Issues and Nonissues in the Gay-Affirmative Treatment of Patients Who Are Gay, Lesbian, or Bisexual

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An article by Eubanks-Carter, Burckell, and Goldfried (this issue) provides a variety of gay-affirmative suggestions about what psychotherapists should know about the gay and lesbian experience if they are to be humane and effective mental health helpers. In the present article I offer several critiques and comments on issues and nonissues pertaining to the analysis and conduct of psychological assessment and intervention with homosexual and bisexual individuals. These issues include (a) the unlikelihood of voluntariness in requests for sexual reorientation, given the prejudice against gay, lesbian, and bisexual (GLB) people; (b) the biases inherent in psychological assessment viewed as a constructionist enterprise; (c) the minor importance of biological theories of sexual orientation in prejudice and discrimination; (d) the hidden negative biases against homosexuality in presumably gay-positive changes in earlier versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM); and (e) the irrelevance of sexual conversion effectiveness in the politics and ethics of efforts to direct sexual preference from the homosexual to the heterosexual.

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Eubanks-Carter, Burckell, and Goldfried (this issue) offer both philosophical and practical guidelines to therapists for helping gay, lesbian, and bisexual (GLB) individuals in ways that do not entail efforts at sexual reorientation. Although GLB individuals have many of the same psychological problems as do nongays, a number of their concerns are unique, and most psychotherapists probably lack sufficient knowledge and sensitivity to address these concerns, such as the stress and isolation from being excluded from decisions normally available to family members, such as assisting in health care choices for one’s loved one. Eubanks et al. provide very useful information on the range of problems that are specific to the gay-affirmative treatment of patients who are GLB. The present article offers a historical perspective as well as a discussion of some issues and pseudoissues pertaining to the conduct of psychotherapy with GLB patients.

THE ILLUSION OF VOLUNTARINESS IN SEEKING ORIENTATION CHANGE

Until the 1980s, psychotherapists directed most of their therapeutic efforts when working with gay or lesbian patients to trying to reduce homosexual and increase heterosexual attraction, and, for the most part, the target population was men. Little if any time was spent by mainstream therapists, regardless of theoretical orientation, in treating the problems that homosexual individuals have rather than the so-called problem of homosexuality. The questions for me, beginning more than thirty years ago (Davison, 1974, 1976), were the following: How can therapists honestly speak of nonprejudice when they participate and/or conduct research in therapy regimens that by their very existence and regardless of their effectiveness condone a societal prejudice and perhaps also impede social change? And how can therapists ignore the immense societal pressure of this prejudice by asserting that they have some sort of general responsibility to accede to a gay patient’s so-called voluntary wish to alter sexual orientation?

Another way to understand the issue is to consider the availability of cosmetic surgery to alter the facial appearance of Asian women by making their eyes rounder and by narrowing the bridge of the nose—changes designed to approximate Caucasian standards of physical attractiveness. What do the availability of these interventions and the desire of many patients for this kind of elective cosmetic surgery say about the way Asian facial features are appraised (Kaw, 1993)?

By providing surgery to alter Asian facial characteristics in the direction of Caucasian features, the medical profession, in my view, unwittingly reinforces the prejudice against such features. Critics of sexual reorientation efforts see in this kind of cosmetic surgery a strengthening of the bias against Asians (Cruz, 1999).
They question as well the meaningfulness of assertions that such women are voluntarily seeking such surgery. What seems to these critics much more likely is that such women are doing so out of the kind of self-hate that lies behind the stated wish of some homosexuals to alter their sexual orientation in a heterosexual direction.

Much has changed over the past 25 years. Instead of being focused almost entirely on how to alter sexual orientation from the homosexual to the heterosexual, articles and books have been published on the treatment of homosexuals for problems other than their sexual identity. This shift of focus away from sexual orientation change has, as predicted and encouraged earlier by some of us (see also Begelman, 1975; Silverstein, 1972), prompted therapists to examine the problems that beset people who prefer as sexual and love partners members of their own sex—without assuming that the only way to alleviate their distress is to work towards sexual reorientation. Many of these problems are the same as those for which heterosexuals seek treatment, such as social anxiety, depression, nonassertiveness, and substance abuse. Sometimes these problems may have little or nothing to do with sexual orientation. When they do relate to sexual identity, they generally do so, I believe, because being homosexual in our society continues to result in discrimination, hostility, and even physical violence.

SOCIAL CONSTRUCTIONISM AND PSYCHOLOGICAL ASSESSMENT

It has been suggested that people seldom go to mental health clinicians with problems as clearly delineated and independently verifiable as what patients usually take to a physician (Halleck, 1971). A person usually goes to a psychologist or psychiatrist because he or she is unhappy; nothing is meaningful; sadness and despair are out of proportion to life circumstances, etc. The clinician then transforms these often vague and complex complaints into a diagnosis or functional analysis, a set of ideas about what is wrong, what the controlling variables are, and what might be done to alleviate the suffering and maladaptation. The argument, then, is that psychological problems are for the most part constructions of the clinician. People come to us in pain, and they leave with a more clearly defined problem or set of problems that we assign to them. This epistemological position bears on how clinicians diagnose or functionally analyze the problems brought to them by GLB patients. Biases against homosexuality likely play a major role in how patient problems are conceptualized and treated (Davison, 1976, 1991).

DISCRIMINATION AND BIOLOGICAL HYPOTHESES ABOUT THE ORIGINS OF HOMOSEXUALITY

Arguments against societal discrimination against GLB individuals often invoke data that suggest that homosexuality has a strong if not immutable heritable or other biological component and that it is therefore not a matter of choice. The supposition is that greater societal awareness of such data will lessen discrimination. In other words, if a gay person was born that way, people will think more kindly of them.

This argument is tempting but I believe it is flawed. Consider that no one doubts that being African-American (or Chinese-American or Native-American, etc.) is genetically determined, and yet this widespread knowledge does not prevent people from having antipathies towards these groups. Thus, from a political point of view—and it is impossible to discuss GLB issues without considering politics (viz., Davison, 1976, 1991)—it is probably a waste of time emphasizing the “anatomy is destiny” proposition. The real issue is the pre-existing attitudes of those who discriminate: If someone hates GLB people, they are going to continue doing so regardless of the assumed origin of the behavior pattern. Those prejudiced against them may be even more negatively inclined if they believed that the despised behavior were a matter of conscious choice, but it is doubtful that they will be less negatively inclined if they considered it to be inborn or otherwise biologically driven.

A related question is whether all inborn characteristics are necessarily unchangeable. Take the example of handedness. No one doubts that handedness is genetically determined (Corballis, 1997). And yet this does not prevent someone who loses his or her dominant limb from learning to use the remaining one, sometimes as successfully as the missing dominant limb was used. This is not to say that it is easy to do so, but it is possible. Trying to reduce discrimination by arguing that genetically or otherwise biologically determined
characteristics cannot be changed is neither a scientifically defensible nor politically prudent strategy.

**HOMOSEXUALITY AND THE DSM: INITIALLY LESS THAN MEETS THE EYE**

The removal of homosexuality in 1973 from the *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed.; *DSM-II*) is cited by Eubanks-Carter, Burckell, and Goldfried as an important step forward. I disagree. It is the case that, in 1973, the American Psychiatric Association substituted “sexual orientation disturbance” for homosexuality, applying it to men and women who are “disturbed by, in conflict with, or wish to change their sexual orientation.” And in 1980, *DSM-III* introduced “ego-dystonic homosexuality,” to be diagnosed in people who found their homosexual arousal disturbing and wished to change to heterosexuality. There was, however, no addition of a category like “ego-dystonic heterosexuality.” In other words, a gay person was to be judged to be abnormal if he or she hated herself as society had taught them to do.

To be sure, these initial changes did signal a shift to a more accepting stance, but I would suggest that it is an exaggeration to assert that these were really important substantive changes. Indeed, if there was a disorder involved, it might better have been characterized as being unduly influenced by other people’s negative opinions of same-sex sexual preference—perhaps something like “Sensitivity to Societal Prejudice Disorder.” The real changes took place with *DSM-III-R* in 1987, when ego-dystonic homosexuality was dropped altogether and when other references to sexual orientation, as in the paraphilias, were dropped.

**NOT CAN BUT OUGHT**

Spitzer’s survey study (2003) and others like it (e.g., Sturgis & Adams, 1978) that suggest that sexual orientation can be changed are not relevant to the arguments put forward in the early-mid 1970s by Silverstein and myself. The propriety of sexual reorientation change is not a matter of whether it is possible to alter sexual orientation. The question is a political and moral one, not an empirical one. The question of whether one can alter another’s sexual preference is separate from the political and ethical issue of whether one should, though this distinction has often gone unappreciated (Sturgis & Adams, 1978). I don’t believe that one can make such changes, but that is beside the point. There are many things that people can do that they elect, for a variety of reasons, not to do. Therapists refuse all the time to accede to certain change requests by their clients, even when there is reason to believe that such changes are possible to effect. Can one conceive of a feminist therapist who would agree to help a woman patient who is subservient to her husband become more comfortable with this even if the patient requested it?

There is, however, a point of intersection between ethics and empiricism that is worth mentioning. As discussed years ago (Davison, 1978) and as demonstrated recently by Shidlo and Schroeder (2002), when conversion therapy fails, it can leave the patient feeling worse than before, blaming themselves for not having tried harder or for not believing sufficiently in God. In addition, the very fact of having tried to change would, it seems, reinforce their self-hate and their belief that they are defective, even hopeless cases. Health professionals do not design and implement cures without having decided a priori that there is a disease that needs curing or a problem that needs solving.

**REFERENCES**


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