What can psychotherapy do? Psychotherapy paradigms and sexual orientation

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Abstract

Homosexuality and same-sex attraction have vexed the psychotherapy field throughout its history and continue to draw controversy in the 21st century. Debates and arguments about the mental health of gay, lesbian and bisexual people reflect, and manifest within, the tremendous tensions that exist in society around this subject. The author examines the troubled relationship of psychotherapy theory and practice with gender and sexual orientation. Psychotherapy ideas, while revolutionizing the understanding of human functioning in the 20th century, blindly incorporated many common western cultural values but also a Christian-Judaic premise that procreative sex was normative. The ensuing conjecture of hetero-normativity created a conceptual bias about homosexuality's supposed pathological nature and left psychotherapy with a toxic legacy.

Key Words: sexual minority paradigms, same-sex attraction, homosexuality, conversion therapy, reparative therapy, ethical practice

Was kann die Psychotherapie tun? Psychotherapie-Paradigmas und sexuelle Orientierung
Zusammenfassung

Homosexualität und die gleichgeschlechtliche Anziehung haben das Psychotherapie Feld, durch seine Geschichte beunruhigt und zieht die Kontroversen auch im 21. Jahrhundert auf sich. Die internen Debatten und Argumente über die geistige Gesundheit von Homosexuellen, Lesbischen und bisexuellen Leute, reflektieren und manifestieren die grosse gesellschaftliche Spannung, welche zu diesem Thema existiert. Der Autor überprüft die gestörte Beziehung der Psychotherapeutischen Theorie und Praxis mit dem Geschlecht und der sexueller Orientierung. Psychotherapeutische Ideen, welche das Verständnis über das menschliche Funktionieren im 20. Jahrhundert revolutioniert haben, übernehmen blindlings westliche kulturelle Werte, die auch eine Christo-Jüdische normierte Wertgrundlage der Sexualität als reine Zeugungsbefähigung, beinhalten. Die daraus folgende Annahme der hetero Normativität, schuf ein konzeptuelles Vorurteil über Homosexuelles als krankhafte Natur, und hat der Psychotherapie so einen giftigen Nachlass beschert.

Schlüsselwörter: Paradigma Sexueller Minderheiten, Gleichgeschlechtliche Anziehung, Homosexualität, Umwandlungstherapie, Reparierende Therapie, Ethische Praxis.

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Que peut faire la psychothérapie? Les paradigmes de la psychothérapie et l'orientation sexuelle
Résumé

L'homosexualité et l'attirance entre personnes du même sexe ont fâché le champ psychothérapeutique à travers son histoire et continue à attirer la controverse au 21e siècle. Des débats et argumentaires concernant la santé mentale des personnes gay, lesbiennes, et bisexuelles reflètent, et témoignent en dedans, les tensions terribles qui existent dans la société autour de ce sujet. L'auteur examine la relation troublée de la théorie et de la pratique psychothérapeutiques et de l'orientation sexuelle et du genre. Les idées psychothérapeutiques, tout en révolutionnant la compréhension du fonctionnement humain au 20e siècle, ont incorporé à l'aveugle beaucoup de valeurs de base de la culture occidentale mais aussi la prémisse judéo-chrétienne que le sexe à but procréatif était la norme. La conjecture ensuite de la normativité-hétéro a créée un concept biaisé concernant la nature supposément pathologique de l'homosexualité et a laissé la psychothérapie avec un héritage toxique.

Mots clés: paradigmes de minorité sexuelle, attirance du même sexe, homosexualité, thérapie de conversion, thérapie réparatrice, pratique éthique

Что может психотерапия? Парадигмы психотерапии и сексуальная ориентация
Резюме

Гомосексуальность и взаимное влечение между людьми одного пола исторически горячо дискутируется в психотерапии. Полемика и расхождение во взглядах продолжаются и в 21 веке. Споры и дебаты о психическом здоровье геев, лесбиянок и бисексуалов отражают огромное напряжение, существующее в обществе вокруг этой темы. Автор исследует запутанные отношения между теорией и практикой психотерапии и вопросами пола и сексуальной ориентации. Несмотря на революционный поворот, произошедший во взглядах на функционирование человека в 20 веке, в систему психотерапии по-прежнему слепо включены многие общепринятые западные культурные ценности, а также христианско-иудаистское предположение о нормативности секса с целью продолжения рода. Вытекающая из вышесказанного гипотеза о гетеро-нормативности создает концептуально предвзятое мнение о патологической природе гомосексуальности и оставляет психотерапии пагубное морально устаревшее наследие.

Ключевые слова: парадигмы сексуального меньшинства, влечение между людьми одного пола, гомосексуальность, конверсионная терапия, репаративная терапия, этические нормы практики

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Author's note: This paper cannot do justice to the breadth of psychotherapy publications about minority sexual orientations. I included ideas and conceptions that, with the benefit of hindsight, appear pivotal to the development of sexual orientation paradigms or illustrate some aspect of historical discourse. Also, the majority of publications on the subject are concerned with male homosexual experience, which leaves lesbian, bisexual and transgender minorities under-represented in comparison. This paper will inevitably reflect such imbalances. I would like to stress, however, that any similarities amongst the range of sexual minority experience should not obscure the many differences between them.

Key Words: sexual minority paradigms, same-sex attraction, homosexuality, conversion therapy, reparative therapy, ethical practice

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The psychoanalytic movement developed in the cradle of 19th century Europe and within the influence of the prevalent religions that shaped European culture at the time. Psychoanalytic engagement with same-sex attraction has been burdened by Christian and Judaic intolerances that cast homosexual acts as errors of nature, unnatural vices, and as acts of grave depravity, especially since the late Middle Ages. By the 19th century, homosexuality had increasingly become the subject of medical literature, in search of some biological basis for same-sex attraction, much of it in the context of criminal cases against homosexual activities, but also in the pursuit of civil rights agendas. The Austrian-Hungarian writer, Kertbeny introduced the term 'homosexuality' in 1869 (Ackerman 2005). By all accounts, it appears that the dice were already heavily loaded against homosexuality when the fledgling psychoanalytic movement was born.

Psychoanalysis nonetheless took a relatively benign view on homosexuality, in line with its generally progressive views on sexuality. But psychoanalysis, conceived both as an instrument to explore the human experience and as an enabling technique, struggled to make sense of same-sex attractions. Whilst Freud did not consider homosexuality an outright illness, he nonetheless approached the study of homosexuality from an unexamined normative bias and, as Friedman (1986) observes, always took for granted that sexual deviation was of some pathological nature. But homosexuality only really became pathologised and viewed as a perversion within psychoanalysis by Freud's successors.

Freud thought that everybody has an innate bisexual potential and viewed homosexuality as a constitutional disposition impacted by psychosocial factors and childhood traumas. Drescher (2007) describes this as Freud's "theory of immaturity", which presented homosexuality as a necessary part of normal heterosexual development while, at the same time, characterizing the homosexual as a developmentally arrested individual, who had not achieved adult heterosexuality. Freud repeatedly returned to homosexuality in his writing (Lewes, 1988), where he considered a number of potential causal factors but also possible treatments, such as hypnosis for example. Lewes (1988) distinguishes four distinct theories that Freud thought could explain the origins and meaning of homosexuality. These hypothesises alternatively linked homosexuality to castration anxiety, to a child's over-attachment to his mother, to the pursuit of the father's love through feminine identification and anal eroticism, and to "reaction formation" when some sadistic jealousy of male siblings or the father turns into love of other men.

But Freud also observed that homosexuality could occur naturally and within normal development in some people and noted that homosexual individuals may function with no impairment or other signs of deviation. Homosexuality, in itself, was not a sign of illness or a symptom arising from psychic conflict, but compatible with high psychological functioning.

> *"It is not for psychoanalysis to solve the problem of homosexuality. It must rest content with disclosing the psychical mechanisms that resulted in determining the object-choice, and with tracing back the paths from these to the instinctual dispositions. There its work ends, and it leaves the rest to biological research" (Freud 1920: 171).*

Nor did Freud view homosexuality as an impediment to psychoanalytic training. Freud believed that homosexuals could, and should, become psychoanalysts and opposed a proposal to bar

them on the grounds that they might discredit the profession (Lewes, 1988). Most remarkable, perhaps, is Freud's intuitive grasp of the complex duality between biology and environmental factors for the aetiology of sexuality. Freud presupposed an inner-outer duality and a primacy of the biological that is in constant conflict with an impinging environment (Newman & Holzman, 1993). In his essays on the theory of sexuality, Freud argues that "*the constitutional factor must await experiences before it can make itself felt; the accidental factor must have a constitutional basis in order to come into operation*" (1905, p. 239).

Psychoanalytic attitudes towards homosexuality hardened after Freud's death, when Neo-Freudian analysts rejected Freud's inclusive stance. Within a year of Freud's passing, Sandor Rado conceptualized non-heterosexual behaviour as a "reparative adjustment", which led to the rise of a psychoanalytic culture that defined the homosexual 'other' as undesirable. The following lines from Rado's (1940) paper remain one of the most frequently quoted references to bolster prejudiced beliefs in today's anti-gay internet sites:

> *"The chief causal factor is the affect of anxiety, which inhibits standard stimulation and compels the 'ego action system in the individual' to bring forth an altered scheme of stimulation as a 'reparative adjustment'. Both the inhibitory and the reparative processes begin far back in early childhood, leading up to the picture which we encounter in the adult." (1940: 466)*

Rado himself was sufficiently concerned about the dearth of knowledge about any biological mechanism of sexual attraction to warrant its mention and speculated about possible causes for same-sex attraction such as "*reflexes, or rather chains of reflexes, susceptible to resuscitation by hormones or other agents*" (1940: 467).

But Rado's formulation opened the doors to burgeoning Neo-Freudian homosexual theorizing, characterized by stereotyping, contempt or outright homophobia. Homosexual pathology was attributed to conflicts over heterosexual impulses and associated with social dis-adaptation, anxiety, neurotic and depressive states, and with suicidal tendencies. With hindsight, such phenomena seem hardly surprising and indeed match what one would expect amongst any minority group faced with marginalization, social exclusion and persecution. These Neo-Freudian conceptions effectively turned psychoanalysis from a socially progressive into a conservative-reactionary force in sexual matters. For the three decades following Freud's death, 'reparative therapy' (Drescher, 1998) received approval from a majority of the psychiatric and psychoanalytic establishment in the Western world (Lewes, 1988). As another consequence, gay, lesbian and bisexual psychotherapists and psychiatrists had to hide their sexual orientations or risk professional exclusion, ostracism and disgrace.

The publication of Kinsey's report on the "Sexual Behaviour in the Human Male" in 1948 catapulted sexuality and same-sex relations from the margins on to the centre stage of general culture. Kinsey's pioneering research controversially challenged established beliefs about sexuality and demonstrated that same sex experiences were far more common than previously assumed. Kinsey, who used a behavioural scale to establish a relative balance of same and opposite sex experiences, concluded that humans had an intrinsic basic capacity to respond erotically to both same and opposite sex stimuli. Kinsey himself was reportedly unconvinced of any biological origins for homosexuality and apparently rejected such arguments (Sprigg & Dailey, 2004). Crucially, Kinsey's report broke new ground in allowing a deconstruction of conventional polarizing categories of gender and sexuality and opened an alternative to Freud's innate bisexuality theory.

But the Kinsey report was good for another surprise: in 1951, the International Journal of Psycho-Analysis published a letter Freud had written in 1935, which had been handed to Kinsey by its recipient, an American mother inquiring about her homosexual son. From beyond his

grave, Freud's letter reiterated and extended his inclusive paradigm on homosexuality:

> *"I gather from your letter that your son is a homosexual. I am most impressed by the fact that you do not mention this term yourself in your information about him. May I question you why you avoid it? Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be a variation of the sexual function produced by a certain arrest of sexual development. Many highly respectable individuals of ancient and modern times have been homosexuals, several of the greatest men among them (Plato, Michelangelo, Leonardo da Vinci, etc.). It is a great injustice to persecute homosexuality as a crime and cruelty too." (1951, p. 786)*

But Freud also allows himself to be drawn on the question of conversion therapy:

> *"By asking me if I can help, you mean, I suppose, if I can abolish homosexuality and make normal heterosexuality take its place. The answer is, in a general way, we cannot promise to achieve this." (1951, p. 786)*

In 1957, Evelyn Hooker pioneered the first psychological test to explore the relationship between homosexuality and psychological development and illness, with two groups of homosexuals and heterosexuals carefully matched in other aspects of their lives, whom she subjected to three psychological tests. Hooker blind-tested the gathered data for any pathological personality traits. The two groups could not be distinguished in terms of mental adjustment, and Hooker concluded that homosexuality, in itself, was unrelated to any psychological disturbance. Homosexuality was not a clinical disorder at all, Hooker proposed, but an atypical sexual preference in otherwise normal individuals whose pathologies chiefly derived from social intolerance.

Neo-Freudians such as Bergler, Bieber and their followers, who had largely ignored the Kinsey report, entrenched their positions further in response to the 1960s social movement for sexual liberation (Lewes, 1989). Some psychoanalytic papers published at the time, caricatured homosexuality grotesquely. But the general decline of stigma attached to pursuits of sexual pleasure made it increasingly difficult to argue against same-sex attraction on moral grounds.

In 1973, following years of criticism from activists and bitter dispute among psychiatrists, the American Psychiatric Association (APA) released a statement that homosexuality was not a mental disorder and removed 'ego-syntonic homosexuality' from its Diagnostic and Statistical Manual of Psychological Disorders (DSM). A new diagnosis, 'ego-dystonic homosexuality', characterized as a sexual orientation, or an attraction, that is at odds with one's idealized self-image, was subsequently added to the third DSM edition in 1980.

'Ego-dystonic' pathology was associated with social dis-adaptation, anxiety, neurotic and depressive states, and with suicidal tendencies – phenomena consistent with the effects of social intolerance. The ego-dystonic conception identified homosexual arousal as the primary source of distress, but largely ignored anxieties and stress arising from family expectations or social discrimination. As such, the ego-dystonic construct provided clinicians with another rationale for directive clinical practice in pursuit of changing sexual orientation.

But the dam had broken. Supported by mounting evidence and growing acceptance of normal variant theories, psychoanalytic writers increasingly questioned the ego-dystonic construct and conceptions that propagated psychoanalysis as a directive method of behavioural control. The reform of neo-Freudian views also allowed lesbian, gay and bi-sexual (LGB) psychiatrists and psychotherapists openly to participate as conversing subjects in psychotherapeutic discourse about same-sex attraction (Drescher, 2007).

In 1974, Serber and Keith established that homosexual patients, who had requested help

to change their sexual orientation, became content with their sexual identity after developing additional social skills to better negotiate social and sexual contacts. Another study which focused on children raised by lesbian or female transsexual parents, showed that their psychosexual development appeared to be typical in at least 36 of the 37 children observed and concluded that parental style has a limited effect on children's sexual orientation (Green, 1978).

A young psychoanalyst, who would later emerge as a leading figure of the relational paradigm, also challenged pathologizing approaches to homosexuality. In a seminal paper, Stephen Mitchell (1978) questioned the presumption that psychodynamic causation implied pathology as a historical artefact of the initial development of psychodynamic reasoning. The psychodynamic point of view, Mitchell argued, had since evolved into a general theory of human development and the workings of the mind, which understood psychodynamic processes from all developmental levels "*to be inextricably woven into healthy as well as pathological functioning* (1978, p. 258). Psychoanalysis could ill afford to ignore possibilities of other meanings or motives, for example a wish for intimacy on other levels. Moreover, Mitchell suggested, the original formulation of psychodynamic processes – as causal mechanisms in pathological conditions – was getting in the way of developing a better understanding of the complexities of human sexuality.

In a second paper, Mitchell (1981) questioned directive-suggestive psychoanalytic approaches to homosexuality and denounced beliefs that the supposed pathological nature of homosexuality could justify the analyst's departure from the traditional position of non-directive neutrality and permit the analyst to actively discourage homosexual behaviours and encourage heterosexual behaviours. Such practice violated fundamental principles of psychoanalytic practice. Mitchell also questioned clinical practice that focused on overt sexual behaviour to the exclusion of the quality of a patient/client's internal experience and object relations.

Robert Stoller, known for his theories about gender development and sexual arousal dynamics, insists that homosexuality is no more or less an "illness" than heterosexuality and questions conjectures built on presumptions of hetero-normativity. The evidence, Stoller (1985) asserted, points to similar complications in heterosexuality and homosexuality – both are products of conflict, frustration or traumatic struggles during childhood. In 1987, the APA bowed to the mounting evidence and removed 'ego-dystonic homosexuality' from the DSM. In 1992, the World Health Organization followed suit and struck homosexuality from its list of mental illnesses.

But the damage had been done. For nearly half a century, psychiatry and psychotherapy had maintained essentially unfounded theories that retain their influences well into the 21st century. From my personal experience of psychotherapy education in the 1980s and 90s, I recall numerous references to "arrested development", supposedly at the root of same-sex attractions. Such ideas typically surfaced as implicit assumptions within other contexts and were rarely scrutinized or questioned.

My experience is not isolated it appears. A UK study exploring mental health practitioners' current views on treatments to change sexual orientation (King, Barlett & Smith, 2009) compiled alarming figures that raised serious concerns about contemporary practice. Out of a total of 1328 respondents to a postal questionnaire survey, 222 – almost 17 percent – declared that they had assisted at least one client/patient with their wish to change their sexual orientation. In addition, some 159 respondents thought that such support should be available for client/patients wishing to change their sexual orientation. The research included psychotherapists, clinical psychologists, counsellors and medical psychotherapists.

Cultural connotations

Sexual experience is generally constructed within, and mediated by, cultural connotations. Perceptions of sexuality and sexual minorities are far from universal and vary profoundly, both across time and between cultures (Ford & Beach, 1951; Foucault, 1981; Neill, 2009; Sanderson, 2001). Psychotherapeutic ideas, while revolutionizing the understanding of human functioning in the 20th century, blindly incorporated many common western cultural values, as well as a Christian-Judaic premise that procreative sex was normative and divinely commanded.

Friedman (1986) aptly described the psychoanalytic model of male homosexuality as a scientific paradigm with cultural origins. Condemnation of homosexual acts is strongly associated with Christianity and Judaism, two religions that view sexual pleasures as distractions from the supernatural and divine. In the modern world, Islam has now joined their discrimination against homosexuality. But historic perceptions in other parts of the world presented more diverse and often tolerant views on same-sex attraction, for example in Japan, India or ancient Greece.

James Nelson, professor of Christian ethics, argues that Biblical values must be seen in their historical context and points to the strong procreative emphasis characteristic of the Hebrew interpretation of sexuality (1977). Biblical values reflect pre-scientific beliefs that the whole of nascent life is contained in a man's semen. Any deliberate spilling of semen, be that in masturbation, homosexual acts, or *coitus interruptus*, was viewed as a deliberate destruction of human life that deserved judgements similar to those for abortion or murder. Ignorant of female reproductive biology, our forefathers assumed that women only provided an incubating space for a man's seed. But the relatively minor significance given to the issue in sacred scriptures suggests that harsh condemnation of homosexuality may only be a relatively recent phenomena. Ratigan (2009) counts a mere 40 words that refer to homosexual acts in amongst the 180,000 words that make up the New Testament and found similar numbers in the Hebrew Tanakh, and in the Qur'an, some 30 words out of 600,000 and 80,000 respectively.

21st century psychotherapy urgently needs to re-examine any cultural and religious biases that it inadvertently incorporated and actively strive to widen the range of cultural variants it encompasses. Sexual experience rarely conforms to stereotypes about age, orientation, gender, disability or ethnicity, but exists within multiplicities of psychic, corporeal and social contexts and meaning. What constitutes sexual experience is eminently influenced by cultural forces that contextualize, shape and co-create erotic stimuli. As labels of difference, lesbian, gay, bisexual (LGB) can provide shared identity, ensure public visibility, or allow the reality of minority experience to become recognized and validated. As stereotypes, however, LGB labels all too easily facilitate judgements about a degenerate lifestyle, or 'aberrant behaviour' biases, and can only distract from genuine exploration and appreciation of variants of sexual experience.

Erotic and sexual experiences generate profound emotional and psychological responses and play a conspicuous role in the construction of self-hood and identity. Psycho-erotic tensions arise and grow along edges and boundaries in between the 'I' and the 'not-I'. Eros individualizes our experience and awakens the body-mind to itself. Adams and Savran note that eroticism, *"radically undermines oppositions between gender and sexuality, between the psychic and the social"* (2002, p. 9). The 'otherness' of differing genders, behaviours and sexual attitudes invites much curiosity, fascination and excitement, but may equally trigger anxieties or fears. We may see other sexual cultures as 'exotic', a term that is often also equated with 'primitive' or 'immoral' in sexual contexts, or we may label another sexual culture as 'risky'. Such responses, not only signal excitement, but also how we may perceive our identity or selfhood as being at risk from another sexual culture. Numerous psychoanalytic writers have identified homosexuality, the

'other' sexual culture, as the primary source of a client/patient's presenting problems (Lewes, 1989).

However, no one theory or experiment has offered any definitive answers about the causes for different sexual orientations. There is little doubt that sexual behaviour is socially influenced, but the regularity and consistency of sexual behaviour patterns across space and time indicate that it must also be strongly rooted in our biological nature (Sanderson, 2003). And there seem to be no shortage of factors that contribute to our sexual orientations. Numerous studies have demonstrated correlations, but correlations cannot establish causation, and, to date, no evidence has emerged for either socially constructed or biological factors to be a 'cause' for same-sex attraction.

Some studies, for example, show correlations between levels of education and urbanization and the relative percentages of homosexuality, although such urban clustering appears less pronounced for lesbians than for gay men (Sprigg & Dailey, 2004). There could be a number of explanations for such data however. Education and urbanization may influence how comfortable respondents may feel to discuss or disclose their sexual orientation. Equally, sexual minorities may gravitate toward larger cities to find greater acceptance and more substantial LGB communities. Sanderson (2003) notes that homosexuality occurs at very similar rates in most societies – regardless of societal acceptance of homosexuality, or hostility towards it. If homosexuality was indeed a socially constructed choice, Sanderson argues, why would people make such a choice in any society that is intensely homophobic?

Perhaps the most promising theory to date is offered by social psychologist, Daryl Bem. His construct provides the same basic account for opposite-sex and same-sex attraction, and for men and women alike. Bem proposes that biological variables, "*… do not code for sexual orientation per se but for childhood temperaments that influence a child's preferences for sex-typical or sex-atypical activities and peers*" (1996, p. 320). But such preferences may account for a child feeling different from same, or opposite, gendered peers and, crucially, to perceive them as dissimilar, unfamiliar and exotic. Bem suggests that such feelings may produce, "*heightened nonspecific autonomic arousal that subsequently gets eroticized to that same class of dissimilar peers: Exotic becomes erotic*" (1996, p. 320). Bem's theory is based in part on a meta-analysis (Bailey & Zucker, 1995) that showed childhood gender nonconformity to be the strongest predictor of homosexual orientation for both men and women. This theory, Bem argues, accommodates both the empirical evidence of the biological essentialists and the cultural relativism of the social constructionists. Crucially, it recognizes common developmental origins at the root of all sexualities.

The challenges, commonly associated with living as a LGB person or coming to terms with same-sex attraction, are well documented. Belonging to a minority involves multible stress factors of which members of the heterosexual majority remain mostly oblivious. These include: awareness of orientation difference, secrecy and covertness, (non-)acceptance of their orientation, moment-to-moment decisions whether to 'come out', but also deciding who will, or should, know. Bisexuals not only struggle for acceptance by heterosexuals, but also with other sexual minorities. King and colleagues (2008) concluded, from their systematic review of LGB mental health needs, that depression, anxiety, alcohol and substance misuse are at least 1.5 times more common in LGB communities. The study also shows higher suicide risks, and that sexual minorities are more likely to seek professional help than the heterosexual majority.

These figures emphasize the importance of improving access to quality psychotherapy services for people with minority sexual orientations. But do they also support calls for a new psychoanalytic theory of homosexuality? A number of psychoanalytic writers have rejected such proposals and argued that psychoanalysis should not concern itself with etiological questions

about homosexuality (Auchinloss & Vaughan, 2001; Ryan, 2005). To date, there has been little evidence that external influences, for example childhood trauma or sexual molestation, can effect same-sex attraction or determine a person's sexual orientation. Sprigg and Dailey (2004) list only one study that showed a statistically significant increase of homosexuality amongst a small sample of 35 male survivors of childhood sexual abuse. This data could have a number of explanations and has not been replicated by other researchers.

What can psychotherapy do?

The serious concerns Mitchell raised in 1981, about issues of psychotherapists subjectivities, and the potential misuse of their authority when working with homosexual clients, remain just as valid today. The culture wars about LGB continue unabated in 21st century general culture. While most Western ultra-conservative groups no longer condemn homosexuality as an outright perversion, or as illness, they nonetheless continue to promote homophobic perceptions aggressively and to portray same-sex attraction as a "normal development aberration", or describe homosexuals as "the lepers amongst us" (Reynolds, 2007), before hastening to say that neither should be discriminated against. Such manipulative uses of imagery may avoid discrimination charges, but nonetheless likens homosexuality to a frightening disease in the guise of a seemingly compassionate gesture. In Britain and in other countries, ultra-conservative groups and politicians have also attempted to claim that psychotherapy's ethical guidance on 'conversion' or 'reparative therapy' discriminates against those who seek psychotherapeutic help to "overcome" their same-sex attractions and excludes them from the genuine professional support that they want.

For over three decades, the international mental health community has built a consensus that homosexuality is not an illness, and therefore is not in need of a cure. Yet, treatment programs for "unwanted homosexuality" hold out a possibility to reduce or alter same-sex attraction to those who struggle to reconcile their sexual orientation with religious beliefs, or seek to escape social stigma. Such treatments are termed 'conversion' or 'reparative therapy' by their proponents, which covers a range of pseudo-scientific treatments that aim to change sexual orientation (Ford, 2001). To date, there is no credible evidence that shows sexual orientation can be changed. Schroeder and Shidlo (2002) conducted a review with 202 gay and lesbian participants, who all had volunteered for 'conversion therapy' interventions. The study showed that 5 years on from the treatments they received, 96 percent of participants had failed to alter their same-sex attractions. In 2012, Robert Spitzer recanted a controversial and much-quoted study he had published in 2003, which appeared to suggest that sexual orientation change was possible.

Numerous professional organizations in the US and in Britain have issued statements to clarify that altering sexual orientation is not an appropriate goal for psychotherapy or psychiatric treatment. Such statements reflect ethical concerns about treatments offered with insufficient evidence to support their validity, but also concerns about possible distress and harm caused by interventions that attempt to affect sexual orientation. There is currently only anecdotal evidence of harm caused but ethical concerns about conversion treatments are undisputed and compelling:

- a departure from the core principle of non-directive neutrality in clinical practice without a compelling rationale.
- the exploitation of the transference and the patient's shame in the pursuit of sexual orientation conversion;
- the use of a psychotherapist's influence and authority to obtain compliance and submission

from a client or a client believing that 'giving up' their homosexuality is pleasing their therapist;
- the values implied or conveyed to patients/clients when therapists agree to help reduce same-sex attraction.

It is not a question of 'affirmative' psychotherapy (where sexual minorities are actively supported) versus 'conversion' or 'reparative' therapy, as ultra-conservative groups want to make us believe. There simply is no theoretical or clinical rationale to deviate from the well-established and sound psychotherapeutic position of non-directive neutrality in response to any presenting issues of same-sex attraction. Non-directive neutrality constitutes an essential – and many would argue indispensable – principle of psychotherapy. Whilst there are exceptions to this therapeutic core position, these are normally limited to interventions aimed at preventing some imminent and serious harm to a patient/client, or to any third parties. Issues of sexual orientation, however distressful to the individual, cannot meet this standard.

Expressions of sexuality create powerful challenges to the therapeutic relationship. Two manifestations of sexuality are particularly potent in the consulting room: erotic transference and sexual orientation issues. Both may take clinicians, and their clients/patients, into profound and troubling engagement with cultural forces, personal anxieties and conceptual ambiguities. And both will commonly present as the tip of the proverbial 'iceberg', whose submerged mass comes alive in the transference relationship.

Tensions about sexual orientation that so powerfully exist, both intra-psychically and in society, are bound to enter the therapeutic relationship as transference phenomena. As clinicians, we should expect that anxiety-based reactions to homosexuality – so prevalent in both general and in sexual minority cultures – will enter the therapeutic relationship, alongside any anxious ambivalence about revealing (or hiding) gender and sexual orientation or associated fears that any disclosure will, at best, not be appreciated and, at worst, be attacked. The history of troubled relations between psychotherapy and same-sex attraction suggests that such tensions have all too frequently been enacted or 'acted out' in the therapeutic space, rather than constructively engaged with. Our clients and patients should reasonably expect that psychotherapy can provide a 'safe enough' container for the struggles they bring to therapy.

Should it matter what sexual orientation my therapist is? It commonly matters if my therapist is male or female, and it would be hard to argue that my therapist's sexuality is of no consequence in the therapeutic relationship. While issues of sameness and difference cannot determine preference, they warrant mindful awareness and possible acknowledgement at appropriate occasions. Inter-subjective theory postulates that we must be recognized by the 'other' as another subject in order to fully experience and establish our subjective selfhood in the other's presence (Benjamin, 1990). The need for recognition, Benjamin suggests, cannot be fulfilled without a capacity to recognize others in return and, by extension, achieve some mutual recognition. Such recognition must necessarily include sexual orientations, but therapists also need to consider that recognition alone may not meet a client/patient's need for enabling resources and skills.

Conclusion

The issue of changing sexual orientation remains highly politicized in modern societies, amidst continuing efforts by ultra-conservative groups to discredit a growing social acceptance of same-sex attraction as normal variants of human sexuality. Psychotherapeutic clinical practice should not, and indeed cannot, be driven by moral judgements and prejudices. If trauma

cannot be shown as a cause for sexual orientation, all attempts to modify same-sex attractions with any kind of treatment will have no valid scientific basis, and are therefore doomed to fail. There is currently no credible rationale for psychotherapy to approach same-sex attractions in any way differently from all or any other aspects of human life and endeavour, namely with curiosity, openness and a thorough appreciation for the complexities and multi-layered-ness of individual experience.

Good ethical practice requires us to keep an open mind about any presenting gender and sexual orientation issues and allow for other, and perhaps multiple, meanings to emerge in the client/patient's process. Theories that pathologise homosexuality have also failed to support constructive engagement with the powerful transference phenomena that surround issues of same-sex attraction in clinical practice. Psychotherapy does not need new paradigms about sexual orientation, but a much better understanding of the psychic, corporeal and social tensions associated with sexual minority experience and their manifestations in the therapeutic relationship.

Paraphrasing Freud (1951), what psychotherapy can do is to help bring about harmony, or peace of mind, for people who are unhappy, torn by conflicts, or inhibited in their social lives – whatever their sexual orientation may be.

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