Undoing the Damage: Working with LGBT Clients in Post-Conversion Therapy

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As a mecca of diversity, New York City is one of the epicenters for the lesbian, gay, bisexual, and transgender LGBT community. As such, LGBT identified clients present in New York's counseling and mental health agencies with a cross section of issues unique to the LGBT community. One of these issues is the deleterious effects LGBT-individuals face after an experience with conversion therapy. Conversion therapy aims to alter a person's sexual orientation away from homosexuality and into heterosexuality or celibacy. Clients seeking counseling after an experience with conversion therapy present distinct practice challenges that require special consideration in treatment. These clients may experience both sexual and spiritual identity crises, symptoms of depression and anxiety, hopelessness, sexual dysfunction, and symptoms of post-traumatic stress. Integrative solution therapies, grief work, community-based interventions, and trauma work offer healing strategies for treating LGBT clients after conversion therapy.

One associates the practice of conversion therapy with a time when homosexuality was a diagnosable mental illness. Many contemporary clinicians readily classify such practices as unethical and therefore conclude that they are rare in occurrence. Furthermore, prevalence rates of conversion therapy are unclear and vary geographically. Individuals suffering from the adverse effects of conversion therapy appear in diverse urban areas such as New York City's lesbian, gay, bisexual, and transgender (LGBT) affirmative agencies, indicating that it is still a relevant concern for the LGBT community and mental health practitioners serving these populations.

Though we generally consider those who undergo conversion therapy to be bisexual, gay men, or lesbians, transgender individuals have also experienced conversion therapy since not all transpersons identify as heterosexual. Consequently, conversion therapy may affect anyone in the LGBT community.

As an historically underserved sexual minority population subjected to homophobia and transphobia, LGBT clients present with symptoms of depression, anxiety, and post-traumatic stress disorder. These symptoms are the result of overt aggression, physical assault, living with limited civil liberties, microaggressions, and the overall unaccepting social climate of an inherently homophobic society. Embedded in these societal oppressions is the practice of conversion therapy in which a licensed clinician, priest, rabbi, or other spiritual advisor works with the LGBT-identified client to "convert" the individual to a heterosexual, or at least a celibate, lifestyle. In opposition to conversion therapies, the National Association of Social Workers Committee on Lesbian, Gay, and Bisexual Issues (NCLGB) firmly asserts:

> 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.
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> (NCLGB, 2000, p. 1-2)

With this statement in mind, this paper explores evidence-based approaches that affirm and support both the sexual and spiritual identity of the LGBT-identified client seeking mental health services after conversion therapy. Such approaches are referred to as "integrative solutions" (Gonsiorek, 2004). The following case example highlights many of the traumatic experiences unique to LGBT populations involved in conversion therapy.

Consequences of Conversion Therapy

M.H. arrived disheveled and exhausted for counseling services during walk-in hours at a LGBT community center in New York City. LGBT community centers often serve as sanctuaries for LGBT individuals who have experienced trauma by providing them with counseling and case management services. M.H. arrived at the center hoping the agency could help him find somewhere to stay. His affect was flat, and he held his head in his hands as he explained that he was 21 years old and running away from home. His parents, particularly his father, abused him for being gay. His mother and father called him derogatory names and often hit him. In tears, M.H. disclosed that his parents sent him to a Christian conversion counselor who tried to "turn him straight" and also verbally assaulted him. He wanted desperately to move away from his parents but lacked the resources to live on his own. Through his tears, his face remained flat and unanimated as if he were resigned to giving up. He confirmed this sentiment when he stated that he no longer cared whether he lived or died. Unfortunately, the conversion therapy movement profoundly impacted M.H., and the issues he encountered are highly relevant to those working in social services with LGBT populations.

Some consider conversion therapy a phenomenon of the past, but many LGBT clients who seek various types of counseling still encounter ideas and therapies that attempt to convert an individual's sexual orientation, especially in the context of religion. Conversion therapy, also referred to as reparative therapy, began with the idea that LGBT individuals are "sexually broken" (Kort, 2008; Haldeman, 2002b). Despite the removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders in 1973 by the American Psychological Association, these therapies persisted, justified by theological arguments that define homosexuality as a moral transgression. In an attempt to rectify this perceived transgression, conversion therapists used abusive aversion techniques with their clients, which included electric shocks to the hands and genitals when exposed to homosexual material, encourage-

ment of heterosexual activity such as sex and dating, and the teaching of skills to manage homosexual tendencies. Clients who experienced such therapies present unique practice challenges for mental health providers because conversion techniques are frequently associated with religious conviction (Kort, 2008; Gonsiorek, 2004).

A client seeking services after conversion therapy may be in a state of emotional and/or spiritual crisis. Clients seeking counseling after an experience with conversion therapy present with increased levels of depression, low self-esteem, and suicidal ideation and intention (Nicolosi, Byrd, & Potts, 2000). They frequently feel intense shame and self-loathing from internalized homophobia (Carroll, 2010). Furthermore, some consider the infliction of conversion therapy upon an LGBT individual a type of hate crime and sexual minorities endure devastating and long-lasting effects from hate crimes (Rose & Mechanic, 2002). Other studies confirm chronic depression and low self-esteem in post-conversion clients, as well as sexual dysfunction and significant relational issues (Haldeman, 2002b).

In addition to psychological consequences of conversion therapy, individuals experience a series of concrete losses. Clients may feel that they have "failed" at conversion therapy and, as a consequence, may be ostracized by family, community, and work, all of which are significant and potentially incapacitating losses (Haldeman, 2002b). This sense of failure and loss can contribute to debilitating feelings of guilt (Haldeman, 2002b). Clients not only experience the identity trauma of intrinsically homophobic conversion therapy, but also experience another level of psychological pain when they consider themselves failures for not having the ability to change their sexual orientation. When conversion therapy fails to change one's sexual orientation, it eliminates any hope for change a client may have had prior to the conversion therapy. Consequently, clients enter post-conversion therapy attempting to manage the aforementioned issues, and they may also endure dangerous levels of hopelessness.

Clients who seek counseling and mental health services after conversion therapy survived psychological manipulation and possibly physical trauma. They may have suffered some threat to and/or crisis of identity. The identity component of the trauma adds another level of complication to clinical work in mental health counseling, especially when the client cannot decouple spiritual and sexual identity. Historically, the controversy around conversion therapy centered on the ideological debate of whether or not it should exist. Even some mental health practitioners who are not necessarily proponents of conversion therapy argue that client self-determination ranks as a priority over the ethical considerations of the treatment (Carroll, 2010; Haldeman, 2002a). Therefore, many practitioners who honor client choice above other ethical standards believe individuals should have access to conversion therapy.

Working in tandem with sexuality and spirituality creates precarious clinical situations for the practitioner. Researchers highlight the fact that the saliency of spiritual identity and the need for a spiritual belief system often exceed those of sexuality, and a practitioner who suggests "an abandonment of

their spiritual traditions in favor of a more gay-affirming doctrine" may also inflict psychic damage on the client (Haldeman, 2002a, p. 263). Haldeman (2002b) reiterates in another article that religious beliefs can define the self as much as or more than sexual orientation. For some, positive associations with religion, such as comfort, family connection, and routine, are lost with acceptance of sexual orientation, a loss that the practitioner must acknowledge and respect. Furthermore, acknowledgment of sexual orientation does not always automatically earn acceptance into the LGBT community. Some LGBT clients complain that, "it is easier for some individuals to come out as lesbian or gay men in their communities of faith than it is to come out as spiritually or religiously oriented in the LGB community" (Haldeman, 2002a, p. 262). The practitioner must not assume that a client can easily "give up" a religious community in exchange for the LGBT community.

Implications for Practice

Integrative solution therapies propose that mental health clinicians respect all the components of a client's identity and assist the client in making room for a variety of aspects of identity in their overall self-schema (Gonsiorek, 2004). The therapist does not seek to indoctrinate the client into the LGBT-affirmative community, but rather intends to illuminate the ways in which social forces coalesce to devalue, invalidate, and sometimes oppress gender and sexually non-conforming individuals. Frequently, significant loss may be associated with these truths. For example, a client's deeply embedded schema that everything about her religion is true and good will be compromised with the acknowledgement that this fundamentally "true and good" community has also oppressed her in some way. Therefore, grief work will be necessary for such clients (Haldeman, 2002b). After the client acknowledges the pain of her losses, she may need to deal with internalized homophobia, guilt, and shame. Haldeman (2002b) advises:

> Neutralization of shame takes place by examining a self that has been firmly embedded in a socio-cultural environment that did not value the self for who it was, but that required it to change (or hide) in order to be acceptable…this is not a problem of the self, but of the social environment.
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> (p. 121)

Creating an environment that simultaneously affirms and validates both spiritual and sexual identity requires illustrating for the client a concept of the self within a socio-cultural environment. Collectively, some of the integrative solution practice goals for working with clients after conversion therapy include acknowledging and validating pain and loss, neutralizing shame, and encouraging clients to live for themselves rather than the social institutions that pressure them to conform to a certain standard (Haldeman, 2002b).

The literature highlights other important practice considerations when

working with LGBT clients participating in post-conversion therapy. For example, LGBT-identified individuals who attempt conversion therapy commonly believe that their homosexuality resulted from inadequate or inappropriate bonding with one or both parents, that they are morally corrupt, or that homosexuality represents a failure in adequate psychological development (Carroll, 2010; Kort, 2008; Haldeman, 2002a; Haldeman, 2002b). Such clients often need varying amounts of psychoeducation following conversion therapy. The practitioner must address these beliefs without denigrating religious conviction or disparaging the client for her potential belief in such statements. Furthermore, practitioners must be absolutely comfortable with addressing and discussing sex with their clients in order to ensure they have the most accurate information with which to protect themselves. In particular, therapists need to comfortably address the topic of sex because of the way in which trauma and sexual orientation have impacted the client's formation of identity.

In many ways, LGBT clients in post-conversion therapy suffer a double assault to their identity formation. They entered, or were coerced into, conversion therapy because their spiritual and/or self-concept clashed with their sexual orientation. Unfortunately, the trauma experienced in conversion therapy further disturbs a client's sense of self on a less conscious level. For example, traumatic memory remains highly accessible to an individual and, consequently, autobiographical knowledge organizes itself into a new, salient, cognitive schema created by the trauma memory; it may be interpreted as a feature of one's personal identity (Berntsen & Rubin, 2007). Furthermore, trauma creates highly accessible memories which, according to the availability heuristic, cue the victim to overestimate the frequency of the traumatic events. Not only will a client organize any or all knowledge of self into the cognitive schema created by the trauma of conversion therapy, she may expect to be hurt and traumatized again when re-entering treatment after an experience with conversion therapy. Consequently, the client may shut down, be defensive, suicidal, highly anxious, and/or experience symptoms of post-traumatic stress disorder. Knowing and expecting the cognitive effects of trauma equip the practitioner for work with LGBT clients in post-conversion therapy.

The implications of these findings for work with individuals in post-conversion therapy are extensive. The social worker and/or mental health practitioner must consider trauma, spiritual and sexual identity, and any presenting clinical pathology. Distinguishing pathology from the negative effects of a lifetime of internalized homophobia contributes to the complexity of treatment considerations. However, a practitioner has the opportunity to do meaningful and important work by simply providing a client with information incongruent with their maladaptive schema, which commences the process of forming new, healthier, and more adaptive schema (Berntsen & Rubin, 2007). Therefore, a significant component of practice with post-conversion clients involves providing them with schema-deviant material through a series of corrective emotional experiences. Unconditional positive regard, valuing all features of a client's identity, and resisting impulses both to coax her into openly embracing her sexuality and to compel her to integrate into the LGBT community all provide

the client with some level of remedial emotional experience, thus increasing the likelihood that she will remain in treatment and achieve some healing. In order to achieve a safe environment**,** the clinician must recognize her own heterosexual and gender-normative privilege (if she does not identify as LGBT), and acknowledge the grief that comes with losing heterosexual privilege in the community after unsuccessful conversion therapy (Kort, 2008). Other approaches to trauma work, discussed below, are particularly relevant to work with post-conversion therapy clients.

Healing Trauma

Judith Herman (1992) adopts a feminist perspective on trauma theory and practice. Herman describes many of the features characteristic of a traumatized individual. One feature includes "re-living" the trauma in thoughts, actions, and dreams. This phenomenon is particularly relevant in working with clients after conversion therapy. For example, many clients who have undergone conversion therapy report persistent sexual dysfunction. For clients who received aversion stimuli, such as electric shocks, sexual intimacy brings back the moment of conversion therapy trauma, and she may be unable to continue any sexual activity. This repetitive intrusion produces debilitating effects. When she coins the "dialectic of trauma" phenomenon, Herman describes the converse of intrusive re-living experiences in which the traumatized individual vacillates between states of complete numbness and amnesia of the trauma, to states of overwhelming sensitivity and re-living of the event. Practitioners working with individuals in post-conversion therapy should recognize this dialectic vacillation and cultivate awareness of the danger and emotional distress involved in both of these states. According to Herman, the emotional/re-living state could produce complete inhibition in the client, creating a variety of unsafe situations ranging from self-harm, substance abuse, and unsafe sex. Numbness and complete lack of feeling may lead to extreme isolation and the development of symptoms of depression, both pertinent concerns for individuals who identify as LGBT.

Herman (1992) also discusses the way in which trauma affects faith and sense of community, both critical factors involved in working with clients in post-conversion therapy. She asserts that to repair the connection between the traumatized person and the community, the community must concurrently acknowledge the harm inflicted on the individual and take action in response to the inflicted harm. Herman states that "these two responses – recognition and restitution – are necessary to rebuild the survivor's sense of order and justice" (p. 70). This may present a particular challenge to clients in post-conversion therapy. In many cases, the community that inflicted the harm on the individual will neither publicly acknowledge the damage nor take responsibility or action to make amends. In order to achieve recognition and restitution for the traumatized client, the practitioner must investigate resources that help satisfy these needs. For example, a client forced under threat of expulsion by her religious community to engage in conversion therapy has the opportunity

to gain recognition from inclusion in a LGBT-affirmative religious setting. Unfortunately, such resources are difficult to access even in densely populated urban areas because homosexuality is still highly stigmatized within and outside of the context of religion, but the practitioner should remain aware of potential avenues for achieving recognition and restitution within a community.

The best opportunity for recovery from trauma is in interpersonal relationships, rather than in isolation (Herman, 1992). In this way, the survivor rebuilds and repairs the psychological functioning that was jeopardized by the trauma. In discussing the significance of allowing a client to remember and mourn losses, Herman delivers wisdom particularly suited to those who have survived conversion therapy:

> [The survivor] often comes into conflict with important people in her life. There is a rupture in her sense of belonging within a shared system of belief. Thus she faces a double task: not only must she rebuild her own "shattered assumptions" about meaning, order, and justice in the world but she must also find a way to resolve her differences with those whose beliefs she can no longer share.
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> (Herman, 1992, p. 178)

A client seeking LGBT-affirmative treatment after an experience with conversion therapy may confront overwhelming psychic tension in trying to "resolve differences" between conflicting systems of belief. This poses particular challenges for the clinician who may gravitate to theological solutions for the client either by trying to alter the client's system of belief or by trying to find different interpretations of those beliefs. Instead, the clinician must assist the client in deciding which beliefs to cherish and which doctrines to mourn. Herman (1992) describes multiple features of trauma, such as re-living and intrusion of the event into daily life, and the importance of community in healing from the trauma. The aforementioned treatment considerations pertain to affirmatively supporting a LGBT client post-conversion therapy and providing critical tools for working with any traumatized individual.

Conclusion

Though M.H. and I met only once, strong interpersonal factors emerged during this meeting. M.H. maintained a defensive and guarded posture, sitting with his legs double-crossed and his arms tightly crossed around his abdomen. He rarely made eye contact and covered his face so I could not see his tears. He also repeatedly apologized for crying. Such acute discomfort was difficult to witness, and my primary goal during the intake session was to provide constant reassurance, validation, and a sense of safety in the hopes of creating a mini-corrective emotional experience that would be just enough to bring him back for continued services. In an attempt to be as affirmative as possible, I made the mistake of openly judging the community and family from

which he came, and I rushed to reassure him that he had a place in the LGBT community. As discussed, the literature reveals the danger in using such a tactic. In my concern for his well-being, I was extremely eager to whisk him away from his abusive family and community into the LGBT community with which he may not yet, or ever, identify. The outrage one feels for the devastating effects such overt hate and discrimination produce may be one of the most difficult emotions for clinicians working with clients post-conversion therapy. It triggers an impulse to "rescue" or "save" the client which, ironically, are some of the same verbs used by conversion therapists to justify their work. This is a sobering realization.

Future research must explore the ways in which social workers and other mental health practitioners can empower individuals who seek treatment after an experience with conversion therapy. Greater attention to the subject would help contradict the erroneous belief that conversion therapy no longer exists since homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders. Clients who survived conversion therapy suffer a myriad of psychological symptoms ranging from depression and anxiety to PTSD and sexual dysfunction. They may be in spiritual and emotional crisis, experiencing shame, low self-esteem, relational issues, and the loss of family and/or community.

The biggest challenge for practitioners in treating the symptoms of clients exposed to conversion therapy lies in the fact that clients need guidance in resolving the tension between their religious conviction and their sexuality, a very precarious task for the clinician. Integrative solution therapies that attempt to make room for all aspects of oneself (spiritual, sexual, and otherwise) offer some hope for LGBT individuals seeking treatment after an experience with conversion therapy. Integrative therapies also strive to bring awareness to the client of how environmental and social forces contribute to their pain and experiences with homophobia, and they aim to acknowledge and validate pain and loss, neutralize shame, and teach clients to live for themselves rather than for institutions. Trauma and grief work also assist in this process. As demonstrated in the case of M.H., these issues are deeply ingrained and may even be life threatening at times. Despite some social progress, conversion therapy exists and practitioners must be prepared to adequately serve LGBT individuals; they deserve the same non-judgmental, affirmative, and evidence-based therapies as their heterosexual counterparts.

References

Berntsen, D., & Rubin, D. (2007). When a trauma becomes a key to identity: Enhanced integration of trauma memories predicts posttraumatic stress disorder symptoms. *Applied Cognitive Psychology, 21*, 417-431.

Carroll, L. (2010). *Counseling sexual and gender minorities*. New Jersey: Pearson Education.

Gonsiorek, J. (2004). Reflections from the conversion therapy battlefield. *The Counseling Psychologist, 32* (5), 750-759.

Haldeman, D. (2002). Gay rights, patient rights: The implications of sexual orientation conversion therapy. *Professional Psychology: Research and Practice, 33* (3), 260-264.

Haldeman, D. (2002). Therapeutic antidotes: Helping gay and bisexual men recover from conversion therapies. *Journal of Gay and Lesbian Pschotherapy, 5* (3), 117-130.

Herman, J. (1992). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror.* New York: Basic Books.

Jenkins, D., & Johnston, L. (2004). Unethical treatment of gay and lesbian people with conversion therapy. *Families in Society, 85* (4), 557-561.

Kort, J. (2008). *Gay affirmative therapy for the straight clinician: The essential guide*. New York: W.W. Norton & Company.

National Committee on Gay, Lesbian, and Bisexual Issues. (2000). *"Reparative" and "conversion" therapies for lesbians and gay men*. Washington, DC: National Association of Social Workers.

Nicolosi, J., Byrd, A., & Potts, R. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports, 86,* 1071-1088.

Rose, S., & Mechanic, M. (2002). Psychological distress, crime features, and help-seeking behaviors related to homophobic bias incidents. *American Behavioral Scientist, 46,* 14-26.