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Not Can but Ought: The Treatment of Homosexuality

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My earlier proposal to terminate change-of-orientation programs rests on moral not empirical grounds. Arguments based on whether therapists can or cannot alter sexual preferences are irrelevant. Therapists, moreover, have no abstract responsibility to accede to requests from clients for certain types of treatment; we work within a host of personal, conceptual, and even legal constraints. Therapists are characterized better as secular priests than as professionals applying ethically neutral techniques. Therapists should attend to large-scale social and political factors in their clients' lives as conscientiously as they attend to intrapsychic and interpersonal variables; our students should study philosophy and politics as well as learning theory and research design. Finally, to urge that therapists desist from sex reorientation programs is not tantamount to exhorting them not to see homosexuals in therapy; indeed, renouncing these widely used programs can help professionals focus on the problems homosexuals (and others) have, rather than on the so-called problem of homosexuality.

I am grateful for the invitation to respond to Sturgis and Adams' (1978) critique of my proposals to terminate change-of-orientation programs for homosexuals (Davison, 1976).

Given the cultural biases against homosexuality, it is problematic to assert that people who ask for change of orientation are expressing a "free wish." We have been remiss in examining why people request certain kinds of treatment (cf. Silverstein, Note 1).

Some of the misunderstanding of my position may stem from a confusion in levels of discourse. Even though I am prepared to argue that *individuals* can benefit from a renunciation of change-of-orientation programs, my proposals are more properly viewed as *institutional* in nature (Rappaport, 1977), that is, as concerned with societal–ethical constraints on human behavior within a framework that is more broad than that familiar to most psychotherapists. Certain issues are better discussed at one level than at another. I believe the issue of therapy for homosexuality should be addressed at an institutional level.

Let me turn now to some of the specific points raised in the critique of Sturgis and Adams (1978). They are entirely correct to claim that my arguments are based on sociopolitical factors rather than on empirical considerations. They have properly grasped the thrust of my 1976 article, but I do not share their displeasure at my being moved by ethical rather than empirical concerns. What they fail to understand is that the issues we are dealing with as therapists are, indeed, philosophical–ethical ones, and these moral considerations transcend research considerations. To discourse on the empirical level, as they do very well, is simply to misperceive the essence of the issue. Their critique is irrelevant to my article.

Those who continue to offer change-of-orientation treatment to homosexuals do not have a monopoly on sensitivity to clients' rights. I do not believe that the issue can be settled by arguing, as they do, that a therapist has some sort of abstract responsibility to satisfy a client's expressed needs. It is not that simple. As Begelman (1975) has pointed out, therapists constrain themselves in many ways when clients ask for certain kinds of help. There is a host of client requests that therapists do not honor. In fact, the courts (cf. Kaimowitz v. Michigan Department of Mental Health, 1973) are becoming involved in denying the "voluntary" requests of patients for certain types of treatment. Requests alone have never been a sufficient criterion for providing therapy.

Clients, moreover, make certain requests of

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some therapists and will not do so with others—though, admittedly, it is difficult to collect good data on this. Therapists are purveyors of social ethics, and it is better to own up to this secular priest role (cf. London, 1964) than to continue pretending that it does not exist.

Sturgis and Adams (1978) are correct in asserting that the normality or abnormality of a behavior is irrelevant to whether therapists should try to change it. My earlier discussion of the normality status of homosexuality could have been omitted, but at the time it seemed worthwhile to review both the evidence and the logic behind the futile attempts that have been made to address the issue.

My colleagues do not show an understanding of the social nature of "empirical evidence." Psychologists, like other scientists, do not merely go out and "gather data." They hold preconceived ideas of what they will find and how they will decide they have found it (Davison & Neale, 1978). Scientists adopt paradigmatic ways of defining the problems they will study and how they will study them (Kuhn, 1962). We do not, as Sturgis and Adams (1978) suppose, simply "arrive at . . . conclusions based on rational, objective logic resulting from an evaluation of empirical evidence" (p. 169).

As noted above, their assertion that I based my arguments on social and political considerations is accurate, but to say that *therefore* I am neglecting a careful assessment of the needs of the individual does not follow, certainly not logically or even empirically. The "psychological needs" of a person are seen by Sturgis and Adams as necessarily separate from their social–political needs or pressures. This separation is neither valid nor necessary, and my exhortation is that mental health professionals expand their perspectives to include those sets of variables that are too often overlooked. It is certainly not inherent to a social-learning approach to ignore political and ethical variables; in fact, our general orientation is well suited to this more comprehensive assessment enterprise, as others have creatively demonstrated (e.g., Bandura, 1969; London, 1969; Ullmann & Krasner, 1975).

Sturgis and Adams (1978) contend that "to propose that a client not be treated unless the therapist is neutral is to eliminate the helping professions" (p. 166). This is erroneous on two grounds. First, I am not proposing that clients not be treated unless therapists are neutral. Rather, I am suggesting (after Halleck, 1971) that therapists can*not* be neutral and that they should realize this. Nowhere, either in what I have written, taught, or practiced, do I advocate we not do therapy because we are not neutral. Second, to admit to one's biases hardly eliminates the helping professions. If anything, it poses exciting challenges, not the least of which concerns the content of clinical training. Courses in politics, sociology, and philosophy would seem at least as appropriate as courses in learning and statistics.

Having cited Halleck (1971) extensively in my 1976 article, it is not surprising that I generally agree with his comments on that effort (Halleck, 1976). A comprehensive assessment is impossible to argue with, and for therapists to make clear their biases (value systems) is precisely what I am proposing. Along with Sturgis and Adams, I agree with this position. But I would ask only that therapists tell a homosexual that his or her sexual orientation is wrong whenever they embark on a change-of-orientation procedure. The alternative, as stated in my 1976 article, is for therapists to be as vigorous in devising sexual enhancement procedures regardless of orientation as they have been in helping homosexuals become less homosexual.

I have been misunderstood (not necessarily by Sturgis and Adams) to have said or implied that I advocate not treating homosexuals. This is hardly the case. It is one thing to say that one should not treat homosexuality; it is quite another to suggest that one should not treat homosexuals. Indeed, I have urged that therapists *do* finally consider the problems in living that homosexuals really have. Such problems are perhaps especially severe, given the prejudice against their sexual orientation. It would be nice if an alcoholic homosexual, for example, could be helped to reduce his/her drinking without having his/her sexual orientation questioned. It would be nice if a homosexual fearful of interpersonal relationships, or incompetent in them, could be helped without the therapist assuming that homosexuality lies at the root of the problem. It would be nice if a nonorgasmic or impotent homosexual could be helped as a heterosexual would be rather than guiding his/her wishes to change-of-orientation regimens. Implicit in my original argument is the hope that therapists will concentrate their efforts on such *human* problems rather than focusing on the most obvious "maladjustment"—loving members of one's own sex.

Perhaps some people can be hurt by my proposals. To suggest otherwise would be naive. But to assume that people are not being hurt by the

prevalent prejudices is at least as naive.[1] I suppose one has to be reminded of the fact that we live in an imperfect world. I trust there are few therapists who deliberately harm their clients. But it is inherent to my comment that great numbers of people are being hurt by the availability of change-of-orientation programs, and these include individuals who themselves are not seeing therapists. I believe far fewer people would be distressed if we eliminated that option and instead devoted our energies to (a) societal prejudices and (b) to the whole range of problems that homosexuals, heterosexuals, and those in between, have as we all negotiate our way.

I hope the debate continues.

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[1] Begelman (1975) takes a different approach in countering the argument that these proposals against sex orientation change are misguided because they may not make people happy. He questions whether the right thing for therapists to do is necessarily what will make their clients happy. Sometimes it is ethical to make a client *more* distressed rather than less so, as when the client's behavior is morally wrong, or when, as is the issue here, the goals of the treatment are ethically questionable.

Reference Note

1. Silverstein, C. *Behavior modification and the gay community*. Paper presented at the annual meeting of the Association for Advancement of Behavior Therapy, New York City, October 1972.

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