themselves to this kind of sexual enhancement enterprise? I doubt it.

**NOT CAN BUT OUGHT**

When trying to garner support for my proposal that we should stop trying to change homosexual orientations, I was interested for some time in documenting the failure of various behavior change regimens in eliminating homosexual inclinations. Of particular interest was the question of whether aversion therapy of various kinds has proved effective in stamping out homosexual behavior and inclinations. And indeed, I tend to believe that there is precious little evidence for a suppression of homosexual behavior and inclinations. Nonetheless, even if one were to demonstrate that a particular sexual preference could be modified, there remains the question of how relevant these data are to the ethical question of whether one should engage in such behavior change regimens. The simple truth is that data on efficacy are quite irrelevant. Even if we could effect certain changes, there is still the more important question of whether we should. I believe we should not.

**PSYCHOTHERAPY, POLITICS, AND MORALITY**

The arguments put forth here should be viewed at what Rappaport (1977) calls the institutional level, not the level of the individual. An institutional analysis of human problems is concerned with those values and ideologies that guide the basic decision making of a particular society. This is the domain of workers who typically identify themselves as community psychologists or psychiatrists. In contrast, most therapists are accustomed to focusing on the individual, assuming that society is basically benign and that psychological suffering can best be alleviated by helping the client adjust to prevailing values and conditions. My underlying assumption is that issues surrounding therapy for homosexuality should be addressed at an institutional level.

The thrust of this chapter, then, is sociopolitical and ethical. While it may be interesting to present data suggesting that sexual preferences can be altered (for example, Sturgis & Adams, 1978), such efforts are irrelevant and, worse, misleading. It seems preferable to acknowledge candidly that therapists are purveyors of ethics, that they are contemporary society's secular priests (London, 1964, 1986), and that this heavy moral responsibility is inherent to the conduct of psychotherapy.

Indeed, although this chapter has focused on homosexuals in therapy, I have come to believe that all decisions on goals are made ultimately by the therapist. This thesis bothers colleagues of mine—and it should, for the responsibilities of therapists become very onerous indeed if one accepts this argument. Perry London (1964, 1986) suggested some time ago that issues of morality are part of the fabric of the technology of psychotherapeutic change. Contemporary therapists are, as I have just said, society's secular priests. We risk much by not confronting the overwhelmingly lopsided power relationships in any therapeutic alliance and the fact that psychological interventions inevitably entail a judgment by the therapist of how, in a moral sense, a given client should shape his or her existence. Even therapies that view themselves as hands-off (for example, the humanistic-existential group) set parameters for intervention. And if one refrains from suggesting a change, lest he impose his values on the client, is one not willy-nilly sanctioning the status quo, and is that not in itself a therapist decision about the goals of therapy?

It has been suggested that therapists have some kind of abstract responsibility to satisfy a client's expressed need (Sturgis & Adams, 1978). Would that it were so simple. Therapists constrain themselves in many ways when clients ask for assistance, and clients make certain requests of some therapists and will not do so with others. Requests alone have never been a sufficient justification for providing a particular form of therapy.

Finally, there is nothing in the above that advocates not dealing with homosexuals in therapy. It is one thing to say that one should not treat homosexuality; it is quite another to suggest that one should not treat homosexuals. Indeed, what I am suggesting is that therapists finally consider seriously the problems in living experienced by homosexuals. Such problems are perhaps especially severe, given the prejudice against their sexual orientation. It would be nice if an alcoholic
homosexual, for example, could be helped to reduce his or her drinking without having his or her sexual orientation questioned. It would be nice if a homosexual with a sexual dysfunction could be helped as a heterosexual would be rather than guiding his or her wishes to a change of orientation. Implicit in this chapter is the hope that therapists will concentrate their efforts on such human problems rather than focus on the most obvious "maladjustment"-preferring as sexual and love partners members of one's own sex.

CONCLUSIONS

I have argued that change-of-orientation therapy programs are ethically improper and should be eliminated. Their availability only confirms professional and societal biases against homosexuality, despite seemingly progressive rhetoric about its normality. Forsaking the reorientation option will encourage therapists to examine the life problems of some homosexuals, rather than focus on the so-called problem of homosexuality. Viewing therapists as contemporary society's secular priests rather than as value-neutral technicians will sensitize professionals and lay people alike to large-scale social, political, and moral influences in human behavior.

NOTE

1. There may be one sense in which efficacy relates to the ethical issue. If an ineffective reorientation therapy is undertaken, the patient is going to be disappointed and likely therefore to feel even worse about his predicament-he has not only failed to achieve the reorientation goal but comes away continuing to believe that his homosexuality is bad and sick and perhaps feeling even worse about being gay.
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