

ETHICAL AND CLINICAL IMPLICATIONS FOR THE FIELD OF MARRIAGE AND
FAMILY THERAPY REGARDING LGBTQI THERAPEUTIC APPROACHES

by

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Abstract

There are three different approaches for the treatment of lesbian, gay, bisexual, transgender, questioning, and intersex (LGBTQI) sexual orientations: reparative therapies, gay-affirmative therapies, and person-centered approach. These therapeutic approaches will be discussed individually and Kitchener's Model of Ethical Decision Making or Moral Justification will be applied to each of them with the purpose of identifying which is the most ethical. The American Association for Marriage and Family Therapy (AAMFT) scholars have not created guidelines for working with LGBTQI or made a clear stance on what they believe would be the best approach to take, therefore, clinical and ethical implications and recommendations for the field of marriage and family therapy will be discussed.

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Dedication

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CHAPTER 1 - Introduction

“He just kept punching and punching until I blacked out” (Miller, 2009, p. 3). This unsettling quote is what a Kansas State University student, Swanson (a pseudonym given to him to protect his identity) informed to Kansas State University reporter Jason Miller (2009) in a recent interview in the *Kansas State Collegian* as he talked about the time when he decided to have a conversation with his father about his feelings for other men and his non-interest for the naked women in Playboy magazines. His father was so abusive whenever Swanson brought this up, that he was taken to the hospital several times until his mother thought that the hospital would stop believing that he had fallen down the stairs. A decision was made by his parents to take Swanson to “therapy” because of his homosexual interests.

Swanson related that he was told many lies about gay lifestyle by the therapist, such as: all people who were gay suffered from AIDS, therefore he had AIDS; his death was inevitable because he had AIDS; and the government found all gay children and killed them and somehow they would find him and he would suffer the same consequences. After this first session, the second, third, and fourth were geared more towards addressing the “issue” with aversion therapy techniques. This included putting two ice balls on his hands whenever images of two men together were shown so that he would feel the painful cold (which would help him avoid desiring men). Heat pads were used to do the same thing by giving Swanson a painful burning sensation. The last method used was electric shock. Swanson described the pain that he felt as “excruciating” and even today all these methods seemed to work – not by changing his sexual identity, but by traumatizing him to the point that he feels physical pain whenever he hugs another man. To alleviate the psychological and physical pain that he was going through, he decided to take an overdose of the medications that he was prescribed to deal with the pain of the aversion therapy. His attempt, fortunately unsuccessful, only made him sleep for two days. Although his parents took him to the hospital, Swanson related that he has never told his parents the truth about why he took the overdose.

Swanson had a second suicide attempt. He went up to the roof of the three-story building in which he and his family lived. After saying goodbye to his sister he was stopped by his mother who yelled, “I will love you again if you’ll just change!” (December 8, 2009, p. 9). This was

very painful for Swanson to hear, because with that statement his mother recognized that she did not currently love him. In response he took another step and his mother yelled again, “I’ll make the pain go away.” Swanson said that he ran to his mother after hearing this and “became her straight son once again” (December 8, 2009, p. 9). To this day his family believes that he is straight. He is not, but he has found support in the local LGBTQI (Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex) group in Manhattan, Kansas.

LGBTQI in the United States

Like Swanson, many individuals are suffering from the consequences of unethical practices to “treat” sexual identity issues. Persons who are LGBTQI are being oppressed and discriminated against similar to the injustices suffered by African-Americans. This report will start by looking at some basic statistics related to LGBTQI in the United States.

Estimates of LGBTQI in the United States.

There is no exact empirical data regarding the number of people who identify themselves as having a gay, lesbian, bisexual, transgender, questioning, or intersex sexual orientation in the United States. Black, Sanders, and Taylor (2000) asserted that it is difficult to make accurate estimates regarding LGBTQI demographics in the United States because census information does not ask individuals about their sexual orientation. In the 1940s, Kinsey, Pomeroy, and Martin (1948) estimated that roughly 10% of the United States population was gay or lesbian. However, Schneider (2000) stated that the 10% reported on Kinsey’s study had to be taken with caution because, at that time, homosexuality was defined in very broad terms including people that today would not be considered homosexuals. Kinsey et al. (1948) included many participants that were in jail and were more inclined to homosexual behavior. They also included participants who had some type of homosexual experiences, but who ultimately lived heterosexual lives, especially when that was the expectation in such a conservative time. Therefore, the 10% estimates that Kinsey et al. (1948) gave were of people who had primarily engaged in homosexual activities for at least part of their adulthood.

In the book *Sex in America: A definitive survey* (1994), the issue of identifying what percentage of the population is homosexual was addressed. Michael, Gagnon, and Laumann (1994) described three reasons why it is very difficult to come up with an estimated percentage of the population that is homosexual. First, they reported that people may change their sexual

behavior during their lifetime making it difficult to categorize sexual orientation over time. Secondly, they stated that there was not a determined set of specific sexual desires or self-identification that uniquely defines homosexuality. The third reason is that the homosexual behavior is not measured easily. For example, would someone who had 2-3 homosexual experiences and 5 heterosexual experiences be considered a homosexual because s/he identifies him/herself as homosexual or would s/he be considered heterosexual because his/her last 5 partners were of the opposite sex? Another challenge is that many people struggle with their sexual identity and, although they have the sexual desire for people of their same gender, they might not behave or identify as homosexuals for various reasons. Michael et al. (1994) also reported that the National Health and Social Life Survey (NHSLs) found that, based on the interviews they conducted in 1992, 2.7% of males and 1.3% of females identified themselves as gay, lesbian, or bisexuals within the last year; also 4.9% of males and 4.1% of females identified themselves as gay, lesbian, or bisexuals since they were 18 years old.

A specific estimate of LGBTQI is not available. Although there have been surveys made, the percentages are not an accurate representation of the population because of several factors. Mostly because the entire population was not surveyed and it is impossible to know the precise amount of people that feel comfortable with their sexual orientation to report it accurately. With hate crimes, discrimination, and prejudice being different ways in which LGBTQI are being stigmatized, there is a tendency for people to not accept their sexual orientation. For this reason, it is very difficult to come up with a specific number.

Portrayal of LGBTQI in Society

Whether a same-sex sexual orientation is considered to identify a minority group or not, the media, legislation, and activist groups are putting their attention or emphasis in portraying different aspects of LGBTQI. Different television programs, such as *Will and Grace*, and movies, such as *Brokeback Mountain*, are portraying same-sex relationships in a positive way, including programming geared towards adolescents and young adults who are in the process of developing their individual identities, such as *The Secret Life of the American Teenager*. The opposite perspectives (same-sex relationships as bad or immoral) are also portrayed at times, especially when the programming is funded by a religious organization or a conservative group. For instance, there have been several groups created by conservative churches on the social

networking site *Facebook*, with the purpose to inform people of the negative lifestyles that LGBTQI lead. Other web sites that promote their opposing view to homosexual orientations are NARTH and ex-gay ministries.

When it comes to the political aspect, there is an ongoing debate about the “don’t ask don’t tell” military policy, implemented in 1993 and signed by President Bill Clinton, that prohibits people who are not heterosexual to openly serve in the United States defense (Starr, 2009). The current Secretary of Defense, Robert Gates, has been trying to support President Obama’s desire to change this policy, but in the meantime be able to look at ways in which the rules could be altered so that the policy would be applied in a more humane way (Zoroya, 2010). This has caused controversy in the United States politics between those who want the policy to remain unchanged, and those who want it modified. Secretary Gates began to study the impacts of eliminating the policy last month and reported that it would take a year to complete it (Zoroya, 2010). The motivation to change the existing policy derives from the expulsion of qualified and highly experienced individuals in positions already understaffed simply because their sexual orientation is classified as homosexual (Mount, 2010). On the other hand, those who are against the change of the policy feel that it would be untimely because the implications of such change would disrupt the morale and cohesiveness of the armed forces in a time when the United States is in the midst of two wars.

There are other ongoing debates about same-sex marriage and even the recognition of different sexual orientations in relation to hate crimes. People with an LGBTQI identity are having problems having their marriages recognized by the government and have been compared by people in the religious and conservative community and politicians, such as Trent Lott, to alcoholics, kleptomaniacs, and sex addicts (Mills, 1998).

Polarity Presented in Society

There is great polarity between groups of people who believe that LGBTQI should have the same rights as heterosexuals and others who are completely against this position. In a 2007 opinion poll called “Gays’ Orientation Can’t Change”, CNN asked people, “Is homosexuality a result of upbringing/environment or do you believe it is something a person is born with?” Forty-two percent responded that it was a result of “upbringing/environment”, 39% that the people were “born with it”, 10% that it was influenced by both factors (upbringing/environment and

born with it), 6% had “no opinion”, and 3% said “neither”. For this poll 1,029 adults over the age of 18 were surveyed. This same opinion poll asked these participants, “Can homosexuals change their sexual orientation if they choose to do so?” and 56% said “yes”, 36% said “no” and 8% had “no opinion”.

On the other hand, on March of 2007, Gallup conducted a poll called “Tolerance for Gay Rights at High-Water Park.” They asked, “Should homosexuality be considered an acceptable alternative lifestyle (based on views about origin of homosexuality)?” Seventy-eight percent of the respondents who indicated that homosexuals were born with that sexual orientation responded that an alternative lifestyle is acceptable while 68% of those who thought that the origin of homosexuality was the individual’s “upbringing/environment” said that an alternative lifestyle was not acceptable. It is very clear that there are people who do not find an LGBTQI lifestyle and culture acceptable. This leads to the clear polarity among those who want to accept LGBTQI and those who, because of their religious beliefs, values, and conservative mindset, believe that LGBTQI sexual identities should be changed.

Options for Addressing the Help Needed by LGBTQI

Three therapeutic options are presented as solutions to this issue. 1) We can accept LGBTQI and give them the support and help they need and deserve through gay-affirmative therapy, 2) we can change their sexual orientations through reparative therapies, or 3) we can give the client the option of choosing what they ultimately want to do through the person-centered approach. One of the main issues encountered through these approaches is the ethical controversy that exists with reparative therapies among the mental health field. In 1973, the American Psychiatric Association removed homosexuality as a mental disorder from the *Diagnostic and Statistical Manual of Mental Disorders*. However, reparative therapies, such as conversion and aversion therapies, continue to be practiced in an effort to change an individual’s sexual orientation. Serovich, Craft, Toviessi, Gangamma, McDowell, and Grafsky (2008) reported that mental health organizations like the American Psychological Association, American Psychiatric Association, American Counseling 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 “have adopted policies that reject sexual reorientation therapies due to a lack of evidence for the mental illness view of homosexuality and bisexuality” (p. 228).

On the other hand, the American Association for Marriage and Family Therapy (AAMFT) has not taken a clear stance on whether or not reparative therapies are unethical and if they should or should not be discouraged as a possible course of treatment. AAMFT has also not stated specific guidelines, from a systemic perspective, that can help therapists work with LGBTQI. It is imperative for this to occur because the field of marriage and family therapy deals with the family system, which is very important when the clients are seeking support, especially going through a difficult situation. Marriage and family therapists are systemic thinkers and experts in understanding the reality behind how humans relate to their environment and how they are affected by it.

In the case of clients who have an LGBTQI sexual orientation, the social stigma that exists, the community that they are brought up in, their religious beliefs, and their support systems have a direct effect on the individual. There is a great amount of pressure put on them to figure out their sexual orientation and marriage and family therapists have the power to take some of the pressure off their shoulders by looking at the situation from a systemic perspective. Humans are social beings and the field of marriage and family therapy honors that statement by training professionals to look beyond what the individuals bring to the table and looking at whom else is directly involved, which can ultimately be of great help for LGBTQI clients who are confused and seeking truthful answers. For marriage and family therapists to feel more comfortable with helping LGBTQI clients achieve their maximum potential, the field itself needs to provide the therapists with ethical and practical guidelines to protect these clients from harmful therapeutic approaches.

Purpose of the Report

The purpose of the report is to identify ethical and clinical implications for the AAMFT code of ethics, the field of marriage and family therapy, and individual marriage and family therapists regarding therapeutic approaches that deal with LGBTQI sexual orientations. It is imperative to provide clinicians with guidelines that will help them feel more competent and comfortable working with LGBTQI. Also, recommendations will be made regarding therapeutic approaches that exist for working with these clients. Kitchener’s Model of Ethical Decision

Making will be applied to each of the three approaches with the purpose of looking at how ethical they are and coming up with the most ethical and helpful one for working with LGBTQI.

CHAPTER 2 - Literature Review

Nigel Harrison (2000) stated that individuals who identify themselves as LGB, as he referred to them, have been oppressed over the years causing them to create support groups and the so-called “gay lifestyles” to find common ground with others who are going through similar situations. Harrison (2000) identified himself as a gay man who adopted a gay lifestyle in what he describes as “a society which continues to oppose human diversity” (p. 37-38) reporting that he has experienced verbal and physical abuse which has also helped him understand the needs of clients who identify themselves as gay. He described his experiences in therapy and expressed that he wished that the therapist he saw would have had more knowledge about support groups for gay, lesbian, and bisexual individuals as well as information about gay lifestyles. Harrison asserted that therapists who treat people dealing with sexual orientation conflicts should have a vast knowledge on the topic to be able to help these individuals.

Mental health professionals strive to help people with issues related to individual well being as well as their relationships with families and significant others. Therapeutic services are very important in society, because they help people learn that there is someone available that could potentially understand them and provide the services needed. The therapeutic relationship has a very important role in therapy and trust is a key element for this to happen because therapy deals with very personal matters (Horvath, 2005). For people in general to feel welcomed and comfortable, therapists need to provide a trustworthy environment. It is very important to provide mental health services for people without discriminating against them so that everyone can have the option of seeking the services they need. Human services programs around the country are failing to provide their students with the necessary training to help GLBT (Gay, Lesbian, Bisexual, and Transgender) clients, as the author identified the group (Estensen, 2005). These students are also holding back from putting in their full effort into create a therapeutic relationship with LGBT clients because of the false stigma that society has put on these populations, preventing the therapists from working effectively with these clients. Therefore, LGBT clients oftentimes end up getting services from unprepared and biased therapists (Estensen, 2005).

The literature on helping LGBTQI in a therapeutic relationship points out three major approaches from which mental health professionals can work: reparative therapies, gay-affirmative therapy, and a person-centered approach (Haldeman, 2004). Gay-affirmative and reparative therapy approaches have been used for years, since the 1970s and 1980s, while the person-centered approach is the most recent.

Reparative Therapies

Reparative therapies are intended to “reorient” an individual’s sexual orientation from gay, lesbian, or bisexual to heterosexual (Nicolosi, 1991). There are two different kinds of reparative therapy: conversion and aversion therapy. Other names used to refer to these kinds of approaches are reorientation therapy, transformation therapy, and change ministries (Steigerwald & Janson, 2003). Schroeder and Shidlo (2001) stated that some of the theories used by reparative therapists, as reported by the participants, were a combination of cognitive-behavioral therapy, behavioral therapy, psychoanalysis, aversive conditioning, and covert sensitization. A religious component also was often included.

Conversion Therapy

Conversion therapy focuses on and addresses the psychosocial and emotional aspects of sexuality. Haldeman (2001) defined conversion therapy as an effort to reorient gay, lesbian, and bisexual clients to heterosexuality using different techniques to resolve unconscious childhood conflicts believed by reparative therapists to be responsible for homosexuality.

Some of the techniques used by clinicians who practice conversion therapy are: prayer and group support (Haldeman, 2004; Serovich et al., 2008): individual or group counseling with the purpose of having the group support and help members with adapting to a heterosexual sexual pattern and reducing associated problems with that sexual identity, religious conversion (Rogers, Roback, McKee, & Calhoun, 1976; Serovich et al., 2008; Throckmorton, 1998; Wolpe, 1973); religion-based methods that include threats of damnation, reliance on the power of God to change orientation via long-term psychoanalytic therapy to work on childhood experiences that may have “resulted” in homosexuality; church fellowships in which gay and lesbian clients are encouraged to seek a shift in their pattern of sexual arousal (Rogers et al., 1976; Throckmorton, 1998; Wolpe, 1973); group social demand treatments; social skills learning training (Haldeman, 1991; Morgan & Nerison, 1993; Morrow & Beckstead, 2004; Silverstein, 1991); cognitive

restructuring, hypnosis, abstinence training, “gender lessons” (Morgan & Nerison, 1993; Morrow & Beckstead, 2004); and emphasis on accountability to alter behavior (Morrow & Beckstead, 2004).

Aversion Therapy

Aversion therapy refers to behavioral treatments, such as shock therapy, to change someone’s behavior – in this case, sexual orientation (Morrow & Beckstead, 2004). Aversion therapy techniques for changing sexual orientation include biological interventions such as electroconvulsive therapy (McConaghy, 1975; Tanner, 1973, 1975); surgical interventions such as lobotomy, castration and ovary removal; hormonal therapy like steroids and androgens (Morrow & Beckstead, 2004; Silverstein, 1991); use of noxious stimuli (Maletzky & George, 1973); masturbatory and orgasmic reconditioning using visual stimuli (Bancroft & Marks, 1968; Barlow & Agras, 1973; Conrad & Wincze, 1976). Others have reported the use of a combination of these techniques (Conrad & Wincze, 1976; McConaghy, Armstrong, & Blaszczyński, 1981). The majority of these strategies are strictly unethical and illegal today. Still, Swanson’s story can be used as proof that these techniques are still being used today to “reorient” individuals’ sexual identities.

Schroeder and Shidlo (2001) examined reports of participants who stated that their mental health practitioners followed a 12-step program to treat homosexuality as a sexual addiction. However, there were no details provided about what these 12-step program or approaches entailed. Their research study was based on 150 participants that had a history of at least six sessions in reparative therapies with a licensed clinician. These participants had to get a pre-treatment self-report of 5 to 7 (more homosexual than heterosexual to exclusively homosexual) on the 7-point Kinsey scale (Kinsey et al., 1948). Some participants reported that their clinicians used a psychotropic intervention in which psychotropic medications were given to the clients. Sometimes the drugs were used as the sole treatment, other times they were combined with conversion therapy. Some of these medications included anti-depressants and anxiolytics. These were intended to help the clients control their homoerotic feelings and behaviors “or to reduce their sexual fantasy life and desire” (p. 150). In addition to Schroeder and Shidlo (2001), other researchers’ (McConaghy, 1969, 1975; McConaghy & Barr, 1973) participants also reported that their therapists had used drugs to induce nausea or vomiting.

Results or effects of reparative therapies

Reparative therapies have been the focus of heated ethical debates among clinicians. There are those who feel it is effective (Nicolosi, 1991; Rosik, 2003; Throckmorton, 1998) while others believe that it is unsuccessful and even very detrimental (Haldeman, 2004; Jay-Green, 2003; Shidlo & Schroeder, 2002). The relative strengths and weaknesses of reparative therapies will be discussed.

Nicolosi, Byrd, and Potts (1998) reported results of a national survey of 882 participants who engaged in reparative therapies. Out of the 882 participants, 318 rated themselves as exclusively homosexual. After the treatment, 18% of those 318 participants rated themselves as being exclusively heterosexual, 17% rated themselves as “almost entirely heterosexual” and 12% rated themselves as more heterosexual than gay or lesbian. Therefore, 47% of the 318 participants that had rated themselves exclusively homosexual went from a 6 on the Kinsey scale (Kinsey et al., 1948) to less than a Kinsey 2 (Kinsey et al., 1948) rating. Out of the initial sample of 882 participants, 13% remained either exclusively or almost exclusively homosexual after the treatment. This survey asked the clients about the psychological and interpersonal adjustments before and after therapy and they reported significant improvements in areas such as: self-acceptance, personal power, self esteem, emotional stability, depression, and spirituality (Nicolosi et al., 1998). Throckmorton (1998) stated that those clients who have had some prior heterosexual experience and that are motivated to change their sexual orientation are much more likely to report sexual orientation change after treatment. He also reports that for some clients, reparative therapies are helpful with increasing assertiveness, addressing a learned fear of relationship with the opposite sex, and with the development of heterosexual social skills.

On the other hand, Schroeder and Shidlo (2001) stated that the majority of the participants in their study reported that their therapists told them false information, such as: “(a) homosexuality is in itself a psychological disorder or is a symptom of another disorder; (b) homosexuality does not exist; and (c) gay lives are inherently unhappy” (p. 140). Participants also reported that they were told that gay persons were “undesirable, unhealthy, and unhappy” (p. 143) and that gay men did not have monogamous relationships; therefore they would have unfulfilling relationships. These statements indicate that the therapy approach that these clinicians used, involved false information that could potentially create a damaging and false self image and of gay lifestyles for the clients.

Some of the negative effects that researchers have identified as resulting from reparative therapies are: higher levels of guilt, anxiety, and depression; difficulty developing relationships with other men; a general sense of “de-masculinization;” an increase in self-hatred, suicidal ideation and attempts, drug abuse, and HIV-risk behaviors (Beckstead and Morrow, 2004; Garnets, Hancock, Cochran, Godchilds, & Peplau, 1991; Haldeman, 2001; Schroeder & Shidlo, 2001; Shidlo, Schroeder, & Drescher, 2001); long-term sexual dysfunction; lowered self-esteem; loss of family and loved ones; loss of religiosity; and a decreased sense of spirituality (Beckstead and Morrow, 2004; Haldeman, 1994; Haldeman, 1999). Davison (1976) and Shidlo and Schroeder (2002) reported that when conversion therapy has been considered unsuccessful, the clients report feeling worse after the intervention than they did before seeking therapeutic help. They also blame themselves because they feel as if they did not try hard enough during the process; therefore, they develop a lot of guilt and shame for not trusting and believing enough in God. Haldeman (1994) reported that clients usually conform to the ideal and beliefs of those around them, such as heterosexuals and/or Christians. This ultimately makes participants feel shame and fear and they are often conflicted with what they are feeling because it is very difficult for them to act as if they are following those ideals or beliefs, but at the same time having an internal conflict between that and how they really feel.

Exodus, one of the largest ex-gay religious groups, was founded in 1976 by Michael Bussee, Gary Cooper, and others (Mills, 1998). Bussee and Cooper were both ex-gays and worked together to convert others into heterosexuality; however, they were secretly involved in a romantic and sexual relationship with each other and ended up leaving Exodus at the same time in 1979 (Jay-Green, 2003). Mills (1998) interviewed Bussee and he stated: "The desires never go away, the confrontations begin and the guilt gets worse and worse" (p. 8). Bussee also reported that some of the people that went through the Exodus program committed suicide. Others hurt themselves by cutting their genitals with a razor and some went through sex-change operations to address their sexual desires. Mills (1998) reported that Bussee stated he and Cooper never met anyone who changed from having a homosexual orientation to having a heterosexual one.

Serovich et al. (2008) created a systematic review of research based on sexual reorientation therapies. The sample size was based on “28 empirically based, peer-reviewed full-length articles and brief reports addressing the efficacy of reparative therapies” (p. 229). In this

study the difference was made between reparative therapies and aversion therapies by categorizing “reparative therapies” under conversion therapy; therefore, reparative therapies were focused more on the psycho-social and psycho-emotional aspect of the process while aversion therapies were more focused on the biological/behavioral aspect of the process. The studies that talked about reparative therapies were published between 1956 and 2004 and aversion therapy studies were published between 1965 and 1981.

In this systematic review, Serovich and colleagues (2008) found that 28% (n = 8) of the therapies were “reparative” and 72% (n = 20) were “aversion” therapies. In the studies that reported reparative therapy, a mean of the age of the participants was not available, but the range went from 19 to 81 years old. The majority of the participants in the studies were Caucasian with a very small percentage of African Americans and Hispanics who were included as well. Native Americans were not reported in any of the samples. The referral sources included the clients themselves (43%) and professional referrals from psychologists or ministers (85%) being this the most frequent one.

In terms of the research studies regarding aversion therapy, Serovich and colleagues (2008) noted that 7 of them included a theoretical background. The age of the participants ranged from 15 to 62 years old and none of them reported race or religion. The sample size seemed to be smaller reporting a number of participants from 3 to 157, but 95% of the studies had a sample of 47 participants or fewer. There was a larger male sample because only one study included females. In terms of the referral sources, 53% reported self-referral while 65% were referred by a professional.

The research based on the outcomes of reparative therapies is lacking theory, inclusion and exclusion criteria for their data collection, and using convenience sampling (Haldeman, 1994; Stein, 1996; Serovich et al., 2008). Incomplete empirical information regarding outcome studies on reparative therapies creates space for doubt and questioning of these methods that are being used by some mental health professionals. Serovich et al. (2008) posed the ethical dilemma of why mental health professionals are conducting these kinds of therapies when there is no empirical evidence supporting their success. They propose that the studies need to “be based on a theoretical framework, must include a standardized definition and measure of sexual orientation, and must include a more gender-balanced sample of heterosexuals, homosexuals, and bisexuals” (p. 236) to be able to provide empirical data on whether reparative therapies are

successful. This will ultimately help the clinicians have a clear understanding of what reparative therapies are capable of doing.

Gay-Affirmative Therapy

In contrast to conversion therapy, gay-affirmative therapy is used to help LGBTQI feel more comfortable with their sexual identity (Haldeman, 2004). In this therapeutic approach it is very important to help the clients with the coming out process and support them in their decision towards positive sexual identity development (Crisp & McCave, 2007; Harrison, 2000; Langdridge, 2007; Lebolt, 1999; Tozer & McClanahan, 1999). Langdridge (2007) reported that gay-affirmative therapy is a positive theoretical framework for practice that is supportive of lesbian, gay, and bisexual people and their lifestyles. When mental health professionals work from a gay-affirmative approach, the clinicians and the clients find a way to incorporate the clients' lifestyle with the LGBTQ sexual identity to create a positive experience adapting to their sexual orientation (Haldeman, 2004; Langdridge, 2007). Langdridge (2007) stated that the therapist who practices lesbian, gay, or bisexual (LGB) affirmative therapy values and recognizes the clients' sexual identity and uses positive affirmation to help the clients deal with the effects of heterosexism and internalized homonegativity. The therapists and clients agree that the ultimate goal is integrating their LGB identity, as the author referred to it, into their lifestyle while the therapists facilitate the psychological, social, and emotional adjustment to fully experience and live as an "LGB-identified person" (Haldeman, 2004).

The "gay-affirmative" approach is important because it helps lesbians, gays, and bisexuals identify some sort of safe place in which they feel comfortable exploring their sexual desires and feelings for people of the same gender (Harrison, 2000; Langdridge, 2007). Lebolt (1999) stated that clients who underwent gay-affirmative therapy described feeling "comfortable" with their "bodies" and their "sexual selves" (p. 364). His participants also reported improvements in the quality of their gay relationships and they became much more comfortable with intimacy. In his phenomenological study, Lebolt (1999) reported that participants who were unsure about their sexual orientation and went through the process of gay-affirmative therapy ended up developing a gay identity which they integrated with other social roles. These same participants felt comfortable enough to come out to their family members, co-workers, and themselves.

In this same study, Lebolt (1999) found that the qualities of therapy and therapeutic relationship the clients found most helpful were when the participants felt a sense of connection with the therapist. This enabled them to feel “comfortable, safe, intimate, completely accepted, special, or valued” (p. 359). One participant described their therapeutic experience as “scary, intimidating, and terrifying, but wonderful, amazing, or enlightening,” another described it as “salvation... a life preserver in a sea of confusion” (p. 359). When describing their therapists, they used words such as “kind, sensitive, concerned, caring, warm, and friendly” (p. 359).

In terms of the professional qualities of the therapist, the participants found it helpful when the therapists were “non-judgemental, open, embracing, or accepting” (p. 360). Some of the clients talked about how much more comfortable it made them feel if their therapist was gay, lesbian, or bisexual as well. Haldeman (2004) reported that there is a potential for gay-affirmative clinicians to experience counter-transference through their clients’ situations and stop thinking about the clients’ needs. It is a very sensitive territory because, although from time to time therapists in general use some self-disclosure to create a connection with their clients, there is always the risk that the therapy will become about the therapist and not about the client, as it should be.

On the other hand, Harrison (2000) seemed to think the opposite, stating that gay clients may benefit from having a gay therapist who self-discloses his/her sexual identity. He stated that these therapists have an advantage because they are able to understand and relate to what the clients are going through and are aware of the resources that are out there for LGB as well as knowing first-hand what gay lifestyles are like. Harrison (2000) also asserted that a heterosexual therapist who is very well informed of resources for LGB as well as with their lifestyles can be objective, non-judgmental, and can help LGB clients feel comfortable around him/her. Therefore, the main qualities for a therapist to have is to be well aware of the coming-out process for LGBTQI clients, approach them in a non-judgmental and comforting manner, and provide them with resources to help ease their anxiety.

Some of the concerns that researchers (Cross, 2001; De Plott, 1997; Goldenberg, 2000; Langdrige, 2007) have regarding gay-affirmative therapy are that those who go through this process do not have the space to explore their sexuality, because the clinician might have the expectation that the ultimate goal is to accept and embrace their LGBTQI identity. If clients are looking for help in developing their sexual identity, they might think that going through gay-

affirmative therapy will not allow them to explore the possibilities of living a heterosexual life. Langdridge (2005) stated that clients need to feel a positive, safe, and encouraging environment from the clinician, but also a neutral one to encourage the development of their own sexual identity.

Person-Centered Approach

The person-centered approach¹ to working with sexual identity questioning is the newest of the three approaches covered in this report. It was proposed by Douglas Haldeman (2004) with the purpose of giving clients a high level of flexibility for their own self-exploration that Haldeman felt the other approaches did not provide. The person-centered approach was created with the purpose of “resolving internal conflict about religion and sexual orientation” (p. 695). Haldeman (2004) reported that religion is a crucial part of many individuals’ sexual orientation acceptance and, for this reason, should be taken into account at the time of providing clients with the help they need. He stated that this model is different from the gay-affirmative approach. Gay-affirmative therapy helps the clients adjust to the ultimate goal of becoming comfortable in their LGB (as he refers to this specific population) identity and the goals for the person-centered approach can be to accept their sexual orientation or find a way to repress it, change it, or repress the homoerotic feelings. Haldeman (2004) described the person-centered approach as a collaborative one in which the therapists and clients work together to identify the treatment goals and, therefore, what interventions are appropriate. He suggested the person-centered approach because he believed that there should not be just one approach available for clients who are having sexual orientation conflicts. Instead, he recommended an approach that collaborates to provide the clients with what they need, whether that is accepting their sexual orientation, exploring their sexuality or changing or suppressing their homoerotic feelings.

There are three general stages to the person-centered approach to help clients dealing with conflict between their religious and sexual orientation: assessment, intervention, and integration. The first stage is the “assessment of the conflicted client” (p. 697) in which the mental health practitioner needs to gather information regarding the factors that serve as motivation for the clients’ desire to change their sexual orientation or the factors that contribute to the clients’ confusion or conflict regarding their sexual orientation. Practitioners need to carefully avoid agreeing with or discouraging clients from their decision. During this stage it is

very important to look at the clients' experience dealing with sexual orientation issues and what they consider to be important aspects in their life. This will help in understanding how these current issues may affect them in terms of their family, religious beliefs, and values. It can also potentially create problems with counter-transference in the therapy process because clinicians need to be very careful to not bring their opinions and biases to the treatment because this approach is collaborative and client-oriented.

The second stage is what Haldeman (2004) called the "Treatment Phase: Psychoeducational Interventions" (p. 701). He explained that after assessing for internalized homonegativity, experiences with oppression through heterosexism, family history, social support availability, and other experiences related to the clients' sexual orientation, it is very important to narrow down themes and narratives that are important to explore further. In addition, the clinicians need to ask about previous conversion therapy experiences to assess for any emotional or psychological damage. Once this is done, the clinicians provide clients with literature and resources to explore and learn about gay culture, gay lifestyles, and gay relationships to allow them to have accurate and truthful information. This part of the process is crucial because many clients come from negative therapy experiences in which the people in charge have given the clients false information regarding the reason behind their sexual orientation, the negative outcomes of gay lifestyles and relationships, and the individual emotional suffering that these individuals supposedly experience because of their sexual orientation. For this reason, Haldeman stresses that clinicians must provide their clients with information that can give them a clear view on what gay cultures and lifestyles are really about.

Shidlo and Schroeder (2002) stated that clients are often misinformed about the experiences of gay, lesbian, and bisexual individuals. Haldeman (2004) stated that these clients needed "corrective experiences" which involve developing a support system or network including friends, family, and the community. In some cases, clients should be given the option of joining LGB support groups such as the local chapter of PFLAG (Parents, Family, and Friends of Lesbians and Gays) and trying out that lifestyle as well as going to a liberal church that accepts and welcomes non-heterosexual individuals. The purpose of this exposure is to help the client discover for himself/herself the truth about LGB lifestyles and culture.

The third phase is what Haldeman (2004) called the "Integration Phase" (p. 706). This stage deals with the differences in sexual behavior and sexual identity. Individuals who have an

LGB sexual identity are sometimes part of a heterosexual relationship. Haldeman explained that sexual behavior may or may not express an individual's sexual identity. For example, a man may identify himself as gay, but he is in a heterosexual marriage and has children. In these cases in which there is incongruence between an individual's sexual identity and his/her sexual behavior, the purpose is to integrate both aspects in a functional manner for the client. Some of these clients describe themselves as "functionally bisexual" (p. 707), because they are able to stay in a heterosexual relationship at the same time as having homoerotic feelings. These individuals may have no desire of coming out, especially when there is a family involved (wife/husband and children). Partners of these individuals might want their LGB husband or wife to seek therapy to contain their homoerotic feelings, but they are at times afraid that their LGB husband/wife will leave as soon as their children are independent. In this situation, the therapeutic approach that is advised is one that helps individuals separate their feelings and impulses from the behavior. These approaches are often referred to as "adaptation therapy or sexual identity management" (p. 707) and they are a group of cognitive-behavioral strategies that help clients monitor and control homoerotic feelings.

There is another issue present at this stage of sexual identity management which is the expression of the homoerotic feelings. Haldeman (2004) stated that it is very important for the process of identity management that the clients can express their homoerotic feelings, but that this is a decision that the individual wants to make, especially when s/he is involved in a heterosexual relationship. Some partners might not approve of this, but Haldeman (2004) believes that it is a very effective way to help LGB individuals incorporate their sexual behavior with their sexual identity. Sometimes, if their heterosexual partners do not approve of this, the LGB clients can express their feelings autoerotically which involves acts such as masturbation. Another nonsexual alternative to express their homoerotic feelings is to look for support groups of heterosexually married gay men or women and other social and interest groups that welcome people from any sexual orientation. Ultimately, it is an individual choice that clients make and it is very important to point out that compartmentalization of homoerotic sexual impulses for those who want to stay in the heterosexual marriage is often needed for their partners to feel safe in the relationship and for the sake of their marriage.

There are various concerns about the person-centered approach starting with the fact that Haldeman does not discuss the effectiveness of the treatment, nor does he discuss the secondary

effects of treatment – especially when the clients ultimately choose to live these so-called “bisexually functional” lives with their heterosexual partners. There was no empirical data that supports or discourages this approach. Therefore, it is not clear whether it is ethical to advise clinicians to create a safe therapeutic environment in which the clients can explore their sexual identity, if ultimately clinicians are going to advise clients to only express their sexual identity autoerotically if they want to save their marriage. Further research should be done looking at the long-term effects and benefits of this approach. It would be very helpful to conduct a longitudinal analysis and follow up of these clients to see how they were affected by their decisions, how they describe their marital satisfaction and relationship, and how are they doing individually. This will create a more solid base for this approach and it will help clinicians understand if it truly helps or not.

Summary of the Literature Found for Each of the Therapeutic Approaches

The existing literature on each of these approaches was assessed looking at the techniques and effectiveness of them. Reparative therapies have shown to have some positive effects on those clients who are motivated and eager to change their sexual orientation especially when their motives include religious beliefs and religious support. Reparative therapies have also been associated with negative post-treatment effects that can go from decrease in self-esteem to suicidality. The literature on the effectiveness of reparative therapies shows that although some clients may have found it helpful, others that had found it beneficial have gone back to having a homosexual orientation. It is clear though, that the negative post-treatment effects are potentially harmful for the people that go through this kind of therapy making the approach questionable when looking at the ethical aspect of it.

The gay-affirmative approach seemed to be very helpful for clients as well as extremely supportive of homosexual orientations. Clients who underwent these treatments ended up feeling much better with themselves and found it easier to accept their sexual orientation and embrace it. It should be noted though, that this approach may also constitute certain expectations for clients who are not clear about their preferred sexual orientation and it may cause them to choose a homosexual orientation because of the therapists’ opinion and power in the dynamics of therapy.

Finally, the person-centered approach seems to be the only one of the three approaches that gives the client the liberty of exploring their sexuality by providing them with opportunities to explore homosexual lifestyles as well as heterosexual ones in order for the clients to understand where they feel more comfortable. This is a fairly new approach and lacks empirical research that can provide information on its effectiveness and long-term effects to look at how clients that have chosen to suppress their homoerotic feelings are, especially living a heterosexual lifestyle. The person-centered approach is completely collaborative allowing the clients to choose their therapeutic outcome. It is important to be aware of the fact that this approach can ultimately encourage clients to live a heterosexual lifestyle in order for the client to feel more comfortable and live a bisexually functional life. It is clearly questionable how ethical this is.

There is a very mixed picture of what clinicians should do to effectively work with LGBTQI clients. As Swanson reported, there are still practitioners engaging in behavioral interventions involving heat, cold, and electricity that are obviously not effective and, in turn, leave the clients traumatized. Also, it is very clear that giving the clients a safe and non-judgmental environment in which they can explore their sexuality is very helpful, and these approaches might carry many expectations for the clients which, in the end, will make it difficult for them to possibly develop the sexual orientation they feel most comfortable with. Still, the truth of the matter is that it is very difficult for marriage and family therapists to know what to do in these situations because there is no clear stance from the American Association of Marriage and Family Therapy (AAMFT) regarding what course of action to take. Therefore, recommendations will be made to the field to provide some systemic guidelines for marriage and family therapists as well as evaluating which of these three approaches is the most ethical one.

CHAPTER 3 - Ethical Practice in Marriage and Family Therapy

Introduction

Over time, there have been many debates related to ethics, especially involving human beings. Knowing what is ethical presents a problem in and of itself because ethics are intangible and relative. Ethical boundaries might represent an ideology that for some is true and for others is not. In a country like the United States, and the world, it is very important to look at the general wellbeing of the population, and this is where ethics are relevant. Although there are topics in which the debates are ongoing, the real purpose behind them is to achieve a general understanding of what works better or worse for the general welfare of the population. For this reason, it is very important to look for the most ethical therapeutic approaches that will help stigmatized populations get the best services that they can find beneficial. Ethical practices are crucial for this to happen.

Significance of ethics

Throughout human history, many human rights have been violated. Activists all over the world have fought for things such as equality in the work force, women's suffrage, and civil rights. Behind every one of these actions was the concept of ethics. If ethics were ignored, the equal rights movement in general would not have existed and, most likely, women would not be allowed to do the same jobs that men have become accustomed to doing. For this reason, it is very clear that ethics are extremely important for the protection of each individual's wellbeing and therefore, ethical implications are imperative to consider when we seek to increase the quality of life for the population in general.

Helping professions

Ethics are very important in the helping professions, such as the mental health and medical fields, because they allow professionals to look at universal boundaries that can help each professional understand what to do when specific situations arise. Most professional fields have an organization that dictates, through a code of ethics, what those limitations are to protect the welfare of clients. Still, the codes of ethics might not be helpful in all situations which creates debates regarding the best course of action that can ultimately be considered as ethical.

Marriage and Family Therapy

The marriage and family therapy field, just like any other mental health field, is guided by ethics to protect clients, and to protect the field as well. The clinicians who practice marriage and family therapy need to protect their clients and themselves from potentially harmful incidents that may occur inside a therapy room. The field of marriage and family therapy has addressed many ethical issues within our changing society such as discrimination against race, ethnicity, gender, disability, and sexual orientation. It is very important that the field continues to assess the issues in society over time and make appropriate changes to their code of ethics, when needed.

LGBTQI Issues

LGBTQI have been through a lot of changes over the last 50 years, but they are still not enjoying equal rights. This population is fighting for equal rights such as being able to have their marriages recognized, gaining the right to adopt, and having the ability to buy and/or rent a place to live without suffering from discrimination. Practices that deny another person his/her rights are unethical. Although MFTs do not have the power to change the law system in the United States, they are still able to help these individuals with their issues concerning dealing with society's standards. The basis of helping LGBTQI relies on ethics, making it a very important topic when looking at how marriage and family therapists can provide a neutral, safe, and encouraging environment whenever needed.

Definitions

Zygmund and Boorhem (1989) described *ethics* as “a system of ethical values and ethical theories, which are used to determine what is right in general, not what promotes the welfare of a specific individual or group while harming other individuals or groups” (p. 2). These are decisions based on what is better or worse for all the people involved. On the other hand, *values* are related to our preferences regarding what we think is important and where our priorities lie. Values are personal beliefs of what is best, but they may not take into account the general population's wellbeing, which means values may not always be ethical (Zygmund and Boorhem). *Morals*, like ethics, are also involved in decision making. This term refers to what one considers to be right and wrong (Thiroux, 2001). Morals are often used to create the law, for example, because morals indicate what behavior is considered wrong or right. Also, it is very

important to take into consideration the culture, customs and traditions of the place in which the law is being enforced (Thiroux). For this reason, ethics and morals go hand in hand; morals help dictate right and wrong behavior and ethics state better and worse decisions or situations.

Lastly, *ideology* is a term that is and will be used throughout this report and the Encarta World English Dictionary (2009) defines it as “a set of beliefs, values, and opinions that shapes the way a person or a group such as a social class thinks, acts, and understands the world.”

Ethics will be emphasized throughout the remainder of this paper to help provide guidance for MFTs regarding appropriate professional behavior when working with LGBTQI clients. Ethics are very important for professional associations because they dictate the guidelines within which professionals work. The problem comes when the guidelines that clinicians have to follow are not specific or inclusive enough to inform the professional about what to do in particular situations. This creates what is called an ethical dilemma: “a problem for which no course of action seems satisfactory” (Kitchener, 1984). Ethical dilemmas can arise when ethical guidelines are contradictory creating conflict and confusion between the possible solutions (Kitchener, 1984). There are inevitable gaps in all codes of ethics because it is impossible to address every possible situation that may arise in an ongoing changing society. For this reason Karen S. Kitchener (1984) created a model for ethical decision making that takes professionals through a step-by-step process of making an ethical decision when the code of ethics are not clear enough.

Kitchener’s Model for Ethical Decision Making or Moral Justification

In Kitchener’s Model for Ethical Decision Making or Moral Justification, there are two levels of moral reasoning which Richard Hare (1981) introduced: the intuitive level and the critical-evaluative level. The intuitive level is the immediate response based on what a practitioner thinks is right and wrong. At this level, the clinician falls back to judge the situation through his/her own moral values (Kitchener, 1984). S/he also judges the situation through the empirical facts of the situation. Also at this level, there will be differences in the moral judgment among people depending on each person’s moral values; therefore, there is still the ethical dilemma of who decides which choice is ethically wrong or right when decisions are determined by moral values which will ultimately be subjective and not general. The potential for making an unethical decision is high when one relies only on his/her intuition or ordinary moral sense.

Because the intuitive level is not enough to assure one will make an ethical choice, Hare (1981) suggested that a critical-evaluative level of moral reasoning is necessary to achieve an ethical course of action. At this level, professionals consider the ethical implications of various decisions to identify one that will be judged as either “good” or “bad” under the code of ethics. Kitchener (1984) stated that “the critical-evaluative level is used to illuminate our ordinary moral judgment and to redefine the bases for our actions in similar situations” (p. 45).

Three tiers form the critical-evaluative level, each more abstract than the last: ethical rules, ethical principles, and ethical theory. One begins with ethical rules. If this level does not provide an appropriate answer, one moves to the next level and it continues this way.

Ethical Rules

Ethical rules are the professional codes of ethics, laws, and rules that clinicians are bound to abide. Professional associations have created codes of ethics to help practitioners know what to do in situations in which ethics and values are conflicted. It is clear that there are limitations to ethical rules because it is very difficult for ethical rules to address every single situation that may come up. Still, there is no doubt that these rules or codes of ethics have helped professional organizations to deal with the most common ethical dilemmas that have presented themselves in the different fields.

Ethical Principles

The second tier of Kitchener’s Ethical Decision Making or Moral Justification Model includes ethical principles: autonomy, nonmaleficence, beneficence, justice, and fidelity. Kitchener (1984) discusses that these principles can be generalizable among the world’s population because they compose basic human rights. For this reason, they are chosen to represent the five ethical principles in her model. These principles are very helpful whenever the ethical rules are unable to help with making a moral decision. They provide the professional ethical support.

Autonomy

Autonomy refers to the need to respect that individuals are free to choose what they want for themselves as long as they do not go against others’ well being. There are limits to an individual’s autonomy. First, the person cannot limit other’s sense of autonomy and second, for

individuals to be treated as autonomous people, they need to be able to show competence by having the ability to make rational and competent decisions (Kitchener, 1984). There are many gray areas and ethical dilemmas related to autonomy; for example, clinicians may be trained to respect clients' autonomy, but the clients' ability to be reasonable may not be emphasized.

Nonmaleficence

Nonmaleficence refers to doing no harm to others. There are limits to this statement, as Kitchener (1984) stated, because clinicians need to consider the situation in which harm was inflicted. For example, it is very different to hit someone for no reason at all, then to hit someone because of self-defense. Kitchener also pointed out that codes of ethics imply that clinicians should not do any harm to clients, but what constitutes harming clients is not explained in detail. Again it is evident that ideology comes up because when the codes of ethic are not clear about what harming a client entails, the therapists might end up using his/her subjectivity to explain his/her reasoning for why a specific behavior is considered harmful or not.

Beneficence

Beneficence is actively doing good for the wellbeing of others. Kitchener (1984) reported that there could be issues present when things such as "paternalism" are involved. Paternalism, is "acting like a father towards a person" (p. 49) when someone wants the best for somebody else even if s/he does not want to follow that path. It is clear that this is where the conflict between autonomy and beneficence might create an ethical dilemma, especially if the individual is competent enough to make reasonable decisions. In this case, the clinician needs to assess if it is really helping the client that someone else is making a decision for his/her benefit, or if, in the end, it is a violation of the individual's autonomy. It is an ethical dilemma that has to do with the relative nature of the situation, and this can be a very gray area.

Justice

Justice refers to being fair to others by treating them as equals. Problems with justice may come up because people are usually in conflict over limited resources, for instance, health services. This is something that people struggle with because of the differences that exist between individual values. Some give value to material things such as cars and clothes; others give value to compassion and love. Still there is a struggle to survive in a society that is

constantly racing to be better than others. This is a very important principle to keep in mind as clinicians because it comes with a history and it is still an ongoing ethical dilemma. Clinicians are still having difficulties understanding and knowing how to deal with clients from different cultures and ideologies, religious perspectives, race, socio-economic status, and, of course, sexual orientation. Hate crimes are still happening as well as issues with discrimination. For this reason, there needs to be some type of rule that can provide guidance for people in general.

Fidelity

Fidelity includes being respectful of others, being trustworthy and honest with confidentiality, and maintaining a loyal relationship. For example, informed consents are supposed to be handed to clients whenever they request mental health services. These informed consents help the professional-client relationship be grounded in what the informed consent dictates, helping the clients feel comfortable and trustworthy of the professional and the process. Another example is the role of confidentiality in session. However, confidentiality is not always as simple to maintain as one might imagine. It also can be involved with potential ethical dilemmas. For instance, marriage and family therapists have an obligation to maintain confidentiality of their clients' information except when there is child abuse or neglect, elderly abuse or neglect, suicidal and homicidal ideation or behavior, and when the case goes to court if the records are subpoenaed by the judge. This allows the clients to understand that there are limits to confidentiality. It can create a very difficult position for the therapist when, if the information is divulged, it might do more harm than good for the clients.

Ethical Theory

It is very common that ethical principles create conflict. For instance, when a clinician is bound to report child abuse, but by doing so s/he is putting the life of the child in danger, what should the therapist do in this case? Should the therapist exercise his/her duty to report, or should she protect the children? When this happens, Kitchener (1984) suggested applying ethical theory to help make an ethical decision. She defined two ethical theories: universalizability and the balancing principle.

Universalizability

Universalizability refers to making ethical decisions that can be generalizable to others with the same situation. Therefore, decisions are ethical only when the same decision can be made in similar situations. Zygmund and Boorhem (1989) added three things that students and supervisees should think about to determine if the ethical dilemma solution is generalizable: (a) the therapist should put himself/herself in the clients' position and think about how they would like their therapist to respond, (b) the therapist should put their family in the clients' position and thinking about how he/she would like his/her therapist to respond, and (c) the therapist should put himself/herself in someone else's position and ask himself/herself if how s/he would like their therapist to respond. Zygmund and Boorhem (1989) further stated that if the student and supervisee are unable to agree with the course of action in these three cases, then there is a potential possibility that the decision is unethical.

Balancing Principle

The second ethical theory that Kitchener (1984) talked about is the balancing principle. The purpose is to attempt to balance the possible harms and benefits that may come from a decision in order to achieve the best balance of good over harm. Clinicians should look for the greater benefits and the least amount of avoidable harm for all the people that are involved. Clinicians need to weigh the harms and benefits and opt for a course of action that allows the least amount of harm for the clients.

Application of Kitchener's Model to LGBTQI Therapeutic Approaches

Now that Kitchener's Model of Ethical Decision Making or Moral Justification has been presented and thoroughly explained, it will be applied to each of the three therapeutic approaches presented to deal with sexual orientation issues.

Reparative Therapies

Reparative therapies are used to re-orient, repair, or change someone's sexual orientation from homosexual to heterosexual. The approaches will now be assessed using Kitchener's model to understand how ethical they are.

Ethical Rules

Several professional organizations have taken a clear stance on whether or not reparative therapies are effective as well as whether this therapeutic approach fits within the profession's ethical rules. It needs to be taken into account that each organization has a different history behind it. This can ultimately help explain why some associations have been able to emit a clear opinion regarding reparative therapies and others, such as AAMFT, have not yet done so. In 1997, the American Psychological Association adopted the "Resolution on Appropriate Therapeutic Responses to Sexual Orientation". This resolution states:

For nearly three decades, it has been known that homosexuality is not a mental illness. Medical and mental health professionals also now know that sexual orientation is not a choice and cannot be altered. Groups who try to change the sexual orientation of people through so-called "conversion therapy" are misguided and run the risk of causing a great deal of psychological harm to those they say they are trying to help. (Mills, 1998, p. 3)

The American Psychological Association also stated that the majority of studies on conversion therapies were conducted by organizations that were completely biased rather than by mental health professionals. The research techniques they used were poorly documented and the length of time that they waited to follow up on the participants was too short. This goes hand in hand with what Serovish et al. (2008) found when they looked at the outcome research done in this area.

In 1998 the American Psychiatric Association also adopted a position statement opposing reparative therapies designed to change a person's sexual orientation. They stated:

The American Psychiatric Association opposes any psychiatric treatment, such as "reparative" or "conversion" therapy which is based upon the assumption that homosexuality *per se* is a mental disorder or based upon a prior assumption that the patient should change his/her homosexual orientation (Mills, 1998, p. 3).

The National Association of Social Workers (NASW) Committee on Lesbian, Gay, and Bisexual ISSUES (NCLGB) issued the following statement:

The increase in media campaigns, often coupled with coercive messages from family and community members, has created an environment in which lesbians and gay men often are pressured to seek reparative or conversion therapies, which

cannot and will not change sexual orientation.... NCLGB believes that such treatment potentially can lead to severe emotional damage.... No data demonstrates that reparative or conversion therapies are effective, and in fact they may be harmful. (NCLGB, 2000, pp. 1-2)

In addition to the NCLGB statement, the NASW stated:

An examination of the position statement of the NASW regarding conversion therapy indicates that the social work profession does not endorse the use of conversion therapies. It is equally clear that, as addressed above, the techniques of conversion therapy may violate the core values and ethical principles of the profession. (Jenkins & Johnston, 2004, p. 560)

In 1992, NASW stated: “NASW discourages social workers from providing treatments designed to change sexual orientation or referring clients to practitioners or programs that claim to do so.” (p. 3). In addition, they stated that “NCLGB believes that such treatment potentially can lead to severe emotional damage.” (p. 2).

In March of 1998, the American Counseling Association (ACA) passed a resolution proposed by the association’s Human Rights Committee. The motion to accept was made by representatives of the Association for Gay, Lesbian, and Bisexual Issues in Counseling (AGLBIC) and was titled “On appropriate Counseling Responses to Sexual Orientation”. The original resolution stated:

The American Counseling Association *opposes the use of so-called “conversion or reparative” therapies in counseling individuals having a same gender sexual orientation*; opposes portrayals of lesbian, gay, and bisexual youth as mentally ill due to their sexual orientation and supports the dissemination of accurate information about sexual orientation, mental health and appropriate interventions in order to counteract bias that is based in ignorance or unfounded beliefs about same-gender sexual orientation. (ACA, 1998, p. 1-2)

During the debate that occurred when this resolution was presented, the association decided that they were going to delete the phrase in italics above that pertains to the opposition of reparative therapies (ACA, 1998). The ACA did maintain a position in which they opposed reparative therapies if the clinicians portray “lesbian, gay, or bisexual youth as mentally ill,” if a

counselor gives clients false or inaccurate information or if clinicians have unsupported beliefs about sexual orientation (ACA, 1998, p. 1-2).

All of these mental health professional associations have made clear statements that reparative therapies should not be considered as a course of treatment because of the poor quality of research that exists and also because of the great potential for psychological, emotional, and social damages.

Medical associations have joined the group of professional associations against the use of reparative therapies. The American Academy of Pediatrics stated:

Confusion about sexual orientation is not unusual during adolescence. Counseling may be helpful for young people who are uncertain about their sexual orientation or for those who are uncertain about how to express their sexuality and might profit from an attempt at clarification through a counseling or psychotherapeutic initiative. Therapy directed at specifically changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation. (American Academy of Pediatrics, 1993, p. 633)

The American Medical Association also stated:

Most of the emotional disturbance experienced by gay men and lesbians around their sexual identity is not based on physiological causes but rather is due more to a sense of alienation in an unaccepting environment. For this reason, aversion therapy (a behavioral or medical intervention which pairs unwanted behavior, in this case, homosexual behavior, with unpleasant sensations or aversive consequences) is no longer recommended for gay men and lesbians. Through psychotherapy, gay men and lesbians can become comfortable with their sexual orientation and understand the societal response to it. (American Medical Association, 1994, p. 12)

Medical associations also emphasize that there are other therapeutic needs that are far more helpful and much less harmful than reparative therapies. It is very important to allow the clients to explore their sexual orientation and the expression of that sexual orientation as it is mentioned in these statements and that is something that definitively is not happening in conversion therapy.

Assessment of Reparative Therapies using the AAMFT Code of Ethics

The first principle applying to marriage and family therapists that practice reparative therapies violate is 1.2: “Marriage and family therapists obtain appropriate informed consent to therapy or related procedures as early as feasible in the therapeutic relationship”. As previously discussed, most practitioners of reparative therapies are failing to include in their informed consent realistic expectations for treatment when reparative therapy is used as the therapeutic approach. Some of them also fail to provide a list of possible side effects that clients may encounter from engaging in this particular therapy process. Therefore, it seems that most of the clinicians who practice this approach are going against this principle. It is imperative that clinicians provide consent forms regardless of the therapeutic approach that they prefer using. They should also be thorough in their consent forms giving detailed information about these negative post-treatment effects as well as the efficacy of the proposed intervention and prognosis to be able to create an ethical therapeutic environment.

The second principle that is violated is 1.3: “Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons” (AAMFT, 2001). It was stated in the literature (Haldeman, 2004) that this was one of the main ethical dilemmas in reparative therapies because the clinicians need to be aware of their reactions in the therapy process. These can alter the client’s opinion and create confusion regarding what they are supposed to be feeling and experiencing as well as what they are currently feeling and experiencing. It is also a way of imposing the therapist’s opinion and disregarding the client’s. This makes the clients’ believe that something is wrong with a big part of who they are and can create internalized homonegativity which can be very detrimental to the individual.

The third principle that is in violation is 3.12: “Marriage and family therapists make efforts to prevent the distortion or misuse of their clinical and research findings.” When clinicians are confronted with clients who are asking for reparative therapy or were referred with the purpose of getting reparative therapy, practitioners should be honest about the empirical findings on the effectiveness of conversion therapy and possible negative post-treatment effects. The information provided about sexual orientation clearly needs to be accurate and there should be resources given to the clients about homosexual cultures and lifestyles. Haldeman (2004) discussed how participants reported that their reparative therapists deceived them with false

information about the causes of homoerotic attraction and how these therapists did not discuss with them the possible post-treatment effects that research has empirically proven. This is a direct violation of this principle.

The American Association of Marriage and Family Therapy needs to clearly address this ethical dilemma that jeopardizes clients' mental and physical health just as these mental health and medical associations did. This will give LGBTQI clients the option of seeking ethical therapeutic approaches for their own wellbeing.

Ethical Principles

There will be a thorough analysis of the ethical practices of each of the approaches to determine which one is the most ethical one. In terms of reparative therapies, not having clear ethical guidelines to follow, marriage and family therapists are able to choose reparative therapy as a course of treatment regardless of the possible negative post-treatment effects it may have on the clients. Since ethical rules do not help in this case, clinicians need to move onto the ethical principles.

Autonomy

It is evident that practitioners need to look at this principle carefully because the limitations of it are very important to take into account. Oftentimes individuals seek reparative therapies to help them deal with their sexual orientation conflicts. This usually has to deal with their religious background, support system, and social network; therefore, it is very important to take these facts into account. Since individuals are being urged to "get rid of" their homosexuality, the clients' autonomy is at stake because they are being strongly influenced by their environment knowing that there will be negative consequences if they choose to live a homosexual lifestyle. It is clear that this is a violation of this particular ethical principle because clinicians are not allowing the clients to make their own decisions; in turn, clinicians are asking them to go through a process that can be very harmful because the clinicians assume that a large part of the clients' "self" is "broken". This can impede clients from making life decisions that can be very detrimental for their physical and mental health. This is especially true when clients themselves come asking for reparative therapy. They are highly influenced by the people they respect, that they end up truly believing that something is greatly wrong with them; therefore, they find ways to fix it.

Nonmaleficence

Schroeder and Shidlo (2001) conducted research with a group of individuals who had been through conversion therapy and found out that the therapists were telling the clients false information about homosexuality. Some of the things participants reported were that homosexuality is a psychological disorder, homosexuality is synonym of unhappiness, homosexuality is a disease with a cure, that it is a phase that they will grow out of, that it is a symptom of a psychiatric disorder, and that gay men do not have monogamous relationships. By doing this, the clients felt a lot of self-hatred because it was very difficult for them to get rid of this “disease.” Schroeder and Shidlo also found that low self-esteem can be a result of the false information provided by the practitioners during the conversion therapy process especially when the clients ended up confused about what they were supposed to feel as opposed to what they are currently feeling.

These research findings highlight the harm that has been done by reparative techniques. It illustrates violation of the principle of nonmaleficence. The only consistent data that research studies on reparative therapies have come up with is that they are very harmful for clients (Beckstead and Morrow, 2004; Davison, 1976; Garnets et al., 1991; Jay-Green, 2003; Haldeman, 1994; Haldeman, 1999; Haldeman, 2001; Haldeman, 2004; McConaghy, 1969, 1975; McConaghy & Barr, 1973; Mills, 1998; Schroeder and Shidlo, 2001; Serovich et al., 2008; Shidlo & Schroeder, 2002; Shidlo, Schroeder, & Drescher, 2001).

Beneficence

From the reparative therapist perspective, some of the literature presents them as having the desire to actively do good by helping clients who are struggling with unwanted homoerotic attraction (Throckmorton, 1998). The therapists that practice reparative therapies are wanting to help clients deal with the different issues concerning their homosexual orientation by giving them a chance to change their sexual orientation. Therefore, beneficence is a principle that reparative therapy respects by actively wanting to do good to the clients that are seeking help and that want to change their sexual orientation.

Justice

One common factor in all the codes of ethics mentioned in this report was that the professional practitioners should not participate in discriminatory acts in their relationships with others based on sexual identity. Reparative therapies seem to violate this ethical principle because by choosing this therapeutic approach to sexual identity conflicts, by valuing one sexual identity (heterosexuality) and devaluing another (homosexuality) based on no scientific or mental health research evidence. This results in discrimination against a group of individuals. Instead of accepting a clients' identity, the clinician tries to change it into what is considered as "right" or "acceptable". Ultimately, this can cause internalized homonegativity.

Fidelity

In this principle there are many factors that are being violated by reparative therapists. First of all, their consent forms often do not include the possible harms that reparative therapies can cause (Schroeder & Shidlo, 2001). Second, clients are given false information regarding the American Psychological Association's stance on reparative therapies or misinforming the clients about it (Schroeder & Shidlo, 2001). Therefore, because of therapists not providing the clients with truthful information, as the clients expect their therapists to do, they end up believing that the American Psychological Association considers reparative therapies as beneficial and ethical. Third, clients are told that if the process is not working, it is because the clients' are not motivated enough, because they do not want it enough, and because they are not working hard enough to achieve the goal (Schroeder & Shidlo, 2001). This deception was a prominent theme mentioned by clients who have been through conversion therapy. When the approach did not produce the desired result, the clients were left with the reality of being unable to change their sexual identity.

It is clear that reparative therapies violate four out of the five ethical principles. Therefore, it is considered unethical based on the assessment done through Kitchener's model.

Gay-Affirmative Therapies

After looking at reparative therapies, the attention will be focused on gay-affirmative therapies which are used to help clients from lesbian, gay, or bisexual orientations to accept their sexuality and feel comfortable in it.

Ethical Rules

Gay-Affirmative therapists need to follow a set of guidelines if they want to pursue a gay-affirmative approach with clients. AAMFT does not provide any guidelines for therapists who wish to pursue this therapeutic treatment; therefore, for the purpose of this report, Clark's (1987) guidelines will be used. These guidelines are:

- Therapists need to assess their feelings towards LGB, as Clark (1987) refers to this group, with the purpose of understanding their biases and personal opinions regarding these populations. This is very important to take into account because when therapists have these biases present at the moment of therapy; they will be able to address any counter-transference that may occur. For instance, an example could be if the therapist does not allow room for the clients' identity to develop on its own and, instead, they want the clients to accept their homosexual identity whether that is the clients' goal or not.
- The therapist should refrain from implying that LGB identities are pathological not acceptable because the purpose of gay-affirmative therapy is to provide the clients with a safe and open environment in which they can accept and embrace their sexual orientation.
- It is important that the therapist makes a point to work with society's standards and the effects that has with the LGB clients such as oppression, discrimination, and prejudice.
- The therapist needs to help the client get rid of internalized homonegativity caused by society's standards and give the client the opportunity to explore feelings of anger and frustration related to these issues.
- Therapists also need to provide support for the clients to perceive acceptance of their feelings and sexual impulses. It is very important to actively support the client into seeking out an LGB support group as well as helping them understand and distinguish between society's expectations, and the clients' feelings.
- The therapist needs to help the clients' feel affirmed on their own LGB thoughts and feelings by the authority that the clinicians have because it is a symbol of respect.
- The therapists need to support their clients in their attempts to enjoy and embrace their homosexual identity.

Assessment of Gay-Affirmative Therapies using the AAMFT Code of Ethics

The principle that might be violated by some gay-affirmative therapists is 1.3: “Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons” (AAMFT, 2001). Counter-transference, as mentioned before, needs to be fully addressed with clinicians because they need to be aware of their biases and beliefs before they proceed to provide treatment to clients who are struggling with accepting and embracing their sexual orientation. This falls into this principle because therapists need to understand the power differential in the therapy room as well as the influential power of their opinions and biases. As therapists are unaware of this, it is evident that some clients may come in with expectations that may not match what they were looking for in the first place. It is crucial that therapists that practice gay-affirmative therapy are aware of their potential influence in their clients with the purpose of providing a service that it is fit for the clients’ needs.

Ethical Principles

Autonomy

Those who seek gay-affirmative therapy may encounter ethical dilemmas related to the expectation of becoming gay individuals. Researcher’s concerns have been presented regarding this approach (Cross, 2001; De Plott, 1997; Goldenberg, 2000; Langdridge, 2007). It seems that clients might go in with an expectation from the therapist and the therapeutic process because they think that because of the name of the therapeutic approach, the therapist will want to convince them of becoming homosexuals even if that is not the clients’ goal. This has to be taken into account carefully because it has to do mostly with the counter-transference that the clinician brings to the room, and the level of control that the clinician has about his biases and pinions. Still, this can show that the principle of autonomy might not be respected since there might be therapists who have the assumption that those who seek gay-affirmative therapy are expecting to become lesbians, gays, or bisexuals. On the other hand, there might be therapists who practice this approach and that respect the clients’ autonomy by allowing them to make a decision regarding their sexual orientation that fits what makes the client more comfortable. This would most likely come from a therapist who is aware of his/her biases and does not

influence the client into choosing a sexual orientation over another. This would be a way that the gay-affirmative approach would respect the principle of autonomy.

Nonmaleficence

In gay-affirmative therapy the purpose is to embrace and accept homosexuality and clinicians who practice this kind of approach firmly believe that this is helping the clients. Since research has shown that gay-affirmative therapy is beneficial, most likely, if the therapist is going by the existing guidelines, they are not actively doing harm to the client, especially when it is the client who decides to be a part of the approach. After an assessment on the literature available, the gay-affirmative approach appears to respect this principle.

Beneficence

Research has shown that this type of approach can be beneficial for people with a homosexual identity helping them achieve a better and more positive lifestyle (Lebolt, 1999). Gay-affirmative therapy was created to provide LGBTQI clients with a therapeutic approach that would help support, embrace, and accept their sexual orientation. For this reason, it is very clear that this approach respects the principle of beneficence, because it actively tries to help clients feel comfortable with their sexual orientation by allowing them to learn more about themselves and develop a healthy inner-working model. This gives space for the clients to feel comfortable in their own skin as well as comfortable with their developing identity.

Justice

From the gay-affirmative perspective, it is very easily seen how it honors those who are LGBTQI and allows them to feel comfortable in their sexual identity. The reason why the literature might present this approach to be not as comforting for those who are questioning is because, more than likely, they are brought in with the expectation that by going through gay-affirmative therapy they have made the decision of embracing homosexuality when, in reality, they were not sure if that was the sexual identity they wanted to adopt. From that perspective, it is very possible that gay-affirmative therapy might be going against the principle of justice, but for those who are seeking acceptance of their homosexual identity, gay-affirmative therapy might be the right approach since it gives them a sense of acceptance that they may be lacking from the environment they live in.

Fidelity

The gay-affirmative therapy literature did not mention any problems with informed consents or issues regarding false information given to clients. The relationship between the clients and the therapist is one that creates trust in the session to allow the clients' acceptance of their homosexual identity. Again, if the ultimate goal of the clients is to embrace and accept their homosexual identity, and based on the information known about this approach, it is apparent that gay-affirmative therapy does a very good job of making the clients feel comfortable in therapy by allowing them to be themselves and experience a non-judgmental environment.

Person-Centered Approach

There is very little information regarding the person-centered approach. This is a collaborative approach in which the therapist honors the client's autonomy to the extent in which the client can decide what s/he wants their sexual orientation to look like.

Ethical Rules

This is a new approach that Haldeman (2004) presented with the purpose of adding another alternative for treating clients who are having conflicts related to sexual orientation. There are no rules stated for this approach; therefore, clinicians who want to implement this approach need to continue assessing it through the ethical principles.

Ethical Principle

Autonomy

It seems that this approach respects this ethical principle of autonomy because it gives the clients options in choosing their own outcome of therapy. This, in turn, respects the clients' ability for making decisions about their sexuality. The person-centered approach appears to implement the principle of autonomy almost to the extreme of allowing people who might not be competent enough to make a decision that will ultimately affect their future life. The problem is that if the clients choose to not accept their homosexuality, the therapist can provide the clients with referrals to go through some type of reparative therapy and ultimately suppress their homoerotic feelings and attraction to save their relationship with their spouse and children.

Clinicians need to evaluate if clients are in the position of making a conscious and reasonable decision, or if their decision is being influenced by their environment and/or false information. Practitioners should be advised by their code of ethics to educate individuals to help them understand the reality of their sexual orientation, giving the clients information and resources that can help them explore and deal with their sexuality and, in turn, exercise their autonomy. This approach provides the clients with information about possible LGBTQI lifestyles to help the client integrate their sexual orientation, but it is clear that, as it is stated by the principle, allowing the client to exercise their autonomy through saving their marriage even when that entails suppressing their true sexuality is not what autonomy is about.

Nonmaleficence

The perspective behind the person-centered approach is to provide the clients with options instead of expectations. Although their options might include referring clients to reparative therapists because it is what the client ultimately desires, research has shown that reparative therapies can be very detrimental and harmful. Therefore, the way that this approach takes on this principle may be debatable. Although the therapists are respecting what the client wants, there should be a limit to the options they offer. For instance, if a drug addict states that after trying to be sober he would like to go back to being a drug addict, would the therapist recommend someone who sells drugs? There are definite limits to decisions such as this one.

Beneficence

The person-centered approach has the basic purpose of helping clients feel much more comfortable with who they are and who they want to be because it gives them options to explore the different paths that they can take. The purpose for doing this is to help clients understand and know which orientation feels the most comfortable. Therapists need to respect the clients' opinion because it is what makes the approach beneficial. Therefore, this approach respects the principle of beneficence by looking for different ways and options to create a beneficial therapeutic experience for clients.

Justice

The person-centered approach appears to respect this principle since it is very accepting of heterosexual and homosexual individuals that are having problems with their sexual identity.

Regardless of the options that it provides and whether these are harmful or helpful, they truly value the individuality of each person, making the clients feel comfortable and not tied to one extreme or the other. Still, it would be much more helpful if there was more research done on this perspective to see if it is truly appealing to clients that are struggling with their sexual identity and if they feel as comfortable as the approach makes it seem.

Fidelity

The person-centered approach seems to give a lot of importance to creating a good relationship between the clients and the practitioners for the clients to feel comfortable enough to explore the different options available. In this approach the clinician provides the clients with truthful information regarding gay lifestyles, liberal churches, and other general information with the purpose of helping the clients choose the best alternative for them depending mainly on their religious values and the type of family support available. Unfortunately, this approach failed to provide information regarding the type of informed consent they would use as well as the possible positive or negative consequences of treatment.

Which approach is ethically the best?

To determine which of these three approaches is the best for dealing with sexual orientation issues, ethical theory will be used to compare them side by side and come to a conclusion. This step utilizes two theories that help professionals make an ethical decision: universalizability and the balancing principle. As a reminder, universalizability is when the ethical decision made can be generalized to others in the same situation; the balancing principle refers to professionals looking for the greater benefits and the lesser harms for those involved. Now that these definitions have been reviewed, ethical theory will be applied to the three approaches in an intent to compare them and look and which one would be the most ethical and beneficial one for LGBTQI clients.

First of all, reparative therapies are considered unethical at the ethical principles level; therefore, it is unnecessary to analyze it at the ethical theory level. Still, when the theory of universalizability is applied, it is evident that reparative therapies are unethical. If practitioners are or should be attempting to avoid causing harm for all the people involved in the situation, then it ought to be clear that reparative therapy should not be considered as a course of action because of the harm it can cause to individuals. In addition, four out of five ethical principles are

being violated by reparative therapies. These are: autonomy, nonmaleficence, justice, and fidelity. By violating most of the principles, it is clear that reparative therapies are doing more harm than good and when the balancing principle is applied, it is evident that reparative therapies are completely unethical and very harmful.

Gay-affirmative therapy, on the other hand, appears to respect both theories of universalizability and the balancing principle by allowing people from all sexual orientations to feel accepted and safe. It honors 4 out of the 5 ethical principles which, compared to reparative therapies, it is evident that this approach is much safer for the clients' physical and mental wellbeing. Therefore, it respects the balancing principle because it is looking for the greater benefits in therapy. This theory generalizes the same services, rights, and acceptance to LGBTQI as well as heterosexuals allowing them to accept and embrace their sexual orientation. Because of this, the gay-affirmative approach also respects the theory of universalizability because their ethical rules and the type of therapy they do can be generalized to anyone having problems with sexual orientation. Gay-affirmative therapy provides a safe place for individuals to express their homoerotic and heterosexual feelings without feeling judged. It is clear that gay-affirmative therapy respects the balancing principle and universalizability.

Lastly, the person-centered approach provides clients with different options of exploring their sexuality. Although there is not much research done on this approach, it seems that it respects the theory of universalizability because it invites all of those who are struggling in any way with their sexual orientation to go explore the possibilities that exist and chose the one that represents the less harms. For this reason, this approach also respects the balancing principle because it is looking for what the client believes is beneficial. The one limitation present in this approach, though, is that it still provides clients with the option of going through a reparative therapy process if the clients believe that a homosexual orientation does not feel right. As previously discussed, reparative therapies are clearly unethical and this approach to still provide its clients the option of going through reparative therapy makes the approach somewhat questionable. It appears the person-centered approach relies too much on the clients' autonomy without understanding the fact that the approach can be seen as unethical because reparative therapy is an option.

Table 1.1 Therapeutic Approaches for Dealing with Sexual Orientation Issues

Kitchener's Model	Reparative Therapy	Gay-Affirmative Therapy	Person-Centered Approach
Ethical Rules	A set of rules that provide boundaries and limitations for clinicians does not exist.	It provides guidelines for clinicians who want to use it in therapy.	This approach also does not have any ethical rules to go by for those who want to use it in therapy.
Ethical Principles	This approach violates almost all the principles except for Nonmaleficence.	It respects all ethical principles but limitations could exist in different situations.	Autonomy is imperative in this approach but the principle of Nonmaleficence is violated when reparative therapy is an option.
Ethical Theory	Universalizability is not present because Reparative Therapy is only used for people who want to become heterosexual. The Balancing Principle would state that the harms are much greater than the benefits.	Universalizability is present because this approach is accepting of homosexuals and heterosexuals equally, but the therapists' can experience possible counter-transference. It also has great benefits.	Clients dictate what they want to be their ultimate goal of therapy; therefore, it can be applied to any type of situation regarding sexual orientation. Still, it provides the option of reparative therapy, making it not as beneficial.

Based on this discussion and the information provided in the literature, the gay-affirmative therapy approach qualifies as the most complete and ethical treatment for clients who

are struggling with sexual orientation conflicts. It is clear that this approach takes into account the majority of the ethical guidelines presented through Kitchener's Model of Ethical Decision Making. Still, the literature has provided information on how the name of this approach can create expectations for clients, not allowing them to explore their sexuality, but instead, receiving direct or indirect influence from their therapists to embrace homosexuality. This may be a particular concern for clients who are questioning their sexual orientation and who are looking for a safe place to explore their sexual orientation instead of being persuaded one way or the other. Although this approach is open to any sexual orientation and its primary purpose is to provide LGBTQI clients with an accepting and safe environment, clinicians need to be aware of their own biases and experiences to prevent counter-transference from happening. Still, compared to the other two approaches presented, the gay-affirmative approach seems to be the most ethical one of all.

CHAPTER IV – Discussion

After carefully reviewing the literature and research regarding reparative therapy, gay-affirmative therapy and the person-centered approach, it is clear that more outcome research is needed to determine which one is the most ethical and effective and how to improve therapy for LGBTQI.

AAMFT’s Stance Regarding Reparative Therapies

Several empirical studies report that reparative therapies neglect the clients’ wellbeing and, when Kitchener’s Model of Ethical Decision Making or Moral Justification is applied, it clearly violates several of ethical principles, making it an unethical therapeutic approach. Therefore, it is critical that AAMFT adopts a resolution in which it takes a clear position against reparative therapies. There are obvious ethical violations regarding the use of reparative therapeutic techniques, not only as determined by applying Kitchener’s model, but also according to AAMFT ethical standards. It violates three of the ethical guidelines provided by AAMFT in its code of ethics. This therapeutic approach and its issues should be directly addressed in the AAMFT code of ethics to provide some protection for the clients who are going through reparative therapy. Also, the addition or modification of AAMFT ethical guidelines would provide clinicians with a clearer idea of ethical limitations and boundaries.

AAMFT should provide a specific stance on each of the previously discussed AAMFT principles that reparative therapies violate. By adding a clear stance regarding reparative therapies, it will help clinicians know their limits and boundaries, and it will probably leave less space for ideologies that are subjective. It is understood that many issues in ethics have a gray area and are considered relative, but in this case, therapists are leaving clients in potentially harmful state of minds that are affecting their relationships as well as their day-to-day lifestyles. For instance, in the case of Swanson, he has been unable to have an intimate relationship with another person because of the traumatic “treatment” he received. Also, he was suicidal several times and has been living a double life since his “therapy experience” by not being able to share his sexual orientation with his parents. Therefore, AAMFT should prohibit the use of aversive

techniques when dealing with sexual orientation because it is evident that these interventions only cause more harm to the client.

AAMFT should not allow these kinds of therapeutic approaches, especially when reparative therapies practically advocate for clients to have a double life in which their homoerotic feelings are compartmentalized from those about whom s/he cares. For the sake of the clients who have undergone interventions such as electroshock therapy (i.e. the case of Swanson), AAMFT needs stand up to these unethical so-called professionals and put a stop to treating LGBTQI as mentally ill. By doing so, they will be a part of the many organizations that are fighting against such harmful interventions and opting for a better treatment approach for those who are having sexual orientation issues.

Problems with the Person-Centered Approach

In terms of the person-centered approach, it seems to be a very post-modern approach to dealing with sexual orientation issues. I think that the problem with this approach lies in providing clients with the option of engaging in reparative therapies for their own wellbeing. This should not be an option at all. Instead, this approach should allow clients the choice of working individually or with their partners to achieve the highest level of satisfaction. Based on the existing literature, the person-centered approach lacks empirical evidence of its effectiveness as well as either short-term or long-term effects. When the ethical guidelines were applied to this model, it seemed to violate several of them, but the information was incomplete or unclear to provide a detailed ethical assessment of the approach. For this reason, it is very difficult to consider this approach as ethical, safe, beneficial, and/or effective.

Gay-Affirmative Approach

On the other hand, after assessing the information related to the gay-affirmative approach and applying Kitchener's Model, it is evident that this is the most ethical approach out of the three discussed in this report. Gay-affirmative therapists seem to be genuinely helpful in assisting lesbian, gay, and bisexual clients to accept, embrace, and enjoy their sexuality. When applying the AAMFT code of ethics and Kitchener's Model, this approach violated the fewest guidelines compared to the other two approaches. Still, it is evident that gay-affirmative therapy can create a more ethical and beneficial approach for LGBTQI clients.

It is understood that gay-affirmative therapy affirms all kinds of sexual orientations, but the given name creates expectations for the general population, heterosexual or homosexual, to believe that this kind of approach is geared only towards people who have a lesbian, gay, or bisexual orientation. Although it might be difficult to change the name of the approach, dealing with the issues of counter-transference, biases, and personal beliefs from the therapists, this approach clearly should allow all types of clients dealing with sexual orientation issues to feel comfortable and safe in a non-judgmental environment. Also, a cultural component should be added into the approach. Adding a cultural component can feed into the systemic approach from the marriage and family therapy field because it creates a better understanding of the clients' environment and it takes into account how culture and customs may play an important role in the clients' sexual orientation issue. With this said, it is strongly recommended that AAMFT adopts the gay-affirmative model as the one to be used to address sexual orientation issues. It should not be the only one, but it should definitively be considered as the most ethical and beneficial one of the three.

Creating Guidelines for Working with LGBTQI

Marriage and family therapy scholars should create guidelines for working with LGBTQI. The purpose of these guidelines would be to provide direction for clinicians who work with these clients. These guidelines should incorporate a systemic perspective that addresses not only the individuals who are having a sexual orientation conflict, but also the environment that the clients are in including their family, work area, school, and religion. For instance, a therapist who is working from a systemic perspective with a client who is struggling with his/her sexual orientation might be able to look into the client's family, his/her religious beliefs and values, the strength of the influence of those beliefs, family dynamics, and the support that the client receives. Also, creating a systemic approach for working with LGBTQI clients can help identify possible support systems that are available for the client to feel safe, not judged, and/or encouraged to accept what s/he is feeling regardless of the sexual orientation. Family and friends can even be a part of therapy and provide direct support for the client who can also receive current and empirical information regarding any questions or curiosities they may have. The clinician also can help them understand what information is accurate and which is inaccurate or misleading. This will help clinicians gain a perspective that can help them understand where the

clients are coming from and what the issues are behind the sexual orientation conflict. The field of marriage and family therapy, as a systemic field, has an advantage over other mental health fields because clinicians are trained to think and work in a systemic way and it is clear that this can be very beneficial for the clients.

Cultural Diversity

AAMFT should address cultural diversity when working with LGBTQI because culture includes different societal standards, different ways of expressing sexual behavior, as well as different ways of showing discrimination. This could potentially affect people who are experiencing conflicts with their sexual orientation because it involves differences between the environments in which they were brought up in the belief system the therapist would be dealing with, and the reasons behind the sexual orientation conflict. It also can involve other situations such as religious beliefs and how strongly they are followed in the clients' culture, the consequences LGBTQI can suffer by living a gay lifestyle, as well as the losses the clients would experience by embracing a lesbian, gay, or bisexual identity. Therefore, it is important to address culture in therapeutic approaches that deal with sexual orientation issues.

Grouping Sexual Orientations

Lastly, it is very easy for mental health professionals to group sexual orientations other than heterosexuality into LGBTQI. In the three perspectives discussed, clients who consider themselves as questioning their sexual identity may find it difficult to go into any of these approaches without an expectation from the therapist regarding what sexual orientation s/he should be. In reality, clinicians need to distinguish between gay, lesbian, and bisexual clientele and those who are questioning their sexual orientation instead of combining all of them underneath an acronym that means can mean different things to different people. AAMFT needs to make this clear in its code of ethics when referring to therapeutic approaches regarding sexual orientation issues, because it is likely that those who consider themselves gay, lesbian, or bisexual, have completely different needs from those who are questioning their sexual identity. This distinction is important when choosing the right therapeutic approach depending on the clients' needs. The person-centered approach might be most beneficial for these clients because it creates a safe space for them to question their sexuality and the opportunity to figure out which

sexual orientation fits better with them. However, much research is needed about the person-centered approach's effectiveness and its ethical implications to be able to consider it as an ethical approach for the clients who are questioning their sexual orientation.

AAMFT is in need of advocating for clients who are struggling with their sexual orientation or its implications. It is crucial for AAMFT to create a set of guidelines for working with LGBTQI as well as suggesting ethical and beneficial therapeutic treatments for them taking into account the ethical and clinical implications the approaches may have. This population deserves the same benefits from therapy as heterosexuals, and AAMFT should join the many mental health associations that are working to eliminate unethical therapeutic approaches used with individuals in LGBTQI.

Conclusion

Like Swanson, many LGBTQI clients find themselves having traumatic experiences in therapy with the unrealistic expectation that ultimately their sexual orientation is and will change. Sadly, these individuals end up suffering from various post-treatment problems. Swanson was lucky to find an LGBTQI support group in town that was able to give him information about LGBTQI lifestyles, but not all individuals have this opportunity.

AAMFT should join other mental health organizations that have adopted clear statements against the unethical practices of reparative therapies. If all mental health organizations do this, not only will clients like Swanson will feel protected, safe, and accepted, but also they will not be deceived by inaccurate information or procedures that are not really helpful. Mental health professional organizations have the power to promote ethical practice for clinicians to follow. Clients put their trust in mental health professionals; therefore, it is imperative for AAMFT to take this issue seriously and be proactive in its protection of all potential clients.

References

- American Association of Marriage and Family Therapy. (2001). *AAMFT code of ethics*.
- American Counseling Association. (1998). *On appropriate counseling responses to sexual orientation*. Adopted by the American Counseling Association Governing Council, March 27, 1998.
- American Medical Association. (1994). *Health Care Needs of Gay Men and Lesbians in the U.S.: A Report Presented by the Council on Scientific Affairs to the AMA House of Delegates Interim Meeting*.
- American Psychiatric Association. (1973). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.
- American Psychiatric Association, Committee on Gay, Lesbian, and Bisexual Issues. (1998). *Position statement on psychiatric treatment and sexual orientation*. Washington, D.C.
- American Psychological Association. (1997). *Resolution on appropriate therapeutic responses to sexual orientation*. Adopted by the American Psychological Association Council of Representatives, August 14, 1997.
- American Psychological Association (1998). Appropriate therapeutic responses to sexual orientation: Proceedings from the legislative year 1997. *American Psychologist*, 53, 882-939.
- American Psychological Association, Division 44/Committee on Lesbian, Gay and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients. (2000). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist*, 55, 1440-1451.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073.
- Bancroft, J., & Marks, I. (1968). Electric aversion therapy of sexual deviations. *Proceedings of the Royal Society of Medicine*, 61, 796-799.
- Barlow, D., & Agras, W. (1973). Fading to increase heterosexual responsiveness in homosexuals. *Journal of Applied Behavior Analysis*, 6, 355-366.
- Beckstead, A. L., & Morrow, S. L. (2004). Mormon client's experiences of conversion therapy: The need for a new treatment approach. *The Counseling Psychologist*, 32(5), 651-690.

- Black, D., Gates, G., Sanders, S., & Taylor, L. (2000). Demographics of the gay and lesbian population in the United States: Evidence from available systematic data sources. *Demography*, 37(2), 137-154.
- Clark, D. (1987). *The new loving someone gay*. Berkeley, CA: Celestial Arts.
- CNN. (2007). *Gays orientation can't change*. Opinion poll retrieved on March 18, 2010 from: <http://borngay.procon.org/view.resource.php?resourceID=000007>.
- Conger, J. (1975). Minutes of the annual meeting of the Council of Representatives. *American Psychologist*, 30, 620-651.
- Conrad, S., & Wincze, J. (1976). Orgasmic reconditioning: A controlled study of its effects upon the sexual arousal and behavior of adult male homosexuals. *Behavior Therapy*, 7, 155-166.
- Cramer, R. J., Golom, F. D., LoPresto, C. T., & Kirkley, S. M. (2008). Weighing the evidence: Empirical assessment and ethical implications of conversion therapy. *Ethics & Behavior*, 18(1), 93-114.
- Crisp, C., & McCave, E. L. (2007). Gay affirmative practice. A model for social work practice with gay, lesbian, and bisexual youth. *Child and Adolescent Social Work Journal*, 24, 403-421.
- Cross, M. C. (2001). The appropriation and reification of deviance: Personal consumer psychology and affirmative therapy. A response to Harrison. *British Journal of Guidance and Counseling*, 29(3), 337-343.
- Davies, D. (1996). Towards a model of gay-affirmative therapy. In D. Davis & C. Neal (Eds.), *Pink Therapy: A Guide for Counselors and Therapists Working with Lesbian, Gay, and Bisexual Clients*. Buckingham: Open University Press.
- Davison, G. C. (1976). Homosexuality: The ethical challenge. *Journal of Consulting and Clinical Psychology*, 44(2), 157-162.
- Davison, G. C. (1978). Not can but ought: the treatment of homosexuality. *Journal of Consulting and Clinical Psychology*, 46, 170-172.
- Du Plock, S. (1997). Sexual misconceptions: A critique of gay affirmative therapy and some thoughts on an existential-phenomenological theory of sexual orientation. *Journal of Society for Existential Analysis*, 8(2), 56-71.
- Ideology. (n. d.). In *Encarta Online*. Retrieved from: <http://www.encarta.msn.com>

- Estensten, B. (2005). *Mental heal professionals' attitudes, knowledge, and expertise in providing services for gay, lesbian, bisexual, and transgendered individuals*. Retrieved from ProQuest Full Dissertations and Thesis.
- Gallup Organization. (2007). *Tolerance for gay rights at High-Water park*. Opinion poll retrieved on March 18, 2010 from: <http://borngay.procon.org/view.resource.php?resourceID=000007>
- Goldenberg, H. (2000). A response to Martin Milton. *Journal of Society for Existential Analysis, 11*(1), 103-105.
- Haldeman, D. (1991). Sexual orientation conversion therapy: A scientific examination. In J. Gonsiorek & J. Weinrich (Eds.), *Homosexuality: Research implications for public policy*. Newbury Park, CA: Sage.
- Haldeman, D. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Counseling and Clinical Psychology, 62*(2), 243-251.
- Haldeman, D. (1996). Spirituality and religion in the lives of lesbians and gay men. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health*. Washington, DC: American Psychiatric Press.
- Haldeman, D. (1999). The pseudo-science of sexual orientation conversion therapy. *Angels, 4*, 1-4.
- Haldeman, D. (2001). Therapeutic antidotes: Helping gay and bisexual men recover from conversion therapies. *Journal of Lesbian and Gay Psychotherapy, 5*, 119-132.
- Haldeman, D. (2002). Gay rights, patient rights: The implications of sexual orientation conversion therapy. *Professional Psychology: Research and Practice, 33*, 260-264.
- Haldeman, D. (2004). When sexual and religious orientation collide: Considerations in working with conflicted same-sex attracted male clients. *The Counseling Psychologist, 32*(5), 691-715.
- Halpert, S. C. (2000). "If it ain't broke, don't fix it": Ethical considerations regarding conversion therapies. *International Journal of Sexuality and Gender Issues, 5*(1), 19-35.
- Hare, R. (1981). The philosophical basis of psychiatric ethics. In S. Block & P. Chodoff (Eds.), *Psychiatric ethics*. Oxford: Oxford University.
- Harrison, N. (2000). Gay affirmative therapy: A critical analysis of the literature. *British Journal of Guidance & Counseling, 28*(1), 37-53.
- Hatterer, L. (1970). *Changing homosexuality in the male*. New York: McGraw-Hill.

- Healthcare Needs of Gay Men and Lesbians in the U.S.: A Report Presented by the Council on Scientific Affairs to the AMA House of Delegates Interim Meeting. (December 1994).
- Horvath, A. O. (2005). The therapeutic relationship: Research and theory. *Psychotherapy Research, 15*(1-2), 3-7.
- Green, R. J. (2003). When therapists do not want their clients to be homosexual: A response to Rosik's article. *Journal of Marital and Family Therapy, 29*(1), 29-38.
- Jenkins, D. & Johnston, L. B. (2004). Unethical treatment of gay and lesbian people with conversion therapy. *Families in Society, 85*(4), 557-561.
- Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia: W. B. Saunders.
- Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *Counseling Psychology, 12*, 43-55.
- Langdrige, D. (2004). The hermeneutic phenomenology of Paul Ricoeur: Problems and possibilities for existential-phenomenological psychotherapy. *Existential Analysis, 15*(2), 243-255.
- Langdrige, D. (2007). Gay affirmative therapy: A theoretical framework and defense. *Journal of Gay and Lesbian Mental Health, 11*(1/2), 27-43.
- Lebolt, J. (1999). Gay affirmative psychotherapy: A phenomenological study. *Clinical Social Work Journal, 27*(4), 335-370.
- Maletzky, B., & George, F. (1973). The treatment of homosexuality by 'assisted' covert sensitization. *Behavior Research and Therapy, 11*, 655-657.
- McConaghy, N. (1969). Subjective and penile plethysmograph responses following aversion-relief and apomorphine aversion therapy for homosexual impulses. *British Journal of Psychiatry, 115*, 723-730.
- McConaghy, N. (1975). Aversive and positive conditioning treatments of homosexuality. *Behavior Research and Therapy, 13*, 309-319.
- McConaghy, N., Armstrong, M. S., & Blaszczynski, A. (1981). Controlled comparison of aversive therapy and covert sensitization in compulsive homosexuality. *Behavior Research and Therapy, 19*, 425-434.
- Michael, R. T., Gagnon, J. H., Laumann, E. O., & Kolata, G. (1994). *Sex in America: A definite survey*. New York, NY: Warner Books.

- Miller, J. (2009, December 7). Student recounts painful conversion therapy, abuse. *Kansas State Collegian*, 115(71), pp. 1, 3.
- Miller, J. (2009, December 8). Student finds sympathy, understanding at K-State through 'untherapy'. *Kansas State Collegian*, 115(72), pp. 1, 10.
- Mills, K. I. (August, 1998). *Mission impossible: Why reparative therapy and ex-gay ministries fail*. Retrieved November 3, 2009 from: <http://www.hrc.org/issues/7077.htm>
- Morrow, S. L., & Beckstead, A. L. (2004). Conversion therapies for same-sex attracted clients in religious conflict: Context, predisposing factors, experiences, and implications for therapy. *The Counseling Psychologist*, 32, 641-650.
- Morgan, K. S., & Nerison, R. M. (1993). Homosexuality and psychopolitics: A historical overview. *Psychotherapy*, 30, 133-140.
- Mount, M. (2010, April 2). Pentagon faces hurdles in 'don't ask, don't tell' study. *CNN U.S.* Retrieved from: <http://www.cnn.com/2010/US/04/02/gays.military/index.html?hpt=Sbin>.
- National Association of Social Workers. (1999). *Code of Ethics of the National Association of Social Workers*. Washington, DC: Author.
- National Committee on Gay, Lesbian, and Bisexual Issues. (1992). *"Reparative" and "conversion" therapies for lesbians and gay men*. Washington, DC: National Association of Social Workers.
- National Health Survey. (2003). Lawrence v. Texas, Docket No. 02-102 (U.S. Supreme Court). Footnote 42.
- Nicolosi, J. (1991). *Reparative therapy of male homosexuality*. Northvale, NJ: Jason Aronson.
- Nicolosi, J. (1993). *Healing homosexuality*. Northvale, NJ: Jason Aronson.
- Nicolosi, J., Byrd, A. D., & Potts, R. W. (1998). *Towards the ethical and effective treatment of homosexuality*. Unpublished manuscript.
- 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.
- American Academy of Pediatrics. (1993). Homosexuality and adolescents: Committee on Adolescence. *Journal of Pediatrics*, 32(11), 358-368.
- Ritter, K. Y., Terndrup, A. I. (2002). *Handbook of Affirmative Psychotherapy with Lesbians and Gay Men*. New York: The Guildford Press.

- Rogers, C., Roback, H., McKee, E., & Calhoun, D. (1976). Group psychotherapy with homosexuals: A review. *International Journal of Group Psychotherapy*, 26, 3-27.
- Rosik, C. H. (2003). Motivational, ethical, and epistemological foundations in the treatment of unwanted homoerotic attraction. *Journal of Marital and Family Therapy*, 29(1), 13-28.
- Rosik, C. H. (2003). When therapists do not acknowledge their moral values: Green's response as a case study. *Journal of Marital and Family Therapy*, 29(1), 39-45.
- Schneider, R. (2000). The people gay and the 10 percent debate. *The Gay and Lesbian Review Worldwide*, 7(2), 4-6.
- Schroeder, M. & Shidlo, A. (2001). Ethical issues in sexual orientation conversion therapies: An empirical study of consumers. *Journal of Gay & Lesbian psychotherapy*, 5(3/4), 131-166.
- Serovich, J. M., Craft, S. M., Toviessi, P., Gangamma, R., McDowell, T., & Grafsky, E. L. (2008). A systematic review of the research base on sexual reorientation therapies. *Journal of Marital and Family Therapy*, 34(2), 227-238.
- Shidlo, A. & Schroeder, M. (2001). Conversion therapy: A consumer's report. Unpublished manuscript.
- Shidlo, A. & Schroeder, M. (2002). Changing sexual orientation: A consumer's report. *Professional Psychology: Research and Practice*, 33, 249-259.
- Silverstein, C. (1991). Psychological and medical model treatments of homosexuality. In J. Gonsiorek & J. Wienreich (Eds.), *Homosexuality: Research implications for public policy* (pp. 101-114), Newbury Park, CA: Sage.
- Starr, B. (2009, July 1). Defense chief giving 'don't ask, don't tell' a closer look. *CNN Politics*. Retrieved from: <http://www.cnn.com/2009/POLITICS/07/01/gates.gays/index.html>.
- Steigerwald, F. & Janson, G. R. (2003). Conversion therapy: Ethical considerations in family counseling. *The Family Journal: Counseling and Therapy for Couples and Families*, 11(1), 55-59.
- Tanner, B. (1973). Show intensity and fear of shock in the modification of homosexual behavior in males by avoidance learning. *Behavior Research and Therapy*, 3, 147-160.
- Tanner, B. (1975). Avoidance training with and without booster sessions to modify homosexual behavior in males. *Behavior Therapy*, 6, 649-653.
- Thiroux, J. P. (2001). *Ethics: Theory and practice*. (7th ed.). New Jersey: Prentice Hall.
- Throckmorton, W. (1998). Efforts to modify sexual orientation: A review of outcome literature and ethical issues. *Journal of Mental Health Counseling*, 20(4), 283-304.

- Throckmorton, W. (2002). Initial empirical and clinical findings concerning the change process for ex-gays. *Professional Psychology: Research and Practice*, 33, 242-247.
- Tozer, E. E., & Hayes, J. A. (2004). Why do individuals seek conversion therapy? The role of religiosity, internalized homonegativity, and identity development. *The Counseling Psychologist*, 32(5), 716-740.
- Tozer, E., & McClanahan, M. (1999). Treating the purple menace: Ethical considerations of conversion therapy and affirmative alternatives. *The Counseling Psychologist*, 27, 722-742.
- Wolpe, J. (1973). *The practice of behavior therapy* (2nd ed.). New York: Pergamon Press.
- Yarhouse, M. (1998). When clients seek treatment for same-sex attraction: Ethical issues in the "right to choose" debate. *Psychotherapy*, 35, 248-259.
- Yarhouse, M., & Burkett, L. (2002). An inclusive response to LGB and conservative religious persons: The case of same-sex attraction and behavior. *Professional Psychology: Research and Practice*, 33, 235-241.
- Zoroya, G. (2010, March 25). Pentagon releases new 'don't ask, don't tell' rules. *USA Today*. Retrieved from: http://www.usatoday.com/news/military/2010-03-25-gays-military_N.htm.
- Zygmond, M. & Boorhem, H. (1989). Ethical decision making in family therapy. *Family Processes*, 28, 269-280.

Footnotes

¹ The person-centered approach is different from Carl Roger's Client-Centered Therapy in that the person-centered approach is directive and Roger's approach is non-directive. The person-centered approach gives clients two options from which to choose from and depending on what the clients want to explore, the therapist acts as the expert in the room, something that is not seen in Roger's approach. Lastly, this approach is specifically geared towards LGB individuals and it has not been geared towards the general clientele as stated by the author.