# THE LIVED EXPERIENCE OF MEN IN REPARATIVE THERAPY

by

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## ABSTRACT

This study is a phenomenological exploration of client voice in psychotherapy. Five men were recruited from the Thomas Aquinas Psychological Clinic while in reparative therapy for issues related to unwanted Same-Sex Attraction (SSA). Open-ended interviews were conducted by telephone and then transcribed and analyzed via a phenomenological research methodology. Thematic analysis yielded 11 themes which described these men's experiences in therapy and the impact of therapy on their lives as a whole, including domains such as work, relationships, and sense of self. Reparative therapy for these men emerged as primarily about a struggle for healing of masculine identity. In therapy they worked on identifying bodily-based experiences of shame, understanding past family dynamics, and healing past incidents of abuse and rejection via Body Work and the Eye Movement Desensitization Reprocessing trauma protocol. The men reported a positive experience of psychotherapy. Benefits included being able to build better non-sexual relationships with men, becoming more open to intimate relating to a woman, and improving their sense of themselves as men. While there was some reported decrease in SSA, this did not involve a complete absence of any attractions to the same sex. Rather, the men reported lessening of SSA as well as a reduction in preoccupation with same-sex fantasies and behaviours. The men expressed gratitude at the opportunity to tell their stories, as well as the desire that their therapeutic choices be respected. This research has shed further light on the process of reparative therapy as it is practiced at the Aquinas Clinic. It has also added to the literature on client voice in psychotherapy as well as factors clients find helpful in the healing process.

Key words: sexual orientation, men's issues, masculine identity, reorientation therapy, client voice, positive experience of psychotherapy

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# CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

Individuals pursue psychotherapy for assistance in coping with a wide variety of difficulties. These include depression, anxiety, substance abuse, relational issues, self-esteem, and coping with traumatic experiences. Additionally, up to the present time, a population of clients has sought psychotherapy to reduce unwanted experiences of Same-Sex Attraction (SSA).

This study seeks to give voice to the experiences of a group of men who have undergone psychotherapy at the Thomas Aquinas (TA) Psychological Clinic in Encino, California. As such, it is a study about client voice in psychotherapy. These men have been involved in in-person or telephone therapy for issues related to unwanted SSA. Among those individuals for whom SSA is a significant and ongoing psychological reality, these men represent an under-researched subgroup whose stories have largely not been told (Nicolosi, 1991).

Increasingly, individuals who experience SSA are encouraged by the wider culture as well as mental health professions such as the American Psychological Association (APA, 2009) to integrate their attractions into a gay identity and become more comfortable with the acceptance and expression of those attractions. By contrast, the men in this study have expressed the belief that same-sex sexual behaviour is in conflict with their values and the persons they wish to be. Consequently, they entered therapy in an attempt to reduce those attractions and, in some cases, explore their potential for intimate heterosexual relating.

This project is also, therefore, an investigation into the phenomenon of *agency* as it has manifested in the therapy experiences of these men. This researcher sought to

investigate whether these men described a therapeutic experience that empowered them to function as effective agents in their own change processes and to move ahead with meaningful, self-chosen goals.

**Qualitative Research on Client Voice in Psychotherapy**

There is a relative dearth of qualitative research on psychotherapy from the client's perspective, as compared to the significant amount of quantitative psychotherapy outcome research that has occurred (Currier, Neimeyer, & Berman, 2008; Luborsky, Chandler, Auberbach, Cohen & Robinson, 1971; Norton & Philipp, 2008; Robinson, Berman, & Neimeyer, 1990). Of those studies that have been done, relatively few have employed, as this study has, a descriptive phenomenological methodology. Phenomenological approaches have actually been used more in the fields of nursing, medicine and social work (Erlandsson, Christensson & Fagerberg, 2008; Neander & Scott, 2006). A preoccupation with quantitatively evaluated effects of psychotherapy has led to the relative neglect of qualitative psychotherapy research (including phenomenological approaches, McCloud 2013).

Despite this dearth in the literature, it is increasingly recognized (Clark, Rees, & Hardy, 2004; Davidson, Stayner, Lambert, Smith, & Sledge, 1997) that descriptive research on treatment interventions from the perspective of the client can provide us with a deeper understanding of the therapeutic process (and its sequelae) as it is experienced by clients. The subtleties and nuances that are part of that process can likely neither be captured by quantitative studies alone, nor from the manualized treatment protocols or theoretical expressions of specific treatment approaches that have been developed. As noted by Corey (1996), psychotherapy may be more of an art than a science; as such, its

study may lend itself more particularly to a qualitative approach that focuses on the experiences of individuals.

Though small within the wider scope of research projects in psychology, some published qualitative work to date has highlighted client experiences of psychotherapy, including what was helpful. This research points to the possibility that qualitative methodologies can capture the unique voice of clients and illumine their therapeutic journey.

Watson and Rennie (1994) interviewed eight clients who were asked to recall problematic reaction points they had experienced while engaged in short-term psychotherapy that ranged in length from 12 to 16 weeks. The interviews occurred while the clients were in therapy, and they were asked to bring up the presented problematic reactions to their therapists on the next session after the conclusion of the interview. Watson and Rennie used a grounded theory method to develop a model of the clients' cognitive and affective interpersonal processes that occurred during sessions. The authors found that important correlates of therapeutic change included clients' representation of disturbing material, recollection, and the re-experiencing of emotion, and feelings of eagerness and curiosity during the sessions. They also concluded that the covert nature of many client processes may contribute to the ongoing difficulty of linking therapy process variables to final therapeutic outcome (Watson & Rennie).

Davidson et al. (1997) attempted to redress the revolving door syndrome of repeated hospitalizations for individuals diagnosed with schizophrenia. They employed a phenomenological and participatory action research methodology to examine patient descriptions of re-hospitalization, as well as the circumstances of this event and the

functions it served in their lives. Davidson et al. identified the importance of seeing the persons behind the label of schizophrenia, and remembering that they were subjects of their own experience as well as social agents pursuing their own agendas. Their research also revealed that the traditional understandings of the causes of re-hospitalization for persons with schizophrenia (and the research efforts that flowed from that understanding) were incompatible with the understandings of the patients themselves. Davidson et al. found that re-hospitalization had more to do with patient perceptions of helplessness and powerlessness in the community after discharge. In effect, the lack of resources and sense of being part of a meaningful community made the hospital seem more like a place of refuge and safety than a place of confinement for schizophrenic individuals. Davidson et al. pointed out that their study confirmed the importance of developing treatment interventions (for example, community development models for discharged patients) that flowed from the experiences of the patients themselves.

Paulson, Truscott and Stuart (1999) made use of a methodology called concept mapping (which included both quantitative and qualitative strategies) to explore factors seen as being helpful in therapy by 36 clients who had completed psychotherapy (with an average length of 11 sessions). Paulson et al. undertook a qualitative analysis of the clients' response to the question, "what was helpful about counselling" and arrived at a map of nine primary concepts that were derived from 80 elements the 35 clients had provided. These concepts included having a counsellor with a facilitative interpersonal style, counsellor interventions, the generation of client resources, gaining knowledge, accessibility, client resolutions, new perspectives, emotional relief, and client self-disclosure. Consistent with previous research, Paulson et al. highlighted the particular

importance of the counsellor's interpersonal style and the role of the therapeutic relationship. They also pointed out that the concepts of client resolution, gaining knowledge, emotional relief, and accessibility were client-derived experiences that were unlikely to be obtained from counsellors' perceptions or the categories used by an investigator. As such, their study highlighted the potential fruitfulness of seeking information on effective psychotherapy from clients themselves.

Clark, Rees, & Hardy (2004) interviewed five clients who had completed a brief course of cognitive therapy for depression. They employed the Change Interview Schedule introduced by Elliot's (1996, as cited in Clark et al., 2004) and used grounded theory methods to develop three category clusters which captured their participants' perspectives of change process in therapy. Clark et al. included in their first cluster, called "the listening therapist", categories such as (a) experiencing resistance and fear, (b) being excited and absorbed, and (c) safety. The second category cluster was entitled "the big idea" and included a focus on therapy techniques and procedures that were considered important, such as (a) the model; (b) dealing with thoughts; and (c) understanding patterns and core beliefs (Clark, et al.). Their third category cluster was called "feeling more comfortable with the self" and included categories involving (a) being more confident and comfortable; (b) responsibility; and (c) positive feedback. Clark et al. noted their research suggested clients made use of and valued both specific cognitive interventions as well as more general psychotherapy ingredients.

Giorgi and Gallegos (2005) attempted to explore client perceptions of symptom alleviation obtained through psychotherapy. Their participants consisted of three women ranging in ages from 30 to 50, who were part of a larger study project that involved nine

individuals and employed a phenomenological research approach. In light of the information provided by the three women, the authors indicated that symptom alleviation became in their view an inadequate construct through which to view the psychotherapy process, and they changed their focus to "determine the structures of living through some positive experiences in psychotherapy". Giorgi and Gallegos found that all three clients related their positive experiences of therapy to (a) having a therapist that resonated with them, (b) having a therapist who was safe, (c) having a therapist who showed care to them, (d) having a non-judgmental therapist, and (e) having a therapist who responded to their idiographic needs. In other words, positive characteristics of the therapist (as perceived by the client) were related to perceived positive experiences in therapy as such.

Chang and Berk (2009) explored the lived experience of clients in cross-racial therapy (therapy relationships involving therapists and clients of differing races). Making use of a phenomenological and consensual qualitative methodology they interviewed (through a structured interview protocol) 16 racial minority clients who had received therapy from white therapists. Change and Berk found commonalities between what their participants found helpful in the counselling process and what has generally been found to work irrespective of racial factors (the *etic* factor, examples being the centrality of the therapeutic relationship, therapist self-disclosure, and the ability of client and therapist to negotiate breaches in the relationship). However, they also found with respect to cross-racial dyads some differences in terms of client expectations, such as a desire for more expert guidance, advice and explicit instruction than typically found with white clients who tended to focus more on insight and personal growth.

Other studies have included that of Levitt, Butler, and Hill (2006) who interviewed 26 clients who had completed psychotherapy in the year prior to the study. Levitt et al. found that commitment to therapy, having a caring therapeutic environment, processing material between sessions, and building therapeutic trust were included in those therapy factors found helpful by the clients. Edwards, Ladner, and White (2007) interviewed a Jamaican mother while she was engaged in filial therapy (a therapeutic approach administered by a parent trained in filial therapy on their child) and concluded filial therapy assisted the mother in increasing her parental empathy and also strengthened her relationship with her child. Knox (2008) interviewed 14 individuals who had undergone a person-centered counselling approach, and found that all clients were able to identify at least one therapeutic experience in which they had a sense of relational depth with their therapist.

One recent study by Dollarhide, Shavers, Baker, Degg, & Taylor (2012) used phenomenological analysis to explore the conditions that created a meaningful therapeutic connection. Dollarhide et al. interviewed six counselors and eight clients in an attempt to derive the structure of a meaningful connection from both sides of the counselling dyad. Client participants described meaningful connections as, among other things, being affirmed, validated, understood, heard, cared about, encouraged and empowered. Dollarhide et al. inferred from their results that the facilitation of emotional expression is likely a helpful area for therapeutic interventions to address.

Qualitative research that focuses on the client's perspective of therapy can shed important new light on factors intrinsic to the client experience of therapy. It can also provide insights on the experience of being in therapy that are unlikely to be obtained

from therapist surveys or structured, quantitative research alone (Paulson et al., 1999). This is an important point with respect to the participants in this study, men who are in therapy for issues related to unwanted SSA. Although the following sections will provide a more detailed discussion of reparative and related therapies, it should be noted that many opinions have been offered (Haldeman, 1994) to explain the motivations of individuals undergoing therapy for unwanted SSA. Additionally, assumptions about the nature of such therapy (Schidler & Schroeder, 2002) have often been made from ideological and cultural stances rather than the perspectives of the individuals who have undergone such therapy. These stances may well serve to entrench a priori indictments of therapy for unwanted SSA, but they shed little light on the experience of actual persons undergoing such treatment. For this reason, further research from a client perspective in this area is desperately needed.

**Sexual Orientation and Sexual Identity: Necessary Definitions**

The men in this study have decided, despite the presence of SSA in their lives, not to adopt a gay identity. That is, they have not made their experience of SSA a primary basis for self-identity, nor do they wish to affirm or live out their SSA. Their sexual identity would therefore differ from that of a gay-identified individual. Additionally, these men have embarked on a psychotherapeutic journey to reduce and eliminate their SSA. Concurrently, some also wanted to explore the possibility of relating to a woman in an intimate and sexual manner. As such, these men have been engaged in the process of attempting to change their *sexual orientation*.

Given their relevance for our study participants, we turn now to a brief examination of the concepts of sexual orientation as well as *sexual identity*. The topic of

human sexual attraction and arousal has spawned a massive literature, most of which will obviously be beyond the scope of this chapter. It is widely acknowledged that, like other foundational human phenomena, sexual attraction and arousal are complex subjects that encompass biological, psychological, cultural and social factors, among others (Westheimer & Lopater, 2005). A major component of our personal identities remains connected to our sexual thoughts, feelings and behaviours, including the objects of our sexual attractions.

This is not a study about the causes of SSA as such. It is also not a formal study of whether or not individuals can change their attractions (though we will explore this question from the perspective of study participants). However, as persistent SSA is or has been a salient feature in the lives of the men in this study it will be necessary to explore to some extent the discussion around the nature and development of these attractions. The presence of persistent sexual attractions towards members of one or both genders has commonly been taken to indicate one's sexual orientation.

There has been a great deal of disagreement in the medical and psychological fields concerning the nature and development of sexual orientation. Throckmorton (1998) noted there has been a lack of stability within the mental health professions concerning how sexual orientation is defined, how valid a clinical concept sexual orientation is, and how stable it is over the adult life span. The context of Throckmorton's discussion was a request to the professional counselling community not to foreclose on requests for therapeutic assistance to shift sexual attractions.

Jones and Yarhouse (2000) provided a helpful discussion on differing conceptions of sexual orientation in what has been termed the essentialist-constructionist debate. These two positions will be briefly examined.

*Essentialism* posits that the term sexual orientation indicates an objectively-existing, real aspect of a person's biological or psychological make-up, a stable feature of their personhood in the same way that temperament or eye colour would. For the essentialist, a person's sexual orientation is inextricably bound up with their overall identity as a human being (Jones & Yarhouse, 2000). One important implication of the essentialist perspective is that it becomes possible to refer to same-sex sexually attracted individuals as a distinct people group in the same manner in which one can identify ethnic minorities or, say, women. This fact has had important implications for the gay activist movement in terms of conceptualizing their struggle as a disenfranchised minority group who need to campaign for rights and full societal inclusion (Shilts, 1982).

*Social constructivism* refers to individuals who experience ongoing sexual attractions to a particular gender but would say that the categories used to denote sexual orientation, for example *homosexual* and *heterosexual*, are merely cultural constructs. These are used for convenience in categorizing, in the same way that labels of political affiliation help to identify the opinions of an individual at a given time, but are not necessarily of an enduring nature (Jones & Yarhouse, 2000; see also Jones & Hostler, 2002).

Considerable theorizing has occurred regarding the etiology of SSA. Dreikorn (1998) reviewed psychoanalytic, biological, Darwinian/evolutionary, and social learning explanations for the genesis of SSA. Dreikorn concluded that many of the studies in this

field had methodological design flaws, small sample sizes and were often drawn from clinical patient samples. In light of the diversity of proposed explanations, Dreikorn suggested there may be more than one developmental pathway to SSA. Jones & Yarhouse (2000) proposed a weighted interactionist hypothesis that recognized the role of biological, psychological, and environmental influences (childhood and adult) that may play a role in the genesis of SSA. Jones and Yarhouse concluded after their review of the literature there was insufficient evidence to attribute the cause of SSA solely to biological (be they genetic, hormonal, or other) or psychological (early family influences and sexual abuse) factors. On its website, the APA (www.apa.org/helpcenter/sexual-orientation.aspx) indicated no consensus exists among scientists as to why individuals develop a stable homosexual, heterosexual, or bisexual (i.e. being attracted to members of both sexes) orientation. The APA noted many believe that nature and nurture play complex roles in the development of sexual orientation.

A concept related to that of sexual orientation is that of sexual identity. Yarhouse (2001) provided a helpful discussion of sexual identity by using Althof's conceptualization. Yarhouse wrote that sexual identity is a broad construct that includes (a) *gender identity* (one's sense of being male or female), (b) *object choice* (the sources of one's sexual attraction, which can be related to age, gender, animals, or inanimate objects), and (c) *intention*, referring to what one plans on doing with one's sexual impulses. Yarhouse wrote that the definition of sexual identity can be expanded to include the choice of an individual to act on given sexual impulses, and to experience those impulses as central to identity.

Earlier, Shively and De Cecco (1977) wrote that sexual identity comprised (a) *biological sex,* (b) *gender identity* (i.e. the sense of being male or female), (c) *social sex-role* (characteristics that are culturally associated with being either male or female), and (d) *sexual orientation.* They divided sexual orientation further into *physical* and *affectional preference*.

Frable (1997) wrote that the nineteenth century was the first historical period in which persons who engaged in same-sex sexual behavior came to be defined in terms of those behaviours; in essence the person who engaged in homosexuality now became a homosexual. Frable noted that the initial characterization of such persons was considered a sickness by the medical and psychological establishments. However, with the advent of the gay rights movement, an affirming alternative to the previously negative characterization of same-sex sexual behavior was evolved.

Both Frable (1997) and Yarhouse (2001) discussed theories of gay sexual identity development, such as those of Cass (1979, as cited in Frable, 1997) or Troiden (1982, as cited in Yarhouse, 2001). These are affirmative models of the development of a gay or (for females) lesbian identity, and entail a series of steps or challenges that result in the integration of one's sexual attractions with one's overall sexual identity. As such, the person who adopts a gay identity not only has the experience of sexual attraction to members of the same sex, but also affirms and accepts those attractions, and believes them to be part of their central identity.

Many studies (Chan, 1989; McCarn & Fassinger, 1996; McDonald, 1982; Meyer, 2003; Mohr & Fassinger, 2003) have documented the experiences and challenges experienced by persons who label themselves as gay or lesbian. As noted by Nicolosi

(1991), research has shed much-needed light on personal experiences that previous to the gay movement had been seen in the one-dimensional perspective of pathology.

Yarhouse (2001) noted that all of the major theories of gay or lesbian sexual identity development presupposed that a same-sex attracted individual will eventually come to affirm and accept their attractions and integrate them into a gay or lesbian identity. This process has been referred to by gay activists as the "coming out" process, by which a person discloses first to themselves and then to others the reality of their same-sex attractions. Eventually, they also become comfortable with the expression of those attractions and their central integration into their personal identities.

A psychotherapy (Gay Affirmative Therapy, or GAT) has been developed to assist individuals with the coming out process. Dreikorn (1998) outlined the approach of Dr. Isay, a gay psychiatrist and one GAT treatment provider. Dr. Isay sought in his work with gay clients to (a) explore injuries suffered as a result of parental rejection, (b) counter social discrimination and internalized homophobia (the irrational fear and dislike of gay persons), and (c) assist with the coming out process (Dreikorn). Dr. Isay's approach can be seen as typical of the kinds of activities that GAT engages in.

However, Yarhouse (2001) discussed the role of valuative frameworks in the lives of individuals who experience SSA but do not want to integrate those attractions into a gay identity. He pointed out that for some people, religious or other factors (e.g., a desire for marriage and/or family) led them away- rather than toward - a gay identity, despite the reality of SSA in their lives. Yarhouse made a case for modifying existing models of sexual identity development to make room for those same-sex attracted individuals who do not move towards gay identity. For Yarhouse, such persons should not just be seen as

failed models of successful gay identity development, but as individuals whose framework of values has led them on a different identity trajectory.

Yarhouse's (2001) comments are germane to the attitudes of therapists concerning clients who present for treatment for unwanted SSA. In contrast to the view that such clients are inevitably seeking such therapy due to internalized societal stigma and discrimination (Haldeman, 1994, 2002), Yarhouse (1998) argued that factors such as religious beliefs and value structures are legitimate diversity variables when considering provision of psychological services. Simply put, clients have a right to seek psychological assistance aimed at reducing experiences of unwanted SSA.

In advocating for the rights of individuals to choose a non-gay-affirming identity trajectory, Yarhouse (2001) as well as others have assumed such individuals are able to practice *agency* with respect to their therapeutic goals. One definition of "agency" (found in the Merriam-Webster Dictionary) is "*one through which something is accomplished*". In the present context, agency refers to the ability of a client to pursue a therapy that is meaningful for them and consistent with their values and long-term goals. It is further assumed that a client can undertake such an enterprise without being (unduly) pressured or coerced by external (heterosexist work and life environments) or internal (negative attitudes about same-sex behaviour held by the self) factors.

Out-patient psychotherapy approaches have generally taken it as a given that individuals can be genuine agents in choosing a therapy that is meaningful for them. Nonetheless, this assumption has frequently come under question for those who seek to reduce unwanted SSA. Part of the motivation for this critical stance concerning the treatment of SSA would appear to stem from the genuine stigmatization as well as

discrimination (Haldeman, 1994, 2002) that same-sex attracted persons have experienced in society. However, it has also originated from the ideological stance of gay activism (explored more in the following section), as well as the influence of that activism on the governing mental health bodies (such as the APA).

**Psychotherapy, Homosexuality, and the Treatment of Unwanted SSA**

The rise of the gay rights movement (Shilts, 1982) engendered a shift in the societal perception of same-sex sexual behavior. This was a movement away from a conceptualization of this behavior as a form of pathology, moral decrepitude or criminal act to one of tolerance. The new perspective encouraged by the gay rights movement argued that persons with same-sex attraction were members of a disenfranchised minority who had to campaign for rights in a manner similar to that of Afro-Americans or women.

This shift of perspective was also felt in the fields of psychiatry and psychology and through them, the other mental health professions (Socarides, 1995, Nicolosi, 1991). Dreikorn (1998) provided a history of the gay rights movement as it developed in the United States in the post-World War II years, including the rise of the *Mattachine Society* in 1950. Dreikorn related how the Mattachine Society adopted an antipathology stance concerning homosexual behaviours in 1965, and shifted their advocacy efforts from a cautious and defensive stance to one that was outspoken and took the offensive.

With respect to the American Psychiatric Association, Dreikorn (1998) noted how increased pressure was placed by gay activist groups beginning in 1970. Leaflets were distributed at conventions, and Gay Liberation Front members interrupted the 1970 meeting of the Association as well as several other gatherings. According to Dreikorn's account, the basic objective of the gay activist influence on the American Psychiatric

Association was to delete homosexuality from the nomenclature of the Diagnostic and Statistical Manual (DSM). Gay activist influence found fruition, in large part through the efforts of Dr. Robert Spitzer, a member of the DSM Committee on Nomenclature. In late 1973, a motion which proposed deletion of homosexuality as a mental disorder from the DSM was voted on and passed. Dreikorn noted that only about 40% of the APA membership participated in the resolution.

The third version of the Diagnostic and Statistical Manual (DSM III, 1980, as cited in Dreikorn) contained the term ego-dystonic homosexuality and, following Dreikorn's (1998) account, made provision for an individual who was dissatisfied with his or her homosexual orientation to seek treatment. Dreikorn quoted Milton (1986, as cited in Dreikorn) to the effect that it was decided by the APA to allow each homosexual person to determine if their attractions were unwanted or distressing to them. DSM IV (1994, as cited in Dreikorn) removed all references to homosexuality. The most recent edition (DSM IV-TR, 2000) also contains no explicit reference to homosexuality, but does have a Sexual Disorder Not Otherwise Classified (NOC), which allows for a person to present for treatment or distress related to their sexual orientation. As it currently stands, the classification would appear to make room for individuals also distressed about their heterosexual orientation. Although the current DSM does not have any explicit diagnosis referring to sexual orientation distress, the International Classification of Diseases (ICD) of the World Health Organization does have a diagnosis called Ego Dystonic Sexual Orientation which refers to individuals wishing to change gender identity or sexual preference (homosexual, heterosexual, or bisexual) because of

associated psychological or behavioural disorders (http://apps.who.int/classifications/icd10/browse/2010/en#/F66.1).

Dreikorn (1998) discussed how the decisions made by the American Psychiatric Association with respect to declassifying homosexuality were largely made out of a desire to remove the societal discrimination experienced by persons with same-sex sexual orientations. Since the 1973 decision, there has been an increasing trend towards discouragement of treatment for individuals who want to change a homosexual orientation. Accompanying efforts have focused on the identification and amelioration of negative public attitudes towards same-sex-attracted individuals. The assumption that heterosexuality is the only normative and healthy expression of sexual behavior is often referred to as internalized homophobia or heterosexism. In this sense, a place has been made at the table for the recognition and inclusion of gay, lesbian, bisexual and transgendered individuals for fuller participation in society, as well as a safeguarding of critical civil rights.

While this development has been in many respects laudatory, our discussion on sexual orientation and sexual identity identified a group of individuals who experience same-sex attraction, but do not wish to either engage in same-sex sexual behavior nor to adopt a gay identity. Nicolosi (1991) noted that such a person had "fallen through the cracks of popular ideology". Their desire for seeking treatment to shift sexual attractions has been increasingly ignored or misunderstood by mental health professionals (Nicolosi) as well as the wider culture.

Treatment for unwanted SSA has existed in professional psychiatry and psychology since the inception of these disciplines, going back to Freud (Nicolosi, 1991).

That treatment has continued since the declassification of homosexuality in 1973 up to the present day, albeit with increasing controversy and pressure on therapists who provide any form of reorientation treatment or what was referred to by the APA (2009) as Sexual Orientation Change Efforts (SOCE).

Throckmorton (1998) and Jones and Yarhouse (2007) have provided helpful summaries of published psychotherapeutic attempts to modify sexual orientation, as well as ex-gay religiously-based change ministries. As previously noted, Throckmorton (1998) prefaced his review with the caveat (following Haldeman, 1994) that sexual orientation was not a well-defined concept. Given the lack of consensus on what constitutes a sexual orientation, Throckmorton argued that assistance for questioning individuals should not be limited. He reviewed psychoanalytic, behavioural (Barlow (1973), Phillips, Fischer, Grove & Singh (1976)) group counselling, cognitive (Ellis, 1959), and religiously oriented attempts to change sexual orientation. While specific results varied across this spectrum of approaches, Throckmorton noted that all reported some measure of success and provided evidence that some degree of change in sexual attractions was possible for some individuals.

Similar to Throckmorton (1998), Jones & Yarhouse outlined psychotherapeutic change interventions for unwanted SSA from a number of theoretical perspectives, including psychoanalytic (e.g., Macintosh 1994), and behavioural (Cantom-Dutari, 1974). In their review, Jones & Yarhouse (2007) noted that the majority of published studies on psychotherapeutically mediated sexual orientation change occurred between the 1950's and 1970's. They also noted that published research studies on homosexual orientation change tapered off drastically in the late 1970's.

With respect to religiously mediated attempts to change sexual orientation, Jones & Yarhouse (2007) discussed the work of groups such as Homosexuals Anonymous, the Roman Catholic group Courage, Redeemed Lives, and Pastoral Care Ministries. Jones & Yarhouse noted that while anecdotes of change abound within these religious (and usually Christian) based groups, there have been few published studies to document change effects. They identified one exception as a study by Pattison and Pattison (1980), which investigated a Pentecostal program that sought to assist individuals to transition from homosexuality to heterosexuality. Jones & Yarhouse reported that of nine subjects who were the focus of the Pattison and Pattison study, five reported becoming exclusively heterosexual, three reported some incidental homosexual attractions remaining, and the remainder reported a mixture of homosexual and heterosexual attractions (all had reported being exclusively homosexual prior to joining the church program).

Earlier, Jones and Yarhouse (2000) had devoted some time to discussing the limitations of the published studies to date, including the fact most of this literature is retrospective, does not make use of multiple measures of sexual orientation/attraction, and is not longitudinal (that is, does not track clients over time). The context of their review was, in fact, a prelude to a study undertaken by Jones and Yarhouse (2007) to redress many of the noted deficiencies in the change literature with respect to study design. Jones and Yarhouse studied a large sample of individuals involved in religiously mediated reorientation programs under the umbrella ministry of Exodus International in geographically diverse areas of the United States. Exodus was (prior to its dissolution in June 2013) a Christian-based organization that coordinated and supported ministries that

focused on individuals with SSA. Most of the member ministries of Exodus made use of prayer, Bible study, as well as some psychological materials to assist individuals to transition out of a homosexual orientation (Jones & Yarhouse). They reported that of their sample, followed over three years, 15% reported substantial change in the direction of heterosexual attraction, 23% reported incidental homosexual residual attraction, and 29% reported some change of homosexual to heterosexual sexual attraction. Jones & Yarhouse concluded that their study, the first of its kind to seek to incorporate and redress many of the traditional critiques of this literature, indicated that substantial change of sexual orientation was possible for some through religiously mediated means, and the change attempt, on average, was not harmful.

Given the longitudinal nature of their study, Jones and Yarhouse later (2011) published the results of further interviews with their study participants. Jones and Yarhouse noted their research provided evidence of statistically significant change away from a same-sex sexual orientation and experience.

In a 1998 dissertation study, Dreikorn employed a qualitative in-depth interviewing methodology to investigate the experiences of 15 men who had undergone some form of psychotherapy to change unwanted SSA (and had concluded their therapy at least three years prior to the beginning of his study). Among a total of 83 client themes that emerged, Dreikorn found that 100% of the men reported having a distant, detached, critical or uncaring father/father figure, while 87% reported having a close, overbearing, domineering, or manipulative mother. Additionally, 80% reported they either had not participated or had not been good at sports as children. In terms of factors seen as being helpful in (or as an adjunct to) their reorientation counselling process, having a trusting,

caring, and encouraging therapist, having a therapist who believed that change was possible, working on masculine identity and confidence issues, and building healthy non-erotic male relationships were reported by a majority of Dreikorn's sample.

Spitzer (2003) interviewed 200 former SOCE clients (145 males, 57 females) who reported having had some success in moving from a homosexual to a heterosexual orientation. Using multiple measures of both homosexual (including the number of episodes of homosexual sex per month, being bothered by homosexual feelings, romantic yearnings for a same-sex partner) and heterosexual (including episodes of heterosexual sex per month, emotional and physical satisfaction with heterosexual sex) attractions and behaviours, Spitzer argued that his results indicated some gay men and lesbians reported having made substantial shifts in sexual orientation after being involved in SOCE. Spitzer also noted that the changes reported affected core features of sexual orientation, not just peripheral aspects (fantasies and attractions as well as behaviour).

Spitzer (2003) took some space in his report to discuss the possibility that his participants were either self-deceived or being willfully deceptive. He also acknowledged the real possibility that at least some of his participants actually changed from a predominantly homosexual to a predominantly heterosexual orientation. At the time of that report (2003) Spitzer opined that his participants' reports were largely credible, and as such provided evidence that some individuals can change sexual orientation following SOCE.

Given his role in the declassification of homosexuality from the DSM, Spitzer's (2003) study was one that ostensibly came from an unbiased source. Yet, soon after that study's publication, Spitzer came under severe criticism from professional colleagues

(Bancroft, 2003) as well as the gay community. More recently, Spitzer (2012) reassessed his interpretation of his findings, and concluded there was no way to determine if his participants' accounts were valid. Spitzer also wrote that his initially presented reasons for assuming his participants' reports were credible were unconvincing. Rosik (2012) has offered some commentary on the recent turn of events and wrote that personal and sociopolitical factors (such as pressure from the gay community) may have played a large role in Spitzer's reassessment of his results. Armelli, Moose, Paulk, and Phelan (2012) expressed surprise at Spitzer's reassessment in the absence of any longitudinal follow-up data to his original study. The 2003 study was not retracted from the *Archives of Sexual Behavior* and remains available from that source to the present.

Karten and Wade (2010) explored the relationship of sexual identity, male identity, religiosity, marital status, and gender role conflict in men who reported having experienced change after having undergone SOCE. Similar to Throckmorton and Welton (2005), Karten and Wade found that, among those therapist practices rated as helpful by clients, being encouraged to understand the causes of their same-sex attractions and developing non-sexual friendships with members of the same sex were found to be of most assistance. Karten and Wade also found these clients rated as very helpful professional psychological therapy to the extent it helped them to understand the relationship between childhood events, family dynamics, and their sexual orientation.

**Continuing Controversy**

Psychological treatment for unwanted SSA has been looked at with increasing skepticism by the mental health professions. A full issue (*32*(5)) in *The Counseling Psychologist* (2004) was devoted to an examination of the kind of persons who typically

present for SOCE, as well as an examination of the some of the ethical implications for providing such treatment. Beckstead and Morrow (2004) noted that despite the depathologization of lesbian, gay, and bisexual identities in the majority of mental health professions, a desire for therapies to assist with the reduction of unwanted SSA has persisted for primarily conservative religious clients. A primary orienting framework for the September 2004 issue of *The Counseling Psychologist* was an attempt to depolarize the debates between providers of gay affirmative psychotherapies and those therapies (called conversion therapies in this context) which sought to assist individuals with unwanted SSA. Suggestions were made (Beckstead & Morrow, 2004) for the provision of therapies adopting a middle stance between gay-affirming and conversion therapies, centered around an idiopathic examination of the struggles clients encounter in specific cultural and valuative frameworks (for example, conservative Mormonism). Paradoxically, however, the tenor of this issue, consistent with the general developments noted above, appeared to coalesce around a gay-affirmative stance that viewed the venture to shift sexual attractions with suspicion and imputed that it came from homonegative religious environments. Beckstead and Morrow (2004) questioned the legitimacy of providing freedom of choice to individuals dissatisfied with their SSA, on the grounds that factors external to clients likely played a large role in their decision to pursue conversion therapies.

In another article which examined the experiences of Mormon clients who had undergone some kind of conversion therapy, however, Morrow and Beckstead (2004) did make a plea for practitioners from both gay-affirmative and change-oriented camps to engage in greater dialogue to find solutions for clients who continued to exist in

homonegative and heterosexist systems. This plea found concrete expression in a joint study (Yarhouse & Beckstead, 2011) in which both authors presented their models of group therapy for navigating conflicts between sexual orientation and sexual identity. Morrow, Hayes, and Haldeman (2004) wrote that counselling psychologists needed to take the lead in opposing conversion therapies. Yarhouse (as cited in Brooke, 2005) opined, however, that he found some of the articles in this issue of *The Counseling Psychologist* disappointing and disagreed with the proposal to ban SOCE therapies. Yarhouse argued that such a proposal emanated more from ideology than science.

The APA (2009) updated its position on SOCE treatments through a report from the *APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. In that report, the APA concluded that few of the existing studies on SOCE were scientifically rigorous enough to answer questions about safety and efficacy of SOCE treatment. The APA reaffirmed its position that homosexuality per se is not a mental disorder and concluded there was insufficient evidence to support the use of psychological interventions to change sexual orientation. The report did, however, acknowledge professional recognition of "telic congruence," i.e., that people can choose to live their lives in accordance with personal values. The APA also recommended that multiculturally competent treatments were the best clinical responses for individuals who present with distress about their sexual orientation.

The APA report was critiqued by several clinical members of NARTH in a symposium entitled *APA Task Force on Sexual Orientation: Science, Diversity and Ethicality* (2010). Jones (2010) argued that the APA Task Force applied overly scrupulous and uneven criteria in its review of the published SOCE literature (making

note that some of the important work in this field has been published in books or other non-peer-reviewed sources). Jones also noted that while the task force made use of the absence of evidence to argue that SOCE is unlikely to produce change, it did not refrain from positively recommending approaches such as GAT (noted earlier) despite an absence of research establishing the efficacy of such approaches. Rosik (2010) pointed out the contradiction of the Task Force, on the one hand, recommending an approach that shunned preconceived outcomes and did not prioritize one approach over another, and on the other hand, the implication of a unidirectional movement in which religious values were modified in the service of developing a gay, lesbian, or bisexual identity.

More recently, Beckstead (2012, who was on the 2009 APA Taskforce) updated his review of the SOCE research. He reiterated his earlier conclusions (2004, APA, 2009) that the available research was insufficient to establish the efficacy of SOCE treatments. Beckstead also suggested that the bulk of available evidence pointed to a primarily biological basis for sexual orientation (LeVay as cited by Beckstead). Beckstead made the recommendation that comprehensive treatment plans should be developed which allowed "non-heterosexuals" to live with their sexual orientation and identities. Beckstead ended his article by stating efforts were likely better expended in trying to reduce misunderstanding, discrimination and intolerance within and toward non-heterosexuals than in trying to change aspects of sexuality that are possibly unchangeable. In this, Beckstead essentially reiterated his position as it was expressed in the 2004 *Counseling Psychologist* special issue.

The controversy with respect to SOCE treatments does not show any sign of abating. At the time of this writing, SOCE treatments, while discouraged by the leading

mental health bodies, have not been labeled unethical per se, nor banned (i.e. those licensed mental health professionals who practice SOCE are not under ethical censure for doing so, absent clear ethical infringements in their treatment practice). That said, legislation in California has been signed by its present governor (Bill SB 1172) which would prohibit the provision of SOCE services to minors, and it would appear this bill is on its way to becoming law.

Despite the controversy, some mental health practitioners have continued to provide treatment for unwanted SSA. NARTH, a group previously mentioned, is a formal group of mental health professionals that was founded in 1991 by Drs. Charles Socarides, Benjamin Kaufman (psychiatrists) and Joseph Nicolosi (a clinical psychologist). According to its website (www.narth.com/menus/mission.html) NARTH exists to provide services to those individuals struggling with unwanted SSA, including conducting and collecting scientific information, promoting effective therapeutic treatment, and providing referrals for those seeking assistance. As noted in Dreikorn (1998), NARTH initially began from a heavily psychoanalytic-influenced understanding of the etiology and treatment of SSA. However, it has since grown to encompass clinicians from a variety of theoretical backgrounds (e.g., cognitive-behavioural, humanistic), all of whom share NARTH's goal of providing psychotherapeutic treatment for unwanted SSA.

**Reparative Therapy**

While the term reparative therapy has often been used as an umbrella description for those psychotherapeutic approaches that seek to assist individuals with unwanted SSA, it has most closely been associated with the work of Joseph Nicolosi. Nicolosi is a

clinical psychologist who practices out of the TA Psychological Clinic in Encino, California. Nicolosi's clinical focus has for several decades been on the treatment of unwanted (or ego-dystonic) SSA. Nicolosi has worked almost exclusively with men, as do the other male therapists at his clinic (a female therapist works with female clients). His theory of etiology and treatment of unwanted male SSA has been communicated through primarily three published works (1991, 1993/1995, 2009; see also articles on www.josephnicolosi.com). That theory provides the framework for the clinical model practiced at the Aquinas Clinic and will, therefore, be outlined in this section. There has been little research focused specifically on the work of the Aquinas Clinic, although clients have volunteered for previous SOCE research (Byrd, Nicolosi & Potts, 2008; Karten & Wade, 2010; Spitzer, 2003).

Nicolosi (1991) differentiated between those men who use the label gay (a socio-political term by his definition) to define their same-sex attractions and those who do not. He defined his primary client population as the non-gay homosexual, those men for whom same-sex attractions do not (although describing a feature of their psychology) constitute a primary reference for personal identity. He argued that since the removal of homosexuality from the DSM in 1973, the mental health establishment either wanted to deny the existence of these men, or attributed their reported conflicts to internalized homophobia. Similarly, popular culture, while sympathetically acknowledging a diverse array of personal and sexual issues, did not seem to understand or support the struggle of the non-gay homosexual.

Nicolosi (1991) located his initial therapeutic approach within the wider array of therapies that spring from psychoanalytic theory. As such, his approach proceeded from

the understanding that developmental tasks left uncompleted earlier in life can have important consequences for current psychological functioning. On that basis, he construed the fundamental difficulty of the non-gay homosexual as one of incomplete gender identity development. In *Reparative Therapy*, Nicolosi drew on the pioneering work of Elizabeth Moberly to make use of the concept of defensive detachment to characterize the stance of a male child who is not able to make a fundamental identification with his father during the gender identity stage of development (occurring between one and a half to three years of age). This can occur because of objective characteristics of the father's mode of relating to the child (i.e. harsh and critical or emotionally disengaged and passive *vis a vis* family relations) but can also develop due to perceptions on the child's part that they have been rejected by the father (not based on reality). Whatever the precipitating cause, a fundamental premise of reparative therapy is that a mismatch occurred between the male child and the father or father substitute during the gender identity phase of development that resulted in an incomplete or largely absent identification process for the male child. The child failed to make the critical identification with father and by implication, with his own gender. Additionally, the hurt experienced by the child during this phase of development (objectively based or otherwise) resulted in a walling off from his own gender, effectively foreclosing on future opportunities to gender identify (i.e. with same-sex peers, the next major developmental task in the consolidation of gender identity).

In *Reparative Therapy*, Nicolosi (1991) described another important component of the gender identity phase for the male child as the task of dis-identifying with the mother. In this regard he noted that the male child has an additional developmental task

the female does not. The female child must separate her personal identity from mother, but not her gender identity (given she is of the same gender as mother). The male child, however, must separate both the personal and gender components of his identity from mother, a task which needs to be facilitated by the father. Nicolosi discussed the importance of the father actively engaging the male child to ensure adequate same-sex identification.

Given inadequate or largely absent same-sex identification at the gender identity stage, Nicolosi (1991) developed a causal link between this process and the emergence of same-sex attractions at puberty. Reparative therapy proceeds on the premise that fundamental same-sex identity needs become eroticized with the hormonal activation that is part of puberty. While seeming to be sexual, the drive to connect erotically with a member of the same sex is actually symptomatic of identification (and affectional) needs that have little to do with sex per se. The same-sex drive is then reinforced by actual sexual activity with other members of the same sex, and in many cases, entrance into the gay subculture (where one is then encouraged to identify with one's same-sex attractions rather than understand them).

In light of the foregoing, Nicolosi (1991) construed reparative therapy as a process whereby clients learn to understand (consistent with general emphasis on insight to be found in psychoanalytic and psychodynamic therapeutic approaches (Shedler, 2010)) the meaning of their sexual attractions. After understanding how their sexual trajectory became derailed, clients are encouraged and assisted to resume their incomplete masculine identity development. This process begins with the development of a trusting relationship with a male therapist; Nicolosi has emphasized that reparative

therapy must proceed with a male therapist. Consistent with the psychoanalytic assumption that the therapeutic relationship will be a context where the client will transfer previous experiences and personal perceptions of experiencing others, it is critical that a client in reparative therapy work with a male. It is also in the therapeutic context that the client must begin the task of de-eroticizing legitimate needs for same-sex identification and intimacy (attention, affection and approval).

Nicolosi augmented the theoretical presentation of his framework with *Case Studies in Reparative Therapy* (1993, although it should be noted *Reparative Therapy* also included vignettes of individual and group psychotherapy). *Case studies* presented eight individual therapy case histories, each of which (as noted in the Forward) was a composite of several clients Nicolosi had worked with. This book also includes a chapter describing the process and goals of group therapy, and a summary chapter of the main premises of reparative therapy.

**Expansions of the reparative therapy model.** In *Shame and Attachment Loss* (2009), Nicolosi provided some expansion of his theoretical model and outlined a set of tools that he had acquired in his clinical practice since the publication of his first book. Nicolosi outlined his model of the classic triadic family constellation which is, in his experience, the family environment most likely to set up a male for later SSA. In this constellation, the father is experienced as hostile, emotionally detached, or both. Nicolosi emphasized that the father is perceived by the boy as non-salient in the life of the family. At the same time, the mother is perceived as overinvolved, intrusive, and controlling. This parental combination impacts a boy who is by temperament sensitive, relational, artistic, passive, and likely introverted as well. Nicolosi also discussed the narcissistic

features of this predisposing family pattern, which failed to promote both the general individuation of the male child, as well as affirm his specifically masculine identity. As a result, male children emerging from the triadic family pattern tended to adopt the posture of the *good little boy*, a false caricature of obedient sonship that served to gratify the parents' emotional needs at the expense of the needs of the child.

Although the male child appeared to have a close relationship with the mother, and a correspondingly distant one with the father, Nicolosi (2009) discussed failed attachment processes that began with the mother and resulted in inadequate attunement to the needs of the child. Nicolosi provided considerable discussion of general attachment theory here, as well as the role of interpersonal attunement as a means by which developing individuals are taught to regulate their affect.

A major expansion of Nicolosi's theoretical model in *Shame and Attachment Loss* concerned the role of shame. Specifically, the male child experienced gender shame at his inability to integrate and fully achieve a sense of masculine identity. Nicolosi described shame as an inhibiting affect that cut the individual off from other persons as well as his own authentic emotional experience. For the person who failed to achieve a masculine identity, SSA emerged as a shame-based symptom (specifically shame about gender) as well as a repetition compulsion. Nicolosi outlined a repetition compulsion as consisting of (a) a symbolic attempt at self-mastery, (b) a form of self-punishment, and (c) avoidance of an underlying conflict. For the man with SSA, same-sex behavior is spurred by a fearful anticipation that any attempts at masculine assertion will fail and result in humiliation. Acting out with another man represented a fundamental abdication of masculine assertion, an acceding to another male whose physical and other attributes

seemed to confirm the unworthiness and unmasculine identity of the SSA individual (Nicolosi, 2009).

Nicolosi continued, in *Shame and Attachment Loss*, to emphasize the primary goal of reparative therapy as the ability to connect emotionally with a salient (good and strong) man. Integrated with his additional clinical experience and theorizing, Nicolosi wrote that healing relationships offered a better alternative to sexual enactment for accessing longstanding grief issues. The grief referred to by Nicolosi is one of fundamental attachment loss in childhood, not having been seen for the gendered individual an individual actually was. For Nicolosi, the client has advanced in therapy when they are able to see that their SSA is not primarily about the perceived attractiveness of the other man, but rather how he is feeling about himself.

Nicolosi (2009) outlined a process by which most of his clinical population find themselves engaged in same-sex behavior of various kinds. The starting point of this process is *Assertion*, a state in which the client is feeling good about himself, and is able to connect in an authentic way both with other persons and his own emotional experience. Nicolosi has underscored in a number of contexts that the self-state of assertion has a strong gender component; men who are in assertion will report that they feel masculine, while those in the shame state do not. While in the assertive state, the client will then experience *Shame*, leading them to feel belittled or diminished in their sense of masculinity. Shame can be related to things done or said by others, but it can also arise from the reactions of the individual to seemingly innocuous occurrences. From there, the individual will enter a condition called the *Gray Zone* which represents an affective shutting down, a place in which they lose contact with their own emotional

experience and also disconnect from others. For Nicolosi, the individual that does not break out of the gray zone by authentically connecting with another salient male will then be propelled to the terminus of the process, *Homosexual Enactment* ( for example, having a sexual encounter with another man or going on-line to view same-sex pornography). Nicolosi dubbed this process the *Preceding Scenario for Homosexual Enactment.*

As part of the process by which shame leads to homosexual enactment, Nicolosi described the twin concepts of *Double Bind* and *Double Loop.* Double binds are a communication pattern the client experienced in their family of origin in which there was a disjunction between the expressed content of parental communication and the affective (implicit) message in which that content was delivered. An example might be the child who presents a school project (on which he received a good mark) to a parent, who then replies with a positive statement which is flat and devoid of any positive emotion. The child will feel the disjunction between what was said and how it felt, but will not feel the freedom (or will not be able) to verbalize the fact that the interaction is not sitting right with him. Nicolosi wrote that the child was unable to make sense of this contradiction between the implicit and explicit aspects of parental communication, and as a result learned to distrust his own internal reactions to those communications. This resulted in a habitual inability to connect emotionally with himself.

By contrast, a double loop is a process in which the disconnect between implicit and explicit communication is able to be commented on, and relational disruptions repaired. Nicolosi identified one of the primary opportunities of therapy as that of providing double loop experiences. The client is able to comment on his emotional reactions to the therapist, as well as perceived hurts occurring in the therapy process. The

therapist's serious consideration of the client's concerns and validations of his emotional experience then provides a bridge by which the client can be re-connected to his emotional life. In so doing, Nicolosi wrote that shame can be healed, and the individual can also be re-connected (or connected) to his true gendered self.

Nicolosi (2009) identified his current therapeutic approach as one that focused on affect, and specifically the somatic (bodily-based) experience of emotions while in intimate contact with another person. Nicolosi referenced the insights of short-term dynamic psychotherapists such as Davanloo as well as the affect-focussed work of Fosha. A central focus of the current practice of reparative therapy was assisting clients to access their bodily-based emotional experience as they related to experiences of homosexual enactment (Nicolosi noted these episodes provide fertile material for in-session exploration) as well as past painful shaming experiences.

Another concept important to Nicolosi's developing understanding of the nature and healing of SSA was *Grief.* Although the examination of the preceding scenario to homosexual enactment (i.e. the process that began with assertion and led to homosexual enactment) for Nicolosi occured in present time, grief referred to past unprocessed emotions around the loss of an individual's gendered self. Nicolosi conceptualized SSA as fundamentally about attachment loss which resulted in the loss of the true gendered self. Correspondingly, an important part of reparative therapy (the description of which takes up approximately one third of *Shame and Attachment Loss)* involved providing the client with space to grieve the losses of the past. This is another way that the client can re-connect with his authentic emotional experience and his true gendered self.

Nicolosi (2009) described a number of therapeutic techniques employed to allow the client to connect meaningfully with the therapist and his own bodily-based affective experience. *Body Work* represented a "gentler" (Nicolosi, 2009, p. 148) modification of confrontational techniques developed in intensive short-term psychodynamic therapy (e.g., Bauer & Kobos (1984), Malan & Coughlin Della Selva, (2006)). In reparative therapy, Body Work involved the exploration of a painful memory or episode of sexual arousal/enactment in which the client was instructed to deeply access his bodily experience related to a target event while maintaining contact with the therapist. The *Triangle of Containment* was described by Nicolosi as involving (a) the *Identified Conflict* (i.e. the shame or sexual arousal experience), (b) the client's focus on his bodily experience, and (c) ongoing contact with the therapist. Nicolosi wrote that the purpose of body work is to repair the *interpersonal* and *intrapersonal* disjunction fostered by shame. Nicolosi also made use of Eye *Movement Desensitization Re-Processing* (Shapiro, 2012) to process more severe episodes of gender-based trauma, which he believed are implicated in the genesis of SSA.

*Shame and Attachment Loss* provided considerable expansion of Nicolosi's model of reparative therapy, as well a larger glimpse into the tool kit that he had evolved in his clinical practice.However, a primary theme constant in Nicolosi's approach is that behind the presentation of SSA lies profound damage to masculine identity. Reparative therapy seeks to reduce SSA as a by-product of the larger project of healing the sense of masculine self.

**A Phenomenological Lens**

We have seen that qualitative research can shed light on the perspectives and life experiences of persons in psychotherapy. It is also the case that psychotherapy is a process for which a relative dearth of qualitative mapping exists. In examining the journeys of a group of men undergoing reparative therapy, the opportunity existed to learn more about the process of undergoing psychotherapy.

This study sought to understand better, and give voice to a group of men in a very specific clinical setting, the TA Clinic. I proceeded on the assumption that the best place to start an investigation into this topic was with the voices of the men themselves, the ones who have begun and continued this particular therapeutic journey. A phenomenological qualitative enquiry was ideally suited for this purpose.

Wertz (2005) provided a description of the phenomenological approach to research with reference to the writings of Edmund Husserl in the early 20th century. Phenomenology was a movement that first appeared in the discipline of philosophy and was only later adapted as a research approach in fields such as psychology (Wertz). This qualitative approach involves the attempt to get close to the lived experience of a phenomenon, to capture a psychological phenomenon as it appears to an apprehending subject. To facilitate this project, phenomenology requires the conscious and intentional process of bracketing preconceptions, theories (scientific and otherwise), and assumptions prior to engaging in the research proper (Hein & Austin, 2001). Wertz referred to Husserl's use of the French term *epoche* to describe this process. Bracketing is, per Wertz, a two-stage process in which the researcher (a) first sets aside theoretical preconceptions to arrive at experience as it is lived and seen by the subject's lifeworld

(*Lebenswelt* ), and (b) then reflects on how the lifeworld presents itself, seeking to delineate its "constitutive meanings" (Wertz).

Given the welter of assumptions surrounding the process of reparative therapy, a continued process of self-conscious bracketing was essential to capturing the experiences of the men in this study. This process is built into all genuinely phenomenological inquiry. For this researcher, both the assumptions that these men proceeded invariably from internalized oppression, as well as that their experiences could be anticipated from an antecedent understanding of Nicolosi's writings, needed to be brought to awareness and set aside throughout the analytic process.

A primary goal of phenomenological research is the discovery of the essence of a given phenomenon. According to Wertz (2005), essence refers to what something essentially is. Wertz discussed various understandings of the term "essence" with reference to Husserl's writings; some of this concerned philosophical minutiae which cannot be engaged here. However, it is important to note that phenomenological analysis (in the context of psychological science) seeks to understand human situations, meanings, and the processes that led to those meanings (Wertz). Phenomenological inquiry distinguishes itself from other, mainstream research methodologies in psychology not only by its "atheoretical" and "low-hovering approach" (Wertz), but by its valuing of subjectivity as a primary means of obtaining knowledge. Rather than seeing subjective experience as an obstacle to the understanding of psychological phenomena, phenomenology targets the *Eigenwelt* (Selfworld) as the appropriate and primary domain for understanding human experience (Wertz).

Phenomenology was chosen to help us to answer a number of important questions with respect to the men in this study. How do they understand their experience of reparative therapy? What does it mean to them? What led them to decide to undertake this kind of therapy? How has this therapy taken its place in, or proven to be a disjunction from, their overall life journeys? Do they feel it has been a hindrance or a help to their personal life goals?

In this regard, phenomenological inquiry has also helped to shed light on the relative role that internalized stigma may or may not have played in these men's journeys. As will become clear in the Discussion, these men were aware of both the controversial status of reparative therapy in the wider mental health profession, as well as the assumption that their quest represented an instance of reaction to internalized stigma. What was their thinking on these points, and how did the researcher's overall experience of interviewing them help to confirm or disconfirm the role of internalized stigma operative in their accounts?

Applebaum (2012) offered some helpful clarifications on the stance of phenomenological inquiry *vis a vis* both the empirical sciences as well as the humanities. This occurred in an article in which he critiqued naïve empiricist assumptions about psychology as science as well as the wholesale and (uncritical) assumption of post-modern stances that increasingly construed qualitative research as being more akin to an artistic performance than the dissemination of inter-subjectively verifiable information about a psychological (or other kind) of phenomenon.

According to Applebaum, science as a collaborative activity is characterized by a "focussed, well-grounded, explicit, shared and repeatable means of data gathering and

analysis" (p. 46-47). This is also true for human science, a type of inquiry which cannot be fitted to an empirical science paradigm, but nonetheless needs to produce results which communicate something of significance about the topic under study. Applebaum referenced a personal communication from Giorgi (2009) to underscore the need for phenomenological inquiry to display fidelity to a common set of methodological procedures to ensure rigour and trustworthiness of results.

This study employed the framework outlined by Wertz (2005) as a guideline for phenomenological research of psychological phenomena. A more detailed description of the course of data gathering and analysis will be provided in the Methodology chapter. Applebaum's (2012) article points to the need for (a well as the ability of) the phenomenological researcher to discover something intrinsic to a given phenomenon that is open to the examination of other researchers. I have, via that methodology, sought to communicate something intrinsic to the experience of doing reparative therapy at the TA clinic.

Additionally, it is important not to place a "one size fits all" understanding on the individual experiences of these men. While each came to the TA clinic for concerns related to SSA, there were important differences as well as unique manifestations of that common goal. A phenomenological approach, which focused on their subjectively given experience of reparative therapy, proved to be the best method for capturing the narrative richness of their accounts.

# CHAPTER 2: METHODOLOGY

## Study Design

The primary intent of this study was to describe and understand the lived experience (Marshall & Rossman, 2006) of a group of men undergoing reparative therapy. We sought to provide a context for them to communicate significant and essential aspects of their life journeys relative to their experience of therapy at the TA clinic. Such an exploration, contingent as it is on apprehending and delineating subjective meanings and experience was best served, as has been noted, by employing a qualitative research method.

This author felt that the needs of this project would be best served by adopting the lens of empirical phenomenological analysis in the conduct of open-ended and in-depth interviewing (Marshall and Rossman, 2006). As noted in the literature review, there is abundant theorizing within professional psychology as to the origins and status of SSA. Additionally, political and religious factors also contribute to the plethora of opinions. It was felt that the individual experiences of men facing this issue are often obscured if not lost within the wider societal context. Moreover, the experience of depth psychotherapy has not been a major area of previous phenomenological investigation. As such, there is a semi-transparency concerning clients' experiences of depth psychotherapy; much of the landscape has yet to be mapped in phenomenological terms.

Phenomenological analysis attempts to bracket theoretical and abstract understandings of phenomena for the purpose of identifying intrinsic or essential properties of an experience as subjectively given (the eidetic reduction, Wertz, 2005). Knowledge within the phenomenological approach is not construed as the apprehension of an objective, non-situated and non-contextual datum, but the accurate, intersubjective

communication of lived experience. Such an approach appeared to provide an opportunity for the men in this study to step out of the welter of assumptions often made about their sexual attractions and what they have chosen to do with them. Additionally, this author held a number of distinct perspectives on the research topic. As such, the conscious bracketing of these perspectives as indicated within the phenomenological framework better facilitated the identification of these men's experiences of reparative therapy as they were represented within the subjectivity of the men themselves.

In common with other qualitative research approaches, this study did not attempt to provide generalizations to a wider population. Rather, the goal was a rich and comprehensive description that captured the essence of participants' experiences. While such a description may well identify general aspects of the phenomenon under investigation, it will be for others to determine how much (or little) this glimpse into participants' lives resonates for them.

**Participant Characteristics**

This study required a group of adult men currently engaged in therapy at the TA clinic for issues related to unwanted SSA. Participants were to be at least 18 years of age, and to have been in therapy at the clinic for a minimum of one year. It was hoped that participants would be at least 25 years of age, on the assumption that men at this age (or older) would have had additional time and life experience on which to base their decision to pursue reparative therapy (rather than, for example, integrating their attractions into a gay identity). However, finding participants 25 years of age or older was a hope, and not a study entrance stipulation (unlike the requirement participants be at least 18 years of age). The participants who volunteered for this study sought out

reparative therapy for help with reducing unwanted SSA and/or with exploring concerns associated with intimate relationships with women.

Initially, this researcher hoped to draw exclusively from clients who were engaged in reparative therapy as in-person clients, that is, travelled to the TA clinic in person and participated in sessions on the premises. However, in light of the resulting recruitment difficulties (discussed in the next section), it was decided that telephone clients were also eligible to participate in this study. In this regard, it should be noted that the TA clinic serves a large population of individuals who do not live in the vicinity of the clinic but who desire reparative therapy and cannot find appropriate resources within their local communities. As a result, telephone counselling constitutes a substantial portion of the TA client caseload.

Excepting the stipulations noted above, there were no other exclusionary criteria for participants. Specifically, the study was open to men from all conceivable ethnic and socio-economic backgrounds, provided they were in therapy at the TA clinic for issues related to SSA, were sufficiently proficient in English to participate in the interviews, and were willing to discuss their experiences of reparative therapy.

While many qualitative paradigms recommend a sample size of 8-15 participants (for example Hill, et al., 2005) this study sought a somewhat smaller sample of 5-8 participants. Wertz (2005), a prominent phenomenological investigator, noted that sample sizes cannot be defined a priori but must be derived from the specifics of a given study. The fact that there were some difficulties with recruitment as well as this author's understanding of the involved process of communicating phenomenological results,

including extensive personal quotation, suggested an initial limit of participants as indicated.

**Participant Recruitment**

From the study inception, this reviewer had anticipated difficulties with study recruitment. There are several reasons that can be offered for this. Unlike men who have integrated their experiences of same-sex sexual attraction into a gay identity, men undertaking reparative (and related therapies) may be expected to harbour more shame and embarrassment, as well as other feelings of discomfort, in relation to their attraction (past or present) to other men. Consequently, they may be less willing to discuss these matters with a researcher. Additionally, the mass media and professional psychology have often represented these men as acting inevitably from internalized societal prejudices (Haldeman, 1994; 2002). There may be a corresponding concern for further perceived misrepresentation through involvement with a researcher.

This study established a small but essential list of criteria for participant inclusion. On the assumption that a group of 5-8 men could be obtained from individuals who were clients at the TA clinic this study used criterion sampling with a view to strict adherence of the inclusionary criteria. These criteria were deemed to define the focus of this research, and were therefore posited as non-negotiable as participant features.

A study notice was constructed (see Appendix) and sent to the TA clinic to be distributed by therapists to clients. The research team engaged in some discussion concerning the best manner in which to inform clients of participation, given that the researcher resided in British Columbia and as such could not personally distribute the study notices. It was suggested to Dr. Nicolosi at the TA clinic that the administrative

assistant on premises could possibly distribute study notices to in-person clients. However, the research team was informed this individual was too busy and did not have time to engage in study distribution.

Dr. Nicolosi suggested in turn that the most efficient way to inform clients of the study was to have him and his therapists make mention of the study in sessions and provide clients with a copy of the study notice. A concern that was raised with respect to this manner of distribution involved the extent to which clients may have felt, explicitly or implicitly, coerced to participate. It was hypothesized that the presence of a respected and socially desirable individual such as one's therapist may act as a powerful incentive for an individual to participate in this study. Additionally, clients may have anticipated disapproval or some other negative reaction from their therapists if they elected to decline to participate.

These issues were discussed between this researcher and his supervisor over a period of several weeks.It was eventually decided to proceed with the suggestion that therapists distribute study notices to clients at the clinic. The primary rationale for this decision was, again, the fact the researcher resided in British Columbia and could not visit the TA clinic in person to distribute or present study notices. It was decided (in discussion with Dr. Nicolosi) that therapists would present the study notice to clients before sessions, and would inform clients they (the therapist) would have no further participation in the study. As a result, Dr. Nicolosi or his therapists would not be aware of client participation unless that client elected to inform them (the researcher had no position with respect to whether clients should or should not inform their therapists of participation; this was left to the discretion of an individual client).

As has been noted, the initial intention had been to recruit in-person clients only. Consistent with anticipation of low recruitment, however, only three in-person clients responded to the study notice (specifically two were exclusively in-person, and one combined in-person with telephone therapy). As a result, it was decided that the study would also be open to individuals participating in telephone counselling. Dr. Nicolosi was asked to inform telephone clients (and to instruct his therapists at the clinic to do the same) of the study in a similar manner as had been done with in-person clients (i.e., presentation at beginning of session), and to provide these clients with the researcher's contact telephone number and/or email address. Once the client contacted the researcher, the researcher could email the study notice as well as other relevant materials (i.e., informed consent form) to the prospective participant. In this manner a total of five men had contacted this researcher for participation in this study by October of 2011. The researcher was also contacted by a sixth individual via telephone who discussed an interest in participating in the study. This sixth individual however, did not contact the researcher further, leading to the assumption on the researcher's part they had declined to participate.

Interviews of these five participants were conducted between October 1 and November 2, 2011. These interviews were reviewed to examine whether a sufficiently rich data set had been obtained to justify proceeding with analysis. Several facets were identified in tracing the background diversity of these participants. The men ranged in age from 22 to 44, providing us stories of therapy engaged at different life and developmental stages. It seems that, based on the writings of Nicolosi, this age range reflects the background of men undertaking services at the Thomas Aquinas Clinic. The

participants were involved in two counselling modalities, in-person and telephone-based therapy. The decision to broaden the original recruitment strategy assisted in enriching the data set in this fashion. And although all of the participants saw a connection between healing for SSA and improved emotional health, the place of spiritual conflicts in motivating dissatisfaction with SSA varied for these men. For some, spiritual commitments did not motivate dissatisfaction with SSA. Two of the men in this study had been involved in some form of psychotherapy prior to their involvement with the TA clinic; of these one participant had been in therapy specifically for issues related to SSA; the other had undertaken therapy for emotional issues not initially related to SSA. These features of participant stories demonstrated success in the recruitment goal of obtaining participation from a sufficiently diverse range of clients currently receiving therapy at the Thomas Aquinas clinic. The research team therefore concluded that the data set was adequate to sustain phenomenological analysis.

Additional background factors include the following. Three of the study participants resided on the west coast, one on the east coast, and one in the American mid-west. One of the five men was married. Three of the men had at least a college education; information on the educational level of the other two was not stated during their interviews.

The men appeared to be comfortable with the interviewer. Two asked the researcher a number of pointed questions about the nature of the study, and also requested a copy of the results once the study was completed. After being provided with some details of the study design and intent, as well as assurance that they would be

provided with the completed research, these individuals proceeded without difficulty to the interview proper.

**The Researcher**

I am a 45-year-old male who is also an adherent of the Christian faith since the age of 19. Since 2010, I have been a member of the Roman Catholic faith.

I experienced some confusion with respect to emotional attractions to two members of the same sex shortly after the death of his mother at the age of 21. Those attractions never manifested themselves in sexual behavior, and it is my perception that my sexual attractions have been essentially exclusively heterosexual. At the same time, I have experienced some struggles and conflict with respect to my sense of masculinity and gender adequacy as a man. I entered a program called Living Waters (LW) in Toronto in 1996, which is a Christian healing and discipleship ministry. LW seeks to address the full gamut of sexual and relational problems from a Christ-centered perspective, and was initially begun by Andrew Comiskey as a means to minister to Christians dealing with unwanted same-sex attraction. In addition to being a LW participant, I was involved in co-facilitating two LW men's groups (the ministry occurs in a large group and smaller same-sex group context) in the early 2000's. During that time, I had the opportunity to get to know several men who were dealing with unwanted SSA as a primary issue in their lives (one of whom was a pastor in a church). My LW experience , in conjunction with the writings of individuals such as Leanne Payne, Dr. Jeffrey Satinover, and Mario Bergner, provided me with the intriguing possibility that unwanted SSA could to some extent be healed. While involved in LW, I also undertook some pastoral counselling with an individual who at the time was coordinator of the program. In their office, I

encountered *Reparative therapy of Male Homosexuality*, Nicolosi's first book (1991). This book appeared to have much resonance to my own masculinity-related issues, even though my primary struggle was not with SSA. At the same time, I began to be acquainted with NARTH. As I continued to work on my own personal issues, I remained intrigued with the personal journeys of those men who undertook psychological treatment as well as religious ministry to shift attractions that went counter to their values and which they felt were inimical to their true identities as men. I continued to read in the area (also being aware of the considerable controversy engendered by psychological treatment to shift sexual attractions) as I proceeded with my own life journey.

I had the opportunity to meet Dr. Nicolosi for the first time in Toronto in 2003 during a Love Won Out conference, hosted by the Christian ministry Focus on the Family. The brief chance I had to speak with him, as well as hear him present, increased my interest in his particular approach to treating men with unwanted SSA. At the same time, I saw applications of reparative therapy to my own masculine identity issues.

In 2008, I began telephone therapy with Dr. Nicolosi as a client. I also was able to conduct a face-to-face session with him when we met at the NARTH conference in Denver in 2008. To date, I have had over 50 sessions with Dr. Nicolosi, although more recently our work has become more sporadic, and in the nature of a tune up (this is term employed by Dr. Nicolosi to describe clients who have finished the bulk of their therapy and who return for intermittent counselling to deal with problematic issues that come up in their lives). I have become quite familiar with the basic precepts of reparative therapy, and have read extensively from Nicolosi's published works. I have also found reparative

therapy to have been a very helpful psychotherapy for dealing with some core masculine identity issues with which I have struggled.

With respect to fundamental presuppositions, I am, as noted, a Christian, and accept the traditional Christian sexual ethic that indicates same-sex sexual behavior is not consistent with God's will for our sexuality. At the same time, I do not bear any prejudice nor ill will to those individuals who, out of a different set of assumptions and worldview, wish to integrate their same-sex attractions into a gay identity. That said, I am sympathetic to the goals of the men who undertake reparative therapy.

**Data Collection**

Data collection in this study occured through in-depth and largely unstructured interviewing. Marshall and Rossman (2006) pointed out that the phenomenological approach is concerned with an examination of lived experience, and the meanings derived therefrom. The men in this study knew its focus before they began to share.

Interviews were structured around two primary questions. The first was: *What led you to the TA clinic?* The second question was: *Can you tell me about your therapy experience at the TA clinic?* It was stressed to participants that the interviews were to be very open-ended, and as such they could talk about anything that seemed important to them about their experience of therapy at the TA clinic. A broad time goal of one hour was set for the length of the interviews, although in actual fact the length of interviews ended up ranging from one hour six minutes in length to almost two hours.

All interviews were conducted in the researcher's vehicle in an isolated area (with windows up for privacy) using their cell phone on speaker mode and having an audio recording device situated nearby. Using this makeshift recording protocol, all interviews

were able to be recorded with sufficient clarity and volume and were subsequently transferred to the researcher's laptop where they could be listened to repeatedly for data transcription and analysis.

With respect to the interviews, a probe protocol had been formulated by the researcher prior to conducting the interviews, with the intention of clarifying or probing specific statements made by the participants. As the actual interviews transpired, this researcher found they did not make extensive use of the anticipated probes, but rather tailored their responses and statements to the material that was offered by the participants. This researcher found they spoke somewhat more during the first interview, and muted their responses for the subsequent four. A key procedural intention was to allow participants to say whatever they felt was important concerning their overall experience of reparative therapy, including how it impacted on areas of their lives outside the therapy room. No assumptions were made concerning the efficacy of reparative therapy for shifting sexual attractions, nor concerning whether or not participants had found their therapy experience to be positive or negative. This was reflected in a statement of surprise by one participant that the researcher had not asked them if they had changed their sexual orientation. Consistent with the goal of attempting to capture something of the essence of the experience of reparative therapy for the men in this study, the researcher attempted to adopt a neutral stance concerning this therapeutic approach, and also did not communicate that they were a client or were familiar with the language and terminology of reparative therapy. This researcher received the impression that the men participating in this study either assumed the researcher was in sympathy with the goals of reparative therapy, or, minimally, was not antecedently hostile to the therapeutic

journey these men had undertaken. In a cultural and political context that has, in this researchers' opinion, often distorted or caricatured the experiences of these men, it was felt important to communicate a strong sense of appreciation, respect, and thankfulness for their willingness to talk about their experiences.

**Data analysis**

After all five interviews were recorded, this interviewer transcribed the first two interviews. This process involved the typing out of the verbatim interview contents, and included pauses, ums and similar paraverbal utterances. In consultation with the research team, it was felt that such an experience would provide further opportunity for immersion in the data. The services of a professional transcriber were enlisted to transcribe the remaining three interviews. This professional also sought to provide a verbatim typed recording of the interview contents, but, in consultation with this researcher, omitted paraverbal utterances (umms…oh's…etc.).

The work of Wertz (2005), Hein and Austin (2001), among others, discussed in depth the analytic process as it is engaged in by the empirical phenomenological researcher. Consistent with other qualitative approaches, this researcher read transcripts several times to immerse himself in the data (Marshall and Rossman, 2006), and without a focus on the specific topic of the study (Wertz, 2005).

The researcher then considered the transcripts in light of the intent to capture the essence of participant's experiences relative to the research question. Unlike some other qualitative approaches phenomenological analysis does not attempt to bring antecedent categories to its research, indeed the protocol of bracketing requires that all such concepts be set aside (although Hein and Austin, 2001, conceded that this is impossible to

accomplish completely). Wertz (2005) noted that coding for the phenomenological investigator serves a preparatory purpose in that the data is better organized for a subsequent structural analysis, that is, an attempt to derive the essential structure of a phenomenon as subjectively experienced.

Consistent with the recommendations provided in Werz (2005), the next phase of data analysis involved parsing the transcripts into meaning units, that is, discrete, smaller complete thoughts that allowed for more in-depth analysis of participant commentary. Wertz noted that it is possible to eliminate redundancy as well as irrelevant and incidental expressions that are not central to the description of the desired phenomenon. This researcher employed a broad heuristic of paraphrasing and condensation to shorten some participant descriptions, particularly for one participant who provided lengthy statements and often became somewhat tangential in their descriptions (i.e. provided opinions and interpretations on topics not directly impacting on the research question of focus). While a better approach may have been to re-direct a given participant to the central topic of the interview, the researcher did not want to impinge on a participant narrative, and circumscribe the manner in which they arrived at their answers. Additionally, given the ethical imperative of giving voice to the men in this study, as well as the researcher perception that these men required the freedom to present their material in a manner most conducive to them, a "hands-off" implicit policy of conducting the interview was applied, in which the interviewer broke into participant descriptions as little as possible.

The researcher condensed participant statements into meaning units. A primary criterion in this process was that the clarified meaning units provided an accurate depiction congruent with participants' narratives and faithful to their descriptions.

The next phase in the data analysis process involved reading through the derived meaning units with a view to obtaining descriptions that pertained to the two primary interview questions. How did the participant's descriptions shed light on the experience of being a client in reparative therapy? The meaning units for each transcript were then organized into major themes that highlighted the key aspects of their experience of reparative therapy.

After refinement of within-participant themes, a broader class of themes were developed which encapsulated descriptions across participants. This was done with a view to the phenomenological project of arriving at a general structural description of the phenomenon under investigation (Wertz, 2005), namely, the experience of participating in reparative therapy. While a general criterion in developing these themes was that a given theme include more than one participant's contributions, it was *not* required that each theme include material from all five transcripts. A more important objective in developing across-participant themes was in depicting material that was perceived to be typical or central to the experience of reparative therapy for the men in this study. As will be illustrated in the Results chapter, a total of 11 such themes emerged. Similar to the process of arriving at within-participant themes, the development of across-participant themes also occurred through research team dialogue.

Finally, an integrative summary was developed, which sought to provide a condensed presentation of the general structure of the experience of reparative therapy as it was derived from these men. This summary sought to highlight connections between the across-participant themes and provide a snapshot of the experience of being involved in reparative therapy.

**Rigour and Trustworthiness**

The neglect of serious research attention to those clients who actively seek reparative therapy has created a gap in the literature. Given the polarized political and ideological environments associated with research in this area, participants required an informed approach that understood the project of reparative therapy and was in sympathy with its goals. A major focus for this project was the honouring of voices that have often been left unheard in the current political and ideological climate.

A number of the measures undertaken to ensure rigour and validity in the present study have already, albeit briefly, been noted. It is important to reiterate the foundational goal of empirical phenomenological research, namely to accurately and comprehensively capture the essence of a phenomenon as it is experienced in individual, situational and concrete subjectivity (Hein & Austin, 2001; Wertz, 2005). Within this paradigm, rigour is associated with fidelity to human experience, to a capturing of the structural essence of that experience, rather than with generalizations of values of a parameter to a population.

**Bracketing and research team dialogue.** Bracketing has already been identified as an integral part of a phenomenological investigation. Although the researcher in this study had an anticipatory sympathy with the perspectives of the participants and a theoretical structure in which their experiences could be interpreted (outlined in the literature review), it is possible that such sympathy and theory could do injury to this researcher's ability to listen to and allow participants' experiences to speak for themselves. As a result, this researcher attempted to engage in an active process of becoming aware and setting aside their general knowledge and beliefs about reparative therapy both during the actual interviews and throughout the analysis process.

In addition to the bracketing engaged in by the primary researcher, the research team also sought to engage in ongoing bracketing throughout the research process. This occurred primarily through team meetings in which participant material and the results derived were exposed to continual questioning and refinement. In this regard, a helpful balance was perceived to have been struck between the primary researcher, who was very familiar with the theoretical framework of reparative therapy, and the thesis supervisor, who was less so. As regards to bracketing, dialogue assisted in teasing out whether meaning units and themes were genuinely emergent from the data or may have been superimposed by the researcher given their prior knowledge of reparative therapy. Bracketing also played an important role in deriving the essential features of reparative therapy as it manifested across these men. For example, in one team meeting, the primary researcher suggested that the 44-year-old participant was something of an outlier in terms of the data set. The rationale for this assertion related to the fact this individual had gone into treatment for opposite-sex attractions that were a source of anxiety. In discussion with the thesis supervisor, who questioned the outlier designation, it became clear that the researcher continued to operate from the assumption that reparative therapy primarily concerned reduction of SSA, rather than broader issues of masculine healing (emergent understanding). From this exploration, it was concluded that rather than being an outlier, the 44-year-old rather represented a typical example of the process of reparative therapy, one that involved a larger set of concerns than just same-sex behavior. The researcher, in dialogue with the thesis supervisor, had to bracket their working assumptions of the nature of reparative therapy.

As noted, the ongoing dialogues engaged in between the researcher and thesis supervisor provided a rich source of ideas and direction for the project. In this context, impressions of participant comments were discussed and at times, debated. A helpful reciprocity developed between the researcher, who was intensely immersed in the data, and the supervisor, who was of necessity further removed from the interviews, and also less familiar with the general concepts and practice of reparative therapy. In this manner, issues such as the typicality of participant experiences as well as the motivation for statements made (for example, internalized homophobia versus authentic agency) could be treated from the perspective of two individuals differentially situated from the participants and practice of reparative therapy. It is believed that the dialogical nature of the analytic process in this manner yielded a better representation of participant experiences than would have been the case had the researcher only proceeded with theme development in solitude.

The researcher also kept a thesis log throughout the analytic process. While not employed on a daily basis, this log provided the researcher with a forum for clarifying thinking about the project, identifying problems and puzzles as they emerged, and also to process their own personal feelings about undertaking and working on this project.

**Empowerment and agreement audits.** This study engaged a population and therapeutic enterprise that is shrouded in controversy. As noted in the literature review, numerous claims have been made that men engaged in reparative therapy (and similar approaches) do so as a response to internalized societal homophobia or other externalized negative influences (for example, religion). As a result, the study design needed to take

into account these concerns, and augment the phenomenological framework with two audit processes.

An empowerment audit was conducted in an attempt to detect, if present, sources of internalized stigma operative in the accounts provided by the men. Given the lack of established means for identifying phenomena such as internalized homophobia, the empowerment audit was in some senses crude and preliminary, rather than exhaustive. However, at the present stage of research, it is uncertain what an exhaustive audit for internalized homophobia and similar phenomena would look like. Nonetheless, a series of investigations were undertaken to attempt to identify what, if any, negative external influences that may have been at play in participants' accounts. A detailed description of this procedure can be found in Appendix B.

Additionally, and more traditionally a part of general qualitative research, an agreement audit was conducted with respect to the derivation of meaning units and themes. This process enlisted the aid of a separate researcher to review portions of each participant transcript to determine level of agreement in the meaning units and themes derived. The agreement audit was intended as further check on the results arrived at by the research team. In so doing, it was hoped that the results would better reflect the material provided by participants.

# CHAPTER 3: RESULTS

This is a study of men engaged in a struggle for healing. In the themes that follow, the men talked about their experience of reparative therapy as it impacted relationships with other men, their sense of themselves, family connections, and other life domains.

For these men, reparative therapy was a struggle to heal masculine identity. That identity was impacted by many things, including painful family relationships, shame, unmet needs for same-sex attention and intimacy, and unwanted behaviours. While the experience of each man is not necessarily reflected in every theme that follows, all of the themes are intended to capture something typical of the experience of doing reparative therapy for these men.

Their experience of therapy was also shaped by age and development. The 22-year-old participant described basic identity struggles typical for someone recently emerged from adolescence. The 44-year-old participant had explored the meaning of his sexual attractions for many years before entering the TA clinic. The range of ages as well as biographies allowed each man to provide a unique perspective.

Despite differences, however, some common themes emerged in the men's accounts. Each spoke of grappling with shame, grief, unwanted same-sex attractions, relationships with men and women, and family dynamics. The participants provided a rich level of description that I have attempted to capture in the following eleven themes.

Another important element of these men's stories was personal choice and commitment, what I have previously referred to as agency. Their experience of SSA was in conflict with the lives they wanted to live. As such, they were forced to choose a path

that went against strong internal drives as well as the understanding of popular culture. For the 44-year-old, that process began many years before he came to the TA clinic. For all participants, the decision to pursue and continue with reparative therapy required that they make difficult decisions. Their stories help to illustrate some of the challenges involved in reparative therapy.

The themes derived from interviews are presented with descriptions and quotations taken from relevant participant meaning units (in some cases, separate meaning units have been combined for greater narrative continuity). The age of the participant is provided in brackets for each individual quotation.

Theme 1: ***Emerging sources of concern*: First awarenesses of SSA, pornography use, sexual contacts, and the question of adopting a gay identity. These concerns implicate spirituality and other life domains.**

This theme provides context for the research question. It describes first awarenesses of the experience of SSA and some of the behavioural sequelae that emerged from those attractions. Each of the participants talked about arriving at a perspective that did not see the presence of SSA, nor the various expressions of it (for example, pornography use, sexual contacts) as a positive thing. These attractions and their lived expressions were seen as being in some way in conflict with the life these individuals wanted for themselves. This theme sheds some light on the antecedent life experiences that led these individuals to pursue therapy at the TA clinic. This theme is, in that respect, an important starting point for these men's journeys.

(22) *Given that I had crushes on girls, I was very surprised at age 13 to notice I was looking at and getting very excited about naked guys on the Internet.*

(22) *I felt really horrible when my parents confronted me after a couple of months about my pornography usage. I didn't think I'd be the kind of person who would be overcome with lust.*

(29) *Further experimentation for me was one night stands. There were no relationships or emotional intimacy involved.*

(29) *Looking at pornography adds more and more shame and you keep going further down in a spiral.*

(36) *The first guy that I fantasized about sexually was someone I knew when I was 19, although I'm sure I probably started fantasizing about guys when I was maybe 15 or 16.*

(36) *Once I got involved in the SSA community there was a month where I had two back to back experiences where I was feeling pressured by guys I'd met. I was in an emotionally vulnerable place, and had huge experiences of mutual masturbation.*

(38) *At the age of 13 I had my first experience with sex when I went into a restroom and a man put his hands on me. He didn't sexually abuse me, but he put his hands on my crotch. My acting out behaviour started after that encounter at 13. I would go to porno movie theatres and have other men put their hands on me and it was enough. I would be able to get off just having other men show me affection.*

(38) *While most therapists at the time I first became aware of SSA would tell me to accept it, I never did accept it. I can't identify as a gay man.*

(44) *I had come out as a gay man when I was 15, quite young.*

(44) *In my twenties I had a conversion to Catholicism, which gave me a very high ideal in terms of sexual expression; namely only in marriage. My experience of the Church's teaching on sexuality was not one of feeling condemned or not accepted, but rather invited to embrace my particular cross. My conversion was a life-giving challenge, not a negative experience.*

(44) *For many years I engaged in a process of self-reflection, daily prayer and meditation in which I saw myself (through the lens of the theology of the body) as good but with a disordered arrangement of desires. I did not see myself as bad. My goal before therapy at the TA clinic was not to act out, and for the most part I was able to do this.*

Theme 2: ***Spiritual integrity, emotional health, working with the best, and unexpected attractions*: Reasons I sought out the Thomas Aquinas Clinic.**

Themes 1 and 2 are intimately connected. A primary sense in which this is true is that they both provide the framework for why these particular individuals pursued therapy at the TA clinic. Theme 2 provides a more focussed illustration of the specific antecedents to work at the clinic. All of these antecedents took place within the larger context (established by Theme 1) of attractions that emerged in participant's lives and were (or became) a cause of concern. Theme 2 more specifically highlights the reasons SSA and related issues were a concern for these individuals (spiritual integrity, emotional health, etc.) and why and how they decided to pursue psychotherapy for their concerns. Some light is also shed (at least for three of the five participants) on why they specifically pursued work at the TA clinic.

(22) *While my parents had been nominal Catholics, I explored the teachings of the Catholic Church, and began to appreciate the teachings of the church, and realized there was a big contradiction between my beliefs and my sexual practices (i.e. internet porn).*

(22) *I didn't buy the arguments about gays being born that way, and I was also scared because if this was true it would mean I was locked into something I had never chosen.*

(29) *I entered therapy because I couldn't find loopholes in my theology to justify homosexual behaviour. My faith tells me that God has designed me as a man for a certain way and for a certain purpose.*

(29) *Therapy was a last ditch effort for sanity and strength in my life.*

(36) *I went into therapy mainly to keep myself from binging and regaining weight, but at some point I found someone who also dealt with SSA. He introduced me to the concept that underneath sexual attractions there are emotional wounds and that these could be dealt with. For some people the sexual attractions could change. This approach really appealed to me and resonated with me because it made a lot of sense that underneath my*

*attractions there were desires for male affection and approval and attention that I just never had. I thought I could work on my SSA issues.*

(36) *In a sense a cure for SSA felt like a cure for so much in my life. I had always longed for those emotional needs. My therapy goals were not driven so much by a desire to be married and heterosexual as it was to be emotionally healthy and fulfilled.*

(38) *From my research I came to the conclusion Joe Nicolosi is the best when it comes to treatment of SSA, so I decided to take treatment with him. You get what you pay for. I didn't want to work with one of the therapists under Dr. Nicolosi, I wanted to go directly to the source.*

(44) *At the time of my conversion I had been openly gay for over 10 years and had been in a couple of long-term relationships. I had also been quite promiscuous and had been in a monogamous relationship. My motivation was initially to live celibately. I did not experience my motivation as internalized homophobia, nor did I experience self-hatred. I found that with a great deal of trial and error I was able to be substantially compliant to my goal of celibacy. Approximately six months before I began therapy at the TA clinic I experienced a spontaneous attraction to women that came up profoundly. This was the reason I went into therapy.*

(44) *My goal of entering therapy at the TA clinic was to become more comfortable with myself as a man and become more comfortable with potentially being involved with women.*

Theme 3: ***EMDR and Body Work*: Strategies we use in session to help me shift forward**

Theme 3 involves a discussion of several in-session techniques and approaches used in reparative therapy to assist individuals in progressing with their goals. Two key approaches included Eye Movement Desensitization Reprocessing (EMDR) and Body Work (BW); these approaches were described in the section above, "expansion of the reparative therapy model". Both were described by participants as a means to overcome pornography, desensitize painful old memories, and come up with new insights

concerning previous experiences and self- perceptions. This theme provides an illustration of what happened in the counselling room during sessions, as well as some discussion of participant's reactions to and evaluations of, the various protocols. Participants expressed a range of responses to the use of EMDR, including surprise at its effectiveness, a sense that they didn't get the results anticipated, and a dislike for this approach coupled with recognition that it was effective for painful memories. One participant noted a distinct preference for BW over against the use of EMDR. The identification of Theme 3 allowed me to form a better picture of the process of reparative therapy in vivo, at least as it was practiced with these five individuals.

(29) *EMDR has been amazing in my therapy in that when I look at pornography now it has nothing to do with the image I'm looking at. It's more of a habit. In the past when I would look at pornography or if I was with a guy there was an excitement and this energy. Now it's more like, can I get this out of the way, can I get on with the rest of my day. SSA is more like a chore now.*

(29) *The EMDR has been helpful with a lot of the healing from my childhood.*

(29) *We've also been using EMDR on OSA stuff and physical relationships with women…it's exciting.*

(36) *Lately in my work with Felix I have asked what other approaches there might be because I have felt a bit despairing of my own progress and felt stuck with the Body Work, maybe a bit cynical.*

(36) *In Body Work, I pick a significant experience (for example, an incidence of SSA) and explore what is going on in the present moment as I relive the experience with Dr. N. The memory I choose to work on could be from 10 years ago or 20 years ago. It could be a moment of sexual attraction or it could be something actually quite different like a day on the playground. Or an experience of peer rejection. We did a number of different types of scenarios out of my life that I sort of intuitively was drawn to bring to therapy. I would pick any one of these memories and Dr. Nicolosi would ask me what I am feeling, where is it in your body, can you describe it…describe it and just stay with that.*

(38) *A lot of times I don't like EMDR, I don't like spending a session on EMDR, but if you ask me about my most traumatic childhood memory, the memories aren't as painful as they used to be.*

(38) *We've been working with EMDR the last few months. As an example, I told him about an incident in 2nd grade when I was verbally abused by someone on a baseball field. He asked me how intense that felt on a scale of one to 10, and then used a tone as I looked from one end of the computer screen to the other (EMDR). We would discuss, see what feelings were being brought up. By the end of the session those feelings were not as traumatic as I perceived them to be before.*

(44) *There is a shift experienced just by having someone telling back to you your internal experiences. In session I would be encouraged by Dr. Nicolosi to sit with something I didn't want to sit with. He would tell me to sit with something for a little bit, and ask me to tell him what was going on. Dr. Nicolosi has been able to direct me to stay on course, not in a way that forces me to do what I don't want to do, but in a way that helps me to manage my experience. While leaving me free Dr. Nicolosi directs me to know what's important. When you're in the Body Work you're kind of in an altered state of consciousness, so it's helpful to have direction.*

(44) *I didn't like using EMDR as a substitute for the Body Work. I prefer the Body Work.*

Theme 4: **In therapy, I am learning to recognize and move past shame (and narcissism). This happens as I become more aware of my body's reactions.**

This theme addresses the issue of shame and, in some cases, its correlate of narcissism. All of the participants in this study identified shame as a pervasive concern, and one they related to SSA-related issues. As such, they gave the impression that much of their therapeutic work, and perceptions of self and others outside therapy, is related to understanding and healing from experiences of shame. As this theme elaborates, the experience of shame as well as recovery therefrom seems to have occurred in reparative therapy through a process of tuning in to somatic (bodily-based) signals that let an individual know when a shame moment was occurring (often in the context of a hurtful

relational interaction). The participants' reports identified shame as a key issue in their therapy process. Theme 4 consequently illustrates a central element in the lived experience of reparative therapy for these individuals.

(22) *Shame has been a big issue in my therapy. The feeling of shame was so ingrained in me that it was something I carried around with me all the time. On the level of the body, it's about the total absence of any affect or feelings; it's a physiological dead sort of feeling.*

(22) *Therapy has changed my old experiences of shame through Dr. Nicolosi allowing me to take those moments, memories and emotions and experience them again with someone sitting in the room (or on the phone) with me. I was given the opportunity to feel the old shameful feelings again with him.*

(22) *An important event was March of 2008 when I was home for Easter break. At church I saw an attractive seminarian. I had been learning in therapy to be attuned to my body, and when I saw the seminarian I heard a voice saying 'You'll never be like him'. Then I felt shame in my body, an absolute drop, like my whole body was collapsing inward on itself. Then I felt a genital surge. I felt like I was watching the whole thing in slow motion. This experience in March 2008 is proof the therapy is true. The pro-gay movement speaks about homosexual feelings as normal and natural, and they seem to be so, when you're not paying attention to yourself. But this incident showed me for the first time that my SSA feelings were not spontaneous, but were based on a horrible, pathological feeling of shame. Nicolosi had told me homosexuality is a shame-based symptom, that you can heal SSA if you deal with the shame, and I believed it, but here I saw it illustrated right before my eyes. My homosexual attractions only happened on top of this feeling of shame.*

(22) *I realized that a major goal of therapy was to arrest shame or reverse it before the SSA would set in to try and cover it up.*

(29) *Another important theme in my therapy has been dealing with narcissism which connects with self-doubt…thinking everything is about me.*

(29) *I certainly still have moments when it feels like the rug's been pulled out from under me, and I go into a narcissistic or shame mode, and I have to pull myself out of it.*

(29) *I can still be vulnerable to shame in difficult moments, but it's different cause I'm going in with a very intentional mindset, I don't just fall into shame or stressful moments.*
(36) *Both therapists I have worked with impressed me with how quickly they picked up on shame. It's like they're spotting a pink elephant in the room. They will just snap to it and tell me, Barnabas you're going into shame. They dig for it, and then tell me 'Barnabas, you know, put the shame away, put it aside and let's go deeper and get real'.*
(36) *I realize that shame is so much a part of my thought process and my day to day that it's very difficult for me to realize when I'm shaming myself. It's like breathing to me. I am becoming a little more cognizant of shame and learning to recognize it. My therapists are very experienced with recognizing and moving past shame.*
(38) *Shame and narcissism are issues we discuss. The sex hardly even comes up. I'm either narcissistic and think I know everything. The world revolves around me, it's all about me-how I dress, how much money I make-it's all about the narcissism. On the other extreme there's the shame, where nothing I do is good enough, I'm too fat, skinny, too this or that. I'm constantly shaming myself.*
(38) *Before I worked with Joe, everything was kept a secret. There was so much shame, I was afraid to even say the word "same-sex attraction".*
(44) *Shame would often manifest in therapy as a feeling in the middle of my gut when I explored sexual attraction to females. It would involve insecurity about myself and would be very debilitating as I imagined scenarios moving forward from initial attraction to actual involvement; engagement either romantically or sexually. Engaging with the opposite sex is not the only scenario where I have had a shame response.*
(44) *Much of the therapy work has involved working through a physiological shift from shame, a gut-wrenching fear of annihilation to confidence and better self-esteem, felt in the chest.*

Theme 5: ***Trusting & relating to men and women*: Therapy & beyond**

Theme 5 extends participants' experiences beyond the therapy room, and includes discussions of how reparative therapy and SSA issues impacted their relationships with men and women, in terms of both friendship and potential romantic involvements. Some areas that are explored in this theme include how much (or little) participants disclosed

their SSA issues to other men, being open to new and more intimate relationships with women, being able (through therapy) to establish non-erotic but emotionally intimate friendships with other men, and relating to OSA (Opposite-Sex Attracted) men. All of the relational issues discussed in this theme were associated by the participants with their work in therapy, either with respect to positive changes they had experienced or struggles they continued to have in establishing healthy relationships (these were often portrayed as issues slated for ongoing work) with men or women. Theme 5 is seen as illustrative of some of the wider relational horizons which were impacted by reparative therapy.

(29) *I think that while there's still a tendency for myself, it's actually much more difficult to be in friendships with girls because I agree with the character of Harry in When Harry Met Sally that men and women can't just be intimate friends. On the one hand it's been frustrating because I still have a lot of friends who are girls, but it's also exciting because I'm looking for a partner that I can be intimate with on every level. I'm seeing women with that kind of potential every single time I meet with them.*

(29) *I've set up more boundaries with my friends who are girls and I don't hang out with them one on one as much as I used to.*

*(29) I don't think I intentionally keep it from people but I think there's always a fear of being labelled as the guy who struggles with SSA.*

(36) *I have guy friends that I'm very close to and open with. I have the relationships I have always dreamed of having, in fact at times it seems I have too many of them and it becomes difficult to manage. It's become very easy for me to make new friends, connect on a deep level, and watch these develop and grow. I definitely attribute this to things I've learned and developed in therapy.*

(36) *I feel less shame and blocks with SSA men, I feel that they understand more. At this time more of my male friendships are SSA, and they could easily be my only close male friends if I allowed them to be. When I'm really deliberate and reaching for what I think God wants for me, I'm reaching out to OSA men and investing time there.*

*(38) I can't have an intimate relationship with my wife, I'm not up to that yet in therapy where I can work on my relationship with my wife.*

(44) *I feel more comfortable about the idea of not only being sexually attracted to a woman, but also actually being involved with a woman. We've done a lot of good work around addressing the fears, shame, and intimidation that come around the dynamic of relating to a woman.*

Theme 6: ***A painful disconnect*: My family relationships play an important role in my struggles with SSA, masculinity, & related issues**

To varying degrees, all of the participants in this study have associated painful family relationships as playing some kind of causal role in their development and experience of SSA. Additionally, three of the five participants identified the exploration (and, where possible, healing) of family relationships (in particular that with the father) as a central issue in their work at the TA clinic. Of the two remaining participants, one spoke of family issues that their therapist had attempted to address but which were (at present) too painful to deal with in sessions. The other participant identified family dynamics which they believed were formative in their experience of SSA, but did not identify dealing with family relationships as a central part of their therapy (this participant was the oldest). Participants spoke of a lack of emotional connection with family members. The material presented in this theme appears to be central to the ongoing life world of these men.

(22) *Although we did a little bit of work on my family in the first year of therapy, but we didn't continue because I find it very upsetting and destabilizing to talk about my family. When I deal with them I want to cut, act out sexually, I just spiral downward. I also feel they have been a barrier to my therapy. My dad has threatened to cut off funding for the therapy. It's better to leave this alone for the time being and work on other things.*

(29) *My therapist helped me to see my parents. I found my dad was not always there for me emotionally, and my mom could be very naggy and put doubts in my head. Family dynamics were the number one issue I have dealt with in therapy.*

(29) *My dad was not emotionally or physically abusive, but he was very intellectual and that was the main way we connected. I knew dad loved me, he was a really great dad in a lot of ways. Although I knew he cared about me and loved me, there was never any experiential element to that. I think my hunger for attention from men came from wanting to experience being loved and knowing what that was like.*

(29) *Probably the most difficult thing in my therapy was dealing with my dad. My dad does not engage in emotional conversations. I can confront my mom about the boundaries she was crossing or when she was nagging me because she's involved, she's engaged. My dad disengages more often than not, so it's much more difficult to heal from. When I went to him sometimes he would shut down, or if we had a really good conversation, it wouldn't change anything.*

(36) *Therapy has helped because I grew up hating myself for not liking my parents. I thought the one commandment I could not keep was to honour my mother and father. I really resented them. Now I can accept that part of me struggles with how I feel about my parents. I see that there are good people in the world who love and accept me. My parent's limitations are more a function of them than me. Their inability to love me has more to do with them.*

(38) *I confronted my father when I was strong enough to understand what Joe was talking about. My father broke down and said he did the best he could, and he apologized. It was the first time my father ever took responsibility for not being there for me when I was a child.*

(38)*I thought for all of those years I was the bad child, I had learned that. I was turning against myself to try to win over the approval of my father. That's the root of where my troubles started.*

(38) *So much of what went on in my childhood explains my acting out behavior. Joe made the connections with my father; in a hundred years I would never have come up with that…I thought I was a bad child. I never thought my father was responsible for me*

*as a child. I grew up thinking I was the bad child and I was responsible for what was wrong.*

(44) *I had a good father, but a very passive one. I had no brothers and tremendous peer rejection for many of my elementary school years. So I had a great deal of starvation for utilizable self-objects.*

(44) *I had no ability to tolerate the sexualization of a mother-son relationship but I could experience the sexualization of a father-son relationship. Not for my father but with that longing in a sexual sense for men or brothers.*

Theme 7: **I have been able to form a productive relationship with a therapist at the TA Clinic.**

In this theme, the men talked about their interactions with their therapist(s). From their accounts, it appears that each was satisfied with the therapeutic working relationship, although there is a considerable range encountered with respect to the experienced intensity and level of emotional bonding perceived by a given participant. Theme 7 allowed me a window into the therapeutic relationship component of reparative therapy for these men.

(22) *I'm getting emotional thinking of this. The most important thing that has come out of this therapy has been working with Dr. Nicolosi. Dr. Nicolosi is like the grandfather I never had. Dr. Nicolosi understands me better than anyone else.*

(22) *I don't think I would be alive today if I hadn't undergone this therapy. Dr. Nicolosi understands me better than anyone else, and probably knows more things about me than anybody else.*

(22) *I remember wishing Dr. Nicolosi could be the father or grandfather who would teach me things (like throwing a ball). I remember thinking it would not be shameful or scary to do things with Dr. Nicolosi, I would be comfortable learning things from him. I wouldn't worry about failing. It's a metaphor for the therapy…it's a difficult thing to grow out of your SSA and into your heterosexual identity. You need a really trusted therapist to do that.*

(29) *I think the transition from Ecclesiastes to Joe was actually really good for me. I appreciate Joe in the sense that he forced me to fight for the therapy I wanted rather than what I got. Joe comes into your sessions and will pick on one thing you say and will want to drive a point home on it. Initially with Joe I didn't feel I had dealt with what I wanted to fully deal with, so that forced me to grow up a bit and fight back against Joe. I wish Ecclesiastes could have encouraged me to fight more with him on things I didn't agree on.*

(29) *With Joe there were a couple of times where I wanted to take breaks. Before I started my tune-ups with Joe I had quit, even though I didn't actually feel that I was fully finished with therapy. I was just tired of talking about it all the time.*

(36) *It's hard for me to believe that anybody really cares. There are times when I feel like a kind of breakthrough because Felix will ask me how I perceive him in the session, right now….he will ask me if I feel connected, if I feel he's getting me. I think I've made progress because there have been times when I really feel connected and I guess I feel like he cares. It's a very hard thing for me to always connect. A lot of times I'll say well, ok, you're here because I'm paying you, you probably want your day to be over, you're just being polite. But there are other times when I do really feel like he cares and is concerned.*

(36) *I feel the relationship with Felix has progressed very quickly and I can communicate with him. I do trust him a little more. I love that Felix hugs me at the end of a session. That means a lot. Philemon would not hug. I asked him and he said no. I think at the beginning Felix was uncomfortable with physical contact, but now it's like a miracle that it's part of the routine. It's meaningful to me because it took time to develop.*

(38) *I tried to sabotage my own recovery, and Joe knew how to handle the situation. He made me aware of what I was doing and then he confronted me in a very strong but accepting way, like a father is told to rebuke the son. He tried to correct the behavior, not tell me I was no good. Joe would reprimand me and tell me the behavior was no good, not that I wasn't good.*

(44) *Early on I had some powerful experiences with Dr. Nicolosi. He's very good at what he does. But the relationship I have with him hasn't played that big a role in my therapy. Personality-wise I just don't think we click that well.*

Theme 8: ***Feelings about myself, connection, abuse and masculine development*: My therapy is more about painful self-issues, than sex.**

Several of the men in this study took efforts to point out that reparative therapy engaged a wide range of issues; as such, it was about much more than simply stopping a given behavior.Theme 8 explores the nature of these wider issues as they related to painful emotions, self-perceptions, the need for authentic emotional connection to a man, healing from abuse, and the development of a more solid masculine identity. Some of the topics in this theme are dealt with in the counselling office by way of the techniques and approaches outlined in Theme 3. By contrast, in Theme 8 participants stand back and reflect on what they feel their SSA issues have really been about, and how reparative therapy has sought to address these concerns.

(22) *For the first year in therapy, major themes included extreme depression, self-hatred and self-injury. I would cut myself a lot. I had a lot of suicidal ideation when I started in therapy, and had been cutting myself in college. We had to deal with a lot of dark stuff in that first year, including extreme shame, numbness, depression, wanting to die and cut myself.*

(22) *My biggest concerns are about core personality issues now rather than SSA. I feel the symptom of SSA is a symptom of shame that will fade away if you approach it the right way.*

(36) *My therapy at the TA clinic doesn't necessarily focus on my sexual attractions. The expectation is that I choose what the topic is going to be. For me the sexual attractions were about 10 per cent of the topic of conversation. More frequently it was about my own feelings around my self-worth, my insecurities, my depression, and my self-destructive behaviours.*

(36) *I had feelings of difficulty relating or connecting to people emotionally. I would put up walls and shut down, isolate myself.*

(36) *I see gay sex for what it is, which is men trying to satisfy emotional needs through physical sexual contact. I feel that's where our attractions and fetishes come from. There's some message that the sex act is going to fulfill something that our heart needs which is emotional.*

(36) *I've realized that what I really want is emotional, not the penis to anus connection as much as I want to know that I'm loved, accepted, am good and acceptable. That's what I really want and that's what I'm finding.*

(38) *For me SSA is not all about sex. I'm learning how to have structure in my life, learning to take responsibility for my actions, learning how to grow up. I wasn't an adult until I started therapy. I always behaved and acted like an immature child. When I started the therapy with Dr. Nicolosi I'm learning how to own up, to have structure in my life, how to be a good father, a good husband. This therapy is not all about same-sex attraction. We don't even discuss sex in our sessions.*

(38) *I want to call it not SSA, but SDB because for me it's about self-destructive behaviours. It's not about same-sex attraction, it's about how I can hurt myself, do damage to myself. How can I make myself as bad as I think I am? I was trying to make myself a bad person the way everybody told me I was bad growing up. I'm learning now how to be comfortable in my own skin because I was never secure and confident about what I was talking about.*

(44) *I believe a normative development tending to produce heterosexuality was forestalled at one or more points earlier in my life. I believe in large part this process of development has been reengaged through this therapy. For most of my life men continue to be a mystery for me.*

(44) *Being comfortable with my growing sense of myself as a man is what brought me into therapy and also very much a part of what I associate with heterosexual development.*

(44) *I'm experiencing some things that 13 or 14 year-olds experience for the first time, but I'm doing it as a 44-year-old. But I believe this is probably what is the normal course of heterosexual development.*

Theme 9: ***Blossoming awareness and masculine growth:*** **My therapy process has helped me lessen same-sex attractions, integrate painful memories, and recognize real needs.**

This theme contains an evaluative as well as a retrospective component, in that participants were asked to look back over and discuss their overall therapy experience to date. The interviewer attempted to couch the questioning for this segment in neutral terms so as not to presume positive (or, conversely, negative) evaluations of reparative therapy. The experience at the TA clinic was seen as a positive one by all five of the clients, with major gains achieved through an unfolding awareness that was intimately connected to their sense of masculinity and personal growth. Participants described a general lessening of same-sex attractions (in one case a very dramatic reduction) as well as a (developing) recognition that their SSA represented unmet emotional needs which were really not about sex. Participants also described the healing and integration of painful past memories (for example, involving abuse or emotional abandonment) as a critical factor in allowing them to move beyond SSA and get on with the lives they wanted for themselves. As such, Theme 9 is seen as a fitting capstone to the participants' explorations of their time in reparative therapy.

(29) *Once I started working with Joe my perceptions of men changed. I think I was getting clarity on who I was and what my real needs were, so I knew how to ask for what I really needed from other men. As my perceptions of men changed, the idea of having a physical relationship with a man wasn't as enticing when it came up. Now I'm looking for emotional intimacy, I'm looking for someone to help me feel a bit more like a man. I'm not looking to get off.*

(29) *I think that when it comes to attractions to other men in real life (as opposed to internet life) I don't have the same attractions as I used to. I do meet guys I'm attracted*

*to on a physical level but I am able to kind of see it for what it is. In college seeing a good-looking guy could debilitate me for the whole day. I would not be able to get that guy out of my head, that was all I could think about. I would think about his perfection and everything he has as opposed to what I don't have. Now when I see a good-looking guy on the road, I think, oh, that guy's good looking and forget about it three seconds later.*

(29) *When I first started the therapy, I would look at moments where I was shamed as a child, and would be ashamed of the memory. Now I am able to look back on those times and look at them for what they were. That was really sad, and someone should have been there for that childhood version of myself to tell me I'm okay. I have reintegrated my childhood memories into myself, and can tell myself that's part of who I was, and that's part of what has made me who I am today, the bad and the good.*

(36) *I am taken by surprise sometimes by the change that's occurred in my attractions. I stumbled upon a picture of a nude woman and I felt a real desire to put my penis inside of her vagina. It felt like a real natural impulse. I felt that there had been some work I had done around females and I felt I had had a breakthrough of understanding differently certain things around women. There are little flashes and moments when I find women attractive or are drawn to them.*

(36) *The draw towards men, sexually and emotionally, is much less painful than it used to be. It used to be the case that if I could not have a certain man I am never going to be happy. But now I feel affirmed and loved enough that if I never had a sexual component to my relationships with anyone, it doesn't matter.*

(36) *My therapy at the TA clinic has helped me to stabilize my emotional maturity. At the TA clinic I've regularly been able to connect with salient men and people who do care and express concern for me and my happiness. I have experienced stability, the ability to connect, to be safer and feel more confident and secure in life.*

(38) *I've been to many therapists, retreats, I've done everything I was supposed to do. But it was only when I met Dr. Nicolosi that the real changes started to happen. Dr. Nicolosi got me to be aware of my behaviours, nobody else ever did that for me. I would never have been able to have a relationship the way I was before I started working with*

*Joe. I was just numb. It didn't matter who the person was, not a man, woman etc. It was all about sex and narcissism, what can I get out of you and how can I abuse you.*
(38) *My therapy is not allowing me to act out like I did before. I told Dr. Nicolosi yesterday it takes me much longer to break myself down to act out than it used to. I'm feeling good about myself. Now I have to work on preparing myself to act out, to be able to enjoy the gay porn the way I used to. I have to break myself down into pieces.*
(38) *I have also learned to accept myself and to be comfortable in my own skin. I can go to a gay meeting or a straight meeting and be myself. I don't have to play a role.*
(44) *The therapy has been very powerful and effective. Since entering therapy the degree of my heterosexuality had increased dramatically. My way of experiencing men has also shifted dramatically. Although there was a dramatic shift before therapy, it has been really galvanized through that work. I was still predominantly same-sex attracted before therapy and now I'm predominantly opposite-sex attracted. This has been a consistent change.*
(44) *My sense of my own masculinity has shifted a great deal, my own sense of how I experience men is different.*
(44) *My attraction to other men is possibly the way predominantly heterosexual men experience attraction to other men. So rather than sort of a response of wanting to have that man or be with that man, it expresses itself differently. My attraction to men now is about wanting to share qualities. Not to be that man, but to be more like that man. To get where those qualities inside myself are responding to qualities in other men.*

Theme 10: **I wish this therapy could be seen as a legitimate option for those men who want it.**

Participants made reference to being aware of the controversial nature of reparative therapy. This theme offers some descriptions of their concerns. For one participant, opposition had been encountered in the context of a 12-step group led at a gay community centre in a major metropolitan city. The participant talked about being "on the defensive" as his efforts to reduce his SSA were seen to be met with vocal opposition and antagonism. This same participant placed this conflict in the wider

context of sharing what he believed to be many relational and childhood factors in common with the other (gay-identified) group members. Another man talked about understanding why the current controversy to reparative therapy exists, but also expressed a desire that the gay community and other cultural groups would see reparative therapy as a legitimate option for those distressed about SSA-related issues. He indicated a desire to provide a therapy of this kind to men one day. While this theme goes some way beyond the personal journeys of the participants in their own therapy process, it does help to situate the work of the TA clinic in a wider cultural context, and also gives voice to the strong concern raised by these participants that their therapeutic choices be seen as legitimate, regardless of whether a given group is in sympathy with their final goals. There were no anti-gay statements made by the men in this study, and the comments in this theme illustrate that they have no quarrel with those who wish to integrate their same-sex attractions into a gay identity. At the same time, these men provide evidence of a mature agency that, for them, has led to a different path.

(38) *My 12-step program is in the Gay and Lesbian Center of our city. It's okay to be gay and it's okay not to be gay. I don't have a problem with being gay.*
(38) *Now I feel like I'm being discriminated against at the Gay and Lesbian Centre because I'm working on same-sex attraction. It's not okay for me to be doing this work, but it's okay for you to be living as a gay man. Now all of a sudden I'm on defence, not on offence. I'm sitting in a room full of gay men and they're attacking me more than people used to attack them. Why is it not okay for me to be doing my work, but it's okay for you to be living your life as you choose to live it?*
(44) *I wish this therapy wasn't so controversial. I would like to provide this therapy to other men myself some day. I have no problem working with men who are same-sex attracted who want to be more comfortable with same-sex attraction either. I trust people's goodness, I trust how God is working with people. I would really love to be able*

*to provide an opportunity for people to go whichever way they need to go with this issue. But I would really like to provide this kind of option for people like myself who really want it and are coming from a place that is at peace about it.*

(44) *I just wish it wasn't so controversial. There's problems on both sides. I really wish people who are for reparative therapy wouldn't be so dismissive of the gay lifestyle, and I wish people in the gay community would not need to feel as attacked by the idea of this. I wish there was a lot less of all of that, but I know things take time to change and I understand why things are the way they are.*

(44) *I hope you are able to publish and get our perspective out there, and help there to be less us and them perspectives. So that there can be room for a lot of different ways that people can explore how therapy can provide options for how we want to live our lives.*

Theme 11: **Talking with you has helped to highlight the significance of my therapy.**

All participants were asked at the end of interviews to comment on how they found the experience of talking with the interviewer. All participants described it as a positive experience, but three offered some more specific observations about the process. One participant noted that the interview allowed them to connect with some strong feelings, while another stated that the interview allowed them to reflect on some of the things they had dealt with in their life. The third participant described the interview process as providing them with more of an objective view of their life, and also reinforced for them how important their therapy process had been ( in the context of wrestling with other life priorities).

(22) *I'm glad you're doing research on this topic. More needs to be done, particularly quantitative research.*

(22) *It's been a good experience to talk about this. Even though I didn't expect to break down crying, I am always looking for a way to connect with feelings of sadness or grief, so that was good.*

(29) *I've found it a positive experience to talk about and reflect on my therapy experience. It's easy to move on with your life and forget some of the things you've dealt with. I am glad you are putting this project together.*
(36) *Talking with you has made me have more of an objective view of where I'm at rather than just living moment to moment. At times recently I have thought maybe I should put other things as a priority above my therapy, but talking to you I see how necessary and important it has been.*

**Integrative Summary**

These themes illustrate different facets of a common experience: struggle to heal a masculine identity. For the participants of this study, reparative therapy has been an important part of that struggle for healing. The effects of their therapy radiated out into their lives, and could not be separated from these men's life journeys as a whole. When the themes were placed beside each other, what emerged was not just one account of doing therapy. Rather, a portrait of a life struggle was obtained that encompassed events at the TA clinic and impacted on relationships, sense of self, and life functioning. Masculine identity was lived through the experience of self, others, and life domains such as work. Along the way, healing involved working through barriers to confidence and fostering new strength for future relationships and endeavours. Same-sex attractions were related to past experiences of abuse and malattunement that derailed the journey to whole manhood.

The men in this study became aware of SSA early in their lives. For most of them, these attractions emerged during their teenage years (although one man noted he had been attracted to men in some form all of his life). The awareness of SSA led these men into a number of behaviours, including pornography use, sexual experimentation

with other men, and for one participant the integration of his attractions into a gay identity as a teenager.

The men reported that for them SSA was or became a cause of concern. Same-sex behaviour was seen to be in conflict with core commitments related to spirituality and emotional maturity. As a result, these men desired to reduce or eliminate their same-sex attractions, as well as explore the possibility of relating to women on an intimate level. In order to pursue a life consistent with their values and vision, these men made a decision to contact the TA Psychological Clinic for professional psychological services. For some, this was not their first experience of psychotherapy.

The men reported that reparative therapy involved a number of in-session techniques including Body Work (BW) as well as Eye Movement Desensitization Reprocessing (EMDR). From their descriptions, both approaches were used to assist clients in better accessing their emotional experiences, process painful memories (for example, involving family members and/or past experiences of abuse), and reduce unwanted behaviours such as pornography use. In BW, clients were asked to stay with their bodily experiences as they related to a specific painful memory; these experiences were fed back between therapist and client in a focussed manner in session. EMDR is a treatment with a standardized protocol; the men described it as an effective way to reduce the pain associated with negative emotional experiences. BW and EMDR functioned as therapeutic treatments which allowed the men to work on distressing memories and current problems (such as pornography use). Participants provided commentary with respect to their preferences and reactions to the therapeutic protocols.

Key themes that emerged in their therapeutic work (and which consequently became the focus of both BW and EMDR) included awareness and healing of shame as well as painful emotional disconnects in family relationships. Shame was described as a bodily-based experience that occurred in relationships (often with other men but also with women and family members) which involved insufficient or non-existent attunement. For them, the lack of attunement resulted in a diminished sense of themselves as sufficiently adequate or masculine men. An important aspect of reparative therapy, based on these men's reports, was the cultivation of awareness that one is in a shame moment, and being able to emerge out of that state. Participants also described painful family relationships in which they either received conditional acceptance or were not able to make significant emotional connections with key figures. A disconnect with their father emerged as a recurrent theme for several of the men.

Participants provided a range of perspectives on the relationship they were able to build with their therapists. All of the men indicated they were able to build a productive working relationship , even in the face of serious challenges that emerged during the course of therapy. There was an emergent sense across their descriptions that this relationship had been of high quality and also (for most of them) contributed to therapeutic progress.

Participants reported that the majority of their therapy did not focus on sexual behaviours or overt sexual issues, but rather on the underlying roots of SSA. This work involved exploration of painful feelings about their masculine self, core personality issues, connecting with males in an intimate but non-erotic way, and relating sexually and romantically to females.

Given that much of their therapy was not spent discussing sexual behaviours, participants expressed some measure of surprise that reparative therapy had, in fact, helped to reduce their SSA as well as make the ongoing experience of their attractions less painful. This was attributed by participants to a growing awareness of underlying emotional needs which they believed to be behind their attractions. Participants stated that reparative therapy helped them to achieve better emotional health and grow in maturity.

One important aspect of personal growth involved a change in the way these participants saw themselves as men. This involved the integration of masculine qualities they had previously seen in other men but felt were missing in themselves. Participants expressed how they were able to build better male friendships but they also felt uncertainty about disclosing their sexual struggles to non-SSA men. Reparative therapy also resulted in some growing experiences of opposite-sex attraction, and openness to the possibility of entering a relationship with a woman.

Participants expressed a general satisfaction with their therapy to date, as well as a confidence for the future. Their journeys demonstrated a consistent ability to make important choices about the direction of their lives and to be effective agents in their own change. The men were open about the challenges they faced while participating in reparative therapy. They described it as a painful process in which many of their basic assumptions about themselves and their lives needed to be re-examined and, often, re-constructed. Challenges came in the form of out-of-control behaviours, deliberate attempts to sabotage therapy, difficulties building therapeutic trust, and the recurring question of whether or not to continue. A commitment to endure pain and stay the course

with respect to learning about oneself and masculine wounding emerged as central to these men's journeys. It appeared that they were able to surmount the challenges encountered, and to consider their therapy a success, if also an ongoing journey. Participants expressed gratitude for the opportunity to participate in this therapy.

Participants acknowledged that reparative therapy is seen by the gay community and others as a controversial approach. The men expressed a desire that their decision to pursue this treatment be seen as a legitimate option by members of the gay community (as well as others). This desire did not involve an attack on those persons who choose to integrate their same-sex attractions into a gay identity. Participants made room for both gay identification as well as the option of pursuing alternative approaches such as reparative therapy.

The men were also clear, however that controversy would not steer them away from the pursuit of healing. For them the healing process itself was primary, and trumped any and all continued misunderstanding they would experience. They welcomed a better understanding of their struggle from the wider culture. Such understanding was clearly secondary, however, to the goal of personal healing for their masculine identities. With or without the blessing or understanding of the wider culture, their accounts suggested they will continue their journeys. The men reported that they will continue to seek, among other things, greater emotional wholeness and a better understanding of themselves. They also spoke of challenging themselves to step out in the life domains of work and relationships.

The men reflected about their experience of participating in the project. They were grateful for the opportunity to talk about their journey, and in doing so re-connect

with important aspects of their therapy outside of sessions. Several men also noted they were glad that this project would be an opportunity to have their voices heard. They hoped others would have the opportunity to hear their perspective.

# CHAPTER 4: DISCUSSION

The goal of this project has been to give voice to a group of men in psychotherapy for issues related to unwanted SSA. The men in this study have given us a window into their experiences of reparative therapy at the TA clinic, as well as the way those experiences have impacted on their wider life journeys. We have been provided with a glimpse of what reparative therapy has looked like for this group of men.

In reflecting on and organizing the material that participants offered through phenomenological analysis a structure of the lived experience of reparative therapy has been obtained. This structure tells us something about what it means to undertake psychotherapy for issues related to unwanted SSA, and thus can help to illuminate that experience of therapy for both the professional reader as well as the individual who struggles with SSA and is contemplating undertaking a similar course.

Beyond the ethical imperative of giving voice to a misunderstood minority, this project also speaks to a need in the research community. We have noted that there is a relative dearth of qualitative literature on the experience of clients in psychotherapy. The studies discussed in the literature review outlined a number of positive contributions that client input can make to our understanding of treatment interventions. There is a great need to undertake further research that explores the experience of psychotherapy from the perspective of clients. This project has contributed something to that more general need.

A number of empirical studies have provided helpful antecedents to this project. Dreikorn (1998) investigated the experiences of men who had undertaken a variety of SOCE interventions, and provided insights into what they found helpful in their therapy.

Dreikorn's study can be seen as a "wider lens" investigation from which the present study has undertaken to examine a more specific clinical context, namely that of the TA clinic.

Spitzer's (2003) study on the experiences of SOCE clients represented an important examination by a respected researcher. Spitzer expressed curiosity that change in sexual orientation change may be possible. As noted in Rosik (2012), the Spitzer study stands today as the report of a group of individuals who claim to have undergone sexual orientation change. Spitzer's focus on the experiences of SOCE clients helped to bring their stories into greater awareness, both for the mental health professions as well as the general public. The Spitzer study showed that some formerly gay-identified individuals reported changing their pattern of attractions.

Jones and Yarhouse (2007, 2011) attempted to redress numerous criticisms that had been made of previous reports of sexual orientation change by undertaking one of the first longitudinal studies of SOCE, focussing on religiously mediated change attempts. Jones and Yarhouse provided both quantitative analysis of their results , as well as some qualitative commentary. In doing so, they provided a model for future SOCE research, and hopefully inspired other researchers to apply their approach.

Beckstead (2012) provided one of the most recent summaries of the SOCE research literature, as well as critiques that closely followed the conclusions of the APA (2009) Task Force Report. These critiques included (a) not accounting for the self-management bias that might lead participants in this research to misreport successes, (b) relying on therapists' subjective impressions, and (c) not using control groups to accurately measure the effects of interventions. Beckstead also discussed ethical concerns about the potential misuses of SOCE research, including the potential to

reinforce societal heterosexism and to harm individuals by providing exaggerated claims of success. Beckstead reiterated the APA Task Force conclusion that few of the published SOCE research reports meet efficacy criteria with regard to evaluating psychotherapy.

Beckstead's (2012) comments notwithstanding, an emerging body of research exploring the experiences of men who undertake SOCE now exists. A large proportion of this research, including the Spitzer study, has focussed on whether or not there is actual evidence of sexual orientation change. Additionally, information has been gathered about the characteristics of men (for example, their religious orientation) who undergo this kind of therapy as well as their evaluations of what was found helpful (e.g., Throckmorton & Welton, 2005) or harmful (Schidlo & Schroeder, 2002) in their experiences.

However, there remains a lack of qualitative research that explores the lived experience of men in SOCE treatment. The present study seeks to make a contribution to the literature by delineating the nature of this therapeutic journey. This research has sought to allow participants to frame the nature of their own experience. Any discussion of change or evaluation of the therapeutic process came from the participants. In so doing, the men have been given the opportunity to describe an experience of psychotherapy.

## The Lived Experience of Reparative Therapy

**Healing of a masculine identity.** The stories these men shared gave us insights into their experiences of reparative therapy. Theirs is primarily a story of the healing of masculine identity as it has been reflected throughout an entire life. Although the

presenting concern for most of these men was a desire to decrease or eliminate unwanted SSA, their stories outline a therapeutic process that has engaged a broad range of life domains as these impacted their sense of themselves as men.

This has been a study of a psychotherapy process; and more than that a life process. Through reparative therapy, these men were engaged in multiple ways and across multiple life dimensions. This process involved their sense of themselves as persons, and most specifically as men. Their journey has involved struggle, pain, and perseverance, as they have sought to overcome their unwanted SSA and the issues that arose from it.

The catalyst for starting these men on their therapy was a desire for reducing SSA. For the 44-year-old participant, therapy also involved addressing anxiety about attractions to the opposite sex. And yet that goal does not represent a fully accurate centering framework for the journey these men have been on. Far more, reparative therapy has, for them, been about the healing and integration of masculine identity, one that was injured in various ways through life experience. The account of reparative therapy for these men involved much more than just what happened in the counselling room. How they felt about themselves as men, as persons, the role of family relationships, perceptions about relating to men and women, the impact of the therapy process on other life domains such as work−all of these were noted in one form or another by the men in this study. Reparative therapy was not just about tackling isolated symptoms. Rather, it engaged an entire life, and the intentional direction of that life toward personally meaningful goals. In one form or another, the men talked about how reparative therapy was, for them, the key to addressing what was wrong with their lives.

One described this concern as a "search for sanity," another as a "reordering" of their life. The 36-year-old participant made the clearest statement when he expressed that "a cure for SSA seemed like a cure for so much in my life."

**Lessons learned from a positive experience of psychotherapy.** It is important to make explicit that these men told us about a positive experience of psychotherapy. That experience impacted broad life domains that included but also went beyond the counselling room. Their stories provide a vivid portrayal of an effective encounter with therapy. As such, this project can contribute to our understanding of the factors clients perceive to be meaningful in assisting them to heal.

It appeared that reparative therapy, although designed to treat a specific presenting problem (unwanted SSA), was also flexible enough to be tailored to the unique needs and circumstances of the men. As has been noted, it was not a "one size fits all" approach. Our research suggests that a positive experience in psychotherapy is more likely if the therapy is able to accommodate clients at their point of presenting need, and adjust itself in a way that makes their concerns and unique situations the primary focus.

Additionally, the participants reported that a major benefit they received from their experience of therapy was having their concerns and presenting distress taken seriously. They were profoundly grateful that someone was willing to take their distress over SSA seriously, and to work with them from a perspective that shared their therapeutic goals and vision for their lives. This result suggests that a positive experience with psychotherapy is made more likely when client distress and concerns are honoured from the perspective of clients themselves.

These insights are consistent with the results of previous literature. Davidson et al. (1997) highlighted that effective interventions involved seeking client perspectives on the nature of the presenting problem. Davidson et al. also suggested that the ways in which clients construe a problem can be very different from those of professionals. One of the three category clusters derived by Clark et al. (2004) to capture client perspectives on change processes in psychotherapy included "the listening therapist". This category suggests that an experience of being effectively heard (and hence, taken seriously) is an important component of a positive experience in psychotherapy. Additionally, Giorgi and Gallegos (2005) found that a key structure their clients related to a positive experience of psychotherapy was having a therapist who responded to their idiographic needs.

The present research suggests a third possible component of a positive experience of psychotherapy, one that may be somewhat more paradigm-specific. It was noted in the literature review that reparative therapy originated in a psychoanalytic framework, and continues to proceed on the assumption that healing from unwanted SSA will occur as clients explore and understand the important factors that lie behind their attractions. As such, reparative therapy is an example of depth psychotherapy, a model that sees a particular symptom (in this case, unwanted SSA) as a manifestation of deeper and largely unknown dynamics.

The men in this study were in agreement that healing proceeded as they became aware of the real needs and wounds that lay behind their unwanted SSA. Their story illustrates how a positive experience of psychotherapy can unfold when individuals are willing to explore in depth the roots of their problem.

**Emerging attractions in conflict with spiritual and life values.** There was continuity at the heart of these participant's stories: the emergence of SSA, eventual conflict with central life values or spirituality, and an emergent decision to pursue healing. These men were aware multiple paths existed, and they made informed choices that flowed out of a clear sense of who they wanted to be. This agency manifested in many different ways in the stories of these men. Examination of their stories helps to clarify the nature of the conflict these men experienced.

For our 22-year-old participant, SSA emerged in early adolescence and was an occasion of surprise, given that he previously experienced heterosexual fantasies and crushes, and had considered himself heterosexual. The 36-year-old participant had a somewhat similar account, in that he related crushes he had had on girls as a child, and sexual feelings towards both sexes in early adolescence. For him, that changed as he progressed through his teenage years, and he found that eventually he was only attracted to other males. Our 29-year-old participant stated that his SSA began to emerge in high school, and then openly experimented with other men when he was in a Christian college. This individual did not talk about his feelings and perceptions upon first becoming aware of his SSA. He did, however, describe a very lonely college experience in which he felt isolated from the men that he had been with, as well as other people in his world (because he did not feel he could talk about his experience of SSA).

For some of the participants, pornography use was a common means by which they experienced and expressed their SSA. For the 22 and 29-year-old participants, pornography use was described as inducing large amounts of shame, as well as being a glaring contradiction to their Christian sexual ethic. For the 36-year-old, concern about

pornography seemed to centre around the fact that it could take control, implying an awareness of a process that had some elements of compulsivity and associated anxiety.

Same-sex pornography (with or without masturbation) was also noted to have been used by nine of the fifteen men in Dreikorn's (1998) study. One of his participants spoke of being 15-years-old and alone in a large European city seeking out a pornography shop. That experience bears some similarity to the experiences of the 22-year-old in the present study, who reported using pornography while in his early teens. He also described how his SSA became more pronounced during a school exchange trip to Europe.

Our 38-year-old participant related an incident in which he had been fondled in a movie theatre by an older man at age 13. This experience, although not involving sexual intercourse per se, was an experience of arousal for this individual, and led to repeated experiences in movie theatres, eventually branching out to gay sex clubs and on-line live interactions with other men. The 38-year-old described a compulsive process of acting out that became pervasive from his late-teens on and had dominated his life since that time.

With the exception of the 38-year-old, none of the participants in the present study reported sexual abuse as occurring in either their childhood or teen years. It is important to note that the lack of such reporting does not necessarily suggest that sexual abuse did not occur for any of the other men. However, the researcher's impression of the interview process was that the men appeared to be comfortable and candid in speaking about matters intimate to them. On that basis, this researcher is fairly confident that experiences of sexual abuse were not withheld in the course of interviews.

As such, the backgrounds of participants in the present study are somewhat in contrast to those of Dreikorn (1998). Dreikorn found that seven of his participants (just under half) reported sexual abuse as occurring in their childhoods.

That said, three of the men in the present study reported incidents and interactions with parents that could be seen as verbally or emotionally abusive. For the 22- and 36-year-old participants, emotional abuse appeared to be in the form of coldness and lack of acceptance, whereas the 38-year-old described several episodes where he had been insulted or attacked by his parents and peers. Dreikorn (1998) found that seven of his participants reported experiencing verbal as well as physical abuse in childhood.

The 44-year-old participant offered the least amount of information about the genesis of his SSA other than to say that he had considered himself attracted to men for most of his life. While this individual could envisage being attracted to a woman only with difficulty (and frequent distaste), he described a powerful and pervasive attraction to other men. He talked about coming out as a gay person at the age of 15 years. Additionally, he lived with that self-label for approximately 10 years, and during that time engaged in promiscuous behaviour as well as several long-term relationships. It would appear that for at least the portion of his life story in which he was gay-identified, the 44-year-old participant did not experience a conflict with regard to the affirmation nor the expression of his SSA.

The 44-year-old participant's experience changed when he underwent a Catholic conversion in his mid-20's. Along with that conversion, he adopted a traditional Catholic (non-affirming) stance with respect to the expression of same-sex behaviour. This individual chose to engage in a solitary process (one that did not involve formal therapy

of any kind) where he sought to understand his SSA as well as curb the physical expression of sexuality with other men. His personal journey was one that involved engaging what he later saw to be the tenets of reparative therapy long before he had heard of or contacted the TA clinic, in the hope of living in conformity with a Catholic sexual ethic.

None of the other men ever adopted a formal gay identity. By this, I mean to imply they did not use the label gay for themselves, nor did they engage in a *coming out* process, which is typically used to describe individuals who have decided to accept, affirm, and act on their experience of SSA, as well as construct an identity and (wider still) join a community of like-minded individuals who will affirm their SSA and encourage them to act upon it.

For three of these men, Christian spiritual commitments played a key role in their desire to stop engaging in same-sex behaviour as well as their resistance to adopting a gay identity. A traditional Christian sexual ethic views the legitimate expression of genital sexuality as occurring between a man and woman in a heterosexual marital covenant. The governing role of this Christian sexual ethic was key for the 22, 29, and the 44-year-old participants. By contrast, religious considerations did not figure largely in the motivation for therapy for either the 38- or 36-year-old participants. The 38-year-old participant primarily wanted to reduce compulsive sexual behaviours, while the 36-year-old described his journey as a search for emotional wholeness and health. The 38-year-old (the only married participant) stated he wanted to improve his intimacy with his wife. None of the other men indicated that marriage was a primary goal of therapy (although several were clearly open to becoming intimately involved with a woman).

Dreikorn (1998) found in his study that six of his participants indicated religious beliefs opposed to homosexuality were key in entering counselling to overcome unwanted SSA. His results differed from the present study in that a majority (11) of his participants began some kind of SOCE because they wanted marriage or children. This was by far the strongest reason Dreikorn's participants gave for undertaking SOCE; the next closest in his study was being overwhelmed/feeling worthless/end of rope/suicidal (endorsed by seven of his participants). In the present study, the 22-year-old spoke of grappling with strong negative emotions when he first began therapy, while the 29-year-old described therapy as a "last ditch effort for sanity".

The spiritual conflicts noted by some participants engaged the broader theme of agency. These men's experiences have been characterized by difficult decisions and competing priorities. They have emerged as radically agentic beings, individuals who have had to wrestle long and hard with what they really wanted and how they intended to reach their life goals.

The question can be posed as to whether the Christian commitments relevant to the SSA-related distress experienced by the 22, 29, and 44-year-old participants represented a truly internalized and self-emanating personal ethic. Their adherence to a traditional Christian ethic could have represented a standard imposed on them from without, either by a religious community, specific representatives of that community, or family members. In such cases, decisions to pursue reparative therapy could represent an externally motivated choice to the demands or requests of others. Our pattern of results, however, show a clear sense of personal responsibility and agency for all participants as they engaged difficult choices and circumstances. Rather than conforming to external

pressures or internalized conventions, these men pursued a path grounded in self-chosen directions.

**Processes of reparative therapy.** In terms of counselling process, the men discussed two primary techniques. One was Body Work (BW, as described in the section above, "expansion of the reparative therapy model"), and involved an exploration of client somatic and affective experience as they focussed on a previous painful memory of abuse, rejection or unwanted sexual attraction. The participant would seek to experience the remembered event as deeply as possible in the therapy session and share with their therapist about what came up for them. Participants talked about new associations as well as surprising insights that emerged for them as they engaged in this process. The 44-year-old participant talked about a shift that occurred in how he saw his experience after BW with Dr. Nicolosi.

Another technique frequently used at the TA clinic involved EMDR, a well-known and well-researched trauma therapy treatment. The men in this study described EMDR as an approach that assisted them to reduce both unwanted sexual attractions, as well as the pain associated with old memories of abuse. The 29-year-old participant described how EMDR had transformed his pornography use from something that used to be about the image to now "just a habit."

Running through all of the men's accounts of BW as well as EMDR was the requirement that they bring identified conflicts, some area of residual pain, to the therapy session. There was some commentary which expressed preferences for one modality over the other. The 44-year-old participant noted that while he had achieved some progress with EMDR he preferred to employ BW. Additionally, the 38-year-old

participant indicated he did not like using EMDR, but admitted it had significantly reduced the pain associated with some old memories.

From the men's accounts, both EMDR and BW appeared to be the holding containers in which the primary themes of their therapy manifested and were worked through. They were the frames of therapy, the "what we do in session" portion of reparative therapy. At the same time, the men's stories indicated that EMDR and BW did not constitute all of the time spent in session. The 22-year-old participant discussed how he had explored with Dr. Nicolosi certain key events in his life, and "what they might mean." The men were encouraged to tailor the interventions offered to their own therapeutic needs, and to decide how they wanted to proceed. In this regard, the 29-year-old discussed that his residual work with Dr. Nicolosi would consist primarily of EMDR to further reduce his same-sex pornography addiction.

**Areas of therapeutic focus.** Both BW and EMDR were seen as helpful in addressing several key areas. One of the primary themes that emerged in the men's stories was that of shame. Shame was mentioned by all participants and it was given a variety of expressions. Shame was something that had been carried around by them for most of their lives, and had been a largely unconscious reality for them until they entered therapy. The 22-year-old participant talked about how he realized after several weeks in therapy that he did not have to continue carrying shame about as he had done. He provided vivid language to describe shame as a dead feeling in which there was a sense of "nothing being there."

Shame was for these men a somatically grounded experience. They talked about learning to identify shame by the way that their bodies felt. Shame manifested as

tightness, sinking in the gut, in addition to a number of other body reactions. Shame emerged through painful interactions with other people, as well from things they said to themselves. It was a pervasive phenomenon that they had to battle on an ongoing basis.

Shame was also an experience that was grounded in gender. When these men experienced shame, they felt diminished and unworthy as men, not just as persons. As they proceeded in therapy, the men began to make a connection between their SSA and experiences of shame that had occurred. The 22-year-old participant provided a particularly detailed account of an experience in which he had a profound experience of shame after seeing a handsome young seminarian. This individual stated that for him the experience was the first time that he "saw the therapy was true." He had told himself, "You'll never be like him," an experience that was followed by a dropping sensation in the stomach, and ensuing genital arousal. Some of the shame experiences occurred as a result of things that were said to these men, but at other times, shame emerged from internal processes. The 29-year-old participant talked about how the rug could "still be pulled out from under his feet" and he could then go into a "shame mode." For the 44-year-old participant, shame emerged as he contemplated entering an intimate relationship with a woman.

For these men, reparative therapy was also about examining their relationships with family members. For one man, there was a recognition that his relationship with both parents had contributed substantially to his shame, but he currently found family issues so painful that he was not yet able to engage them in therapy. Another spoke of his relationship with his father as the most difficult part of his own therapy process. Family issues appeared to be primarily about an emotional disconnect, an inability to

relate on a close level with one or more family members. For at least two of the men, the key family disconnect occurred with the father; for the remainder, there were ruptures in general family relationships that involved both parents and, in two cases, siblings as well. One man asserted he had never known the role that his relationship with his father had played in his SSA issues until he went into therapy. After that time, much in his life that had previously been mysterious was better understood.

The present results are consistent with Spitzer (2003) who reported a majority of his participants dealt with dysfunctional family relationships as well as traumatic childhood experiences in their change therapies. Spitzer also noted his participants spoke of linking childhood and family experiences to their SSA in therapy.

The participants talked about the ways reparative therapy had impacted their relationships with men and women. There was a general reluctance to tell non-SSA men about their struggle, although it was conceded that when they took this vulnerable step it usually was rewarding. The men wondered about how OSA (Other Sex Attracted) men would perceive them if they knew about their struggle; for one participant, this was tied to the fact that most of his social network occurred in a conservative Christian context. Another participant spoke of how he had been able to build a support network of male friendships through what he learned in therapy that were able to meet his emotional needs and redress many of the emotional deficits he encountered in his family of origin. This same individual indicated most of his friendships were with SSA men, and he saw the next step in his personal growth to be the development of OSA friendships.

For all but one of the participants, consideration of their potential for relating intimately to a woman was also an emergent theme. The men entertained the hope that

they would be able to establish a relationship with a woman that included sexual intimacy, and possibly marriage and a family. That participant who was married noted a continuing lack of intimacy with his wife because of ongoing compulsive sexual behaviours. This individual entertained the hope of improving relations with his wife, but had not yet been able to broach that topic in therapy in light of the pervasive nature of his acting out behaviours. Reparative therapy appeared to provide the opportunity for learning to relate to other men in an intimate but non-erotic way, and of approaching women from a fully gender-identified stance as a man. The 29-year-old participant talked about putting up some new boundaries in his female friendships as he held out for a woman with whom he could be fully intimate.

Reparative therapy was a journey that required ongoing assessment as to whether the men wanted to proceed, and in what manner. There were junctures in which the men asked themselves to what extent they wanted to commit to the work, and they underwent seasons in which they placed more or less emphasis on their therapy. Each appeared to have come to a place in which they saw reparative therapy as of central importance in their ability to move on with their lives in a healthy manner. For one man, pervasive acting-out behaviours threatened to sabotage his process, and he came close to quitting on several occasions.

For most of the men in this study, their relationship with their therapist(s) was a critical component in their therapeutic process. The 22-year-old participant manifested this belief most strongly, and indicated that in his opinion the relationship with Dr. Nicolosi had likely saved his life. For him, Dr. Nicolosi represented the grandfather he never had, an older man who would validate him and with whom he could discuss his

deepest conflicts. The 29-year-old participant had switched to Dr. Nicolosi from an earlier therapist, and noted that Dr. Nicolosi's more directive in-session approach forced him to fight for the therapy he wanted (encouraged him to assert himself). The 36-year-old participant explored intimacy issues as he struggled to believe his therapists really cared about him. He slowly began to receive the affirmation and attunement that was offered him at the TA clinic. By contrast, the 38- and 44-year-old participants described a respectful relationship with Dr. Nicolosi that was based more on his demonstrated ability to understand their condition and facilitate their growth than it was on emotional connection per se. In this regard, the 44-year-old participant stated he had a productive working relationship with Dr. Nicolosi, but did not feel that the therapeutic relationship was critical to his own progress.

It appeared that for three of the five men in the present study, the therapeutic relationship played a fairly critical role in their perceived ability to move forward with their healing goals. Interestingly, Dreikorn (1998) also found that two-thirds of his participants (ten out of 15) rated the therapeutic relationships (defined as the "counselor being caring/trusting/encouraging/understanding") as helpful in their evaluation of counselling.

**Not just about sex: New understandings of SSA acquired through therapy.** Reparative therapy engaged a host of issues related to masculine identity and the self. It was not just narrowly concerned with sexual behaviours. For one participant, his therapeutic process had led him to believe that his SSA was just a symptom, one that with additional time and effort he would be able to eliminate. However, he found that therapy had uncovered several personality issues which he now believed it was more important to

work on. This process was likened to the removal of one layer of dysfunction to allow for examination of one that lay deeper. Another participant noted that only about 10% of his therapy time was taken up with explicitly sexual matters; the remainder addressed his loneliness and his need to connect on an emotional level with another man. Ironically, the man for whom compulsive sexual acting out (with other men) appeared to be the most serious difficulty, was also the one who most strongly emphasized that his therapy was not about sex.

An emergent realization for most of these men was that SSA was related to (a) their need to connect on an authentic but non-erotic level with another man, as well as (b) their own deficient sense of masculine identity. For them, healing was about completion of masculine identity. The 44-year-old participant illustrated this poignantly when he noted that through therapy he was able to see other men from the perspective of a more fully internalized masculine identity. As such, the qualities of masculinity he now believed to reside in himself could resonate with those of other men he saw, rather than being a source of erotic attraction. Same-sex erotic attraction came to be understood through therapy as the expression of legitimate emotional needs that had not been fulfilled. In that sense, the men related that SSA itself was "not just about sex."

As the men looked back on their experience in reparative therapy, they related that it had allowed them to heal from many past experiences of gender wounding, experiences that had contributed to shame by making them feel belittled as men (or boys). This occurred through the modalities of BW and EMDR, but also in the general flow of in-session discussions. The men discussed being able to integrate painful memories, and in that sense obtaining some closure regarding old wounds.

Spitzer (2003) noted that his participants made frequent use of a narrative that linked family or childhood experiences to current difficulties. Spitzer also pointed out, following Mahoney (1991, as cited in Spitzer) that this is a change strategy which has commonly been found to be effective in psychotherapy. Consistent with the current study, Spitzer also reported an increased sense of masculinity for his male participants, along with the ability to develop intimate non-sexual relationships with other men. Given these similarities, as well as the fact both groups reported a positive experience with therapy, it may be the case that our men's stories may also help to better understand the men in the Spitzer study.

Dreikorn (1998) discovered that seven of his participants found the development of healthy male relationships to be helpful aspects of their therapy process. Seven participants from Dreikorn's study also found that learning masculine skills and sports assisted them in their goals. Sports were not noted by any of the current participants with the exception of the 22-year-old. He made the interesting observation that for him, masculinity was strongly connected to the acquisition of athletic skills (which he felt he had always lacked). To that end, this individual remembered visualizing a scene in which Dr. Nicolosi taught him how to throw a ball. This transcript excerpt is included in Chapter 4, and represents one of the more poignant memories offered by our participants.

Karten & Wade's findings (2010) were also consistent with the results of the current study. Karten & Wade found that the two highest ratings provided by their participants with respect to helpfulness of therapeutic technique were (a) understanding better the causes of SSA and emotional needs and issues, and (b) developing non-sexual relationships with same-sex peers.

The present study therefore augments the existing research that an improved sense of masculinity as well as better non-sexual relationships with the same sex are important experiences for men who have positive encounters with SOCE.

**Some shift in sexual attractions.** Reparative therapy contributed to a reported lessening of SSA for these men, and in some cases an increase in OSA as well. This was not, however, a linear or straightforward process. None of the men in this study reported a complete absence of SSA. However, they did report that the quality of their attractions had changed, and the intensity with which they experienced SSA had diminished. Where previously they had been preoccupied after seeing images of men they found arousing (either in person or on the internet), the men were now able to process and move on quickly from the experience. In the words of the 29-year-old participant, he "used to be devastated for a whole day after seeing a good-looking man," whereas now his preoccupation would only last for several minutes. The man who appeared to struggle most acutely with compulsive sexual behaviours reported that it now took him longer to act out, because he had to work against the knowledge he had acquired in therapy ("I now know what's going on"). The most extreme report of shift of sexual attraction came from the 44-year-old participant, who stated he had been 80% attracted to men prior to therapy, and was currently 80% attracted to women at the time of our interview. He attributed this to the effects of reparative therapy, which he reported had exerted a powerful influence on his life. This individual, it will be recalled however, had entered therapy due to anxiety related to spontaneous OSA that had emerged approximately six months before he began therapy. In light of his narrative, it appears reparative therapy encouraged the

development of his OSA while assisting him to cope with anxiety that came up about relating to a woman.

For one man, reparative therapy resulted in a shift in his perceptions of women, in which they were seen less as general companions and more as potential mates Another talked of flashes of attraction to women that he had recently experienced, in the context of a general desire that he might one day have children.

There was surprise on the part of several of the men that their SSA had been significantly impacted by reparative therapy. This occurred because of the small amount of time that was actually spent discussing sexual issues. Reduction in SSA appeared to emerge out of a shift in how they saw themselves as men.

The fact that none of the current participants reported a complete or unproblematic elimination of SSA is similar to the findings of Spitzer's (2003) study. Spitzer noted that only 11% of his male (and 37% of his female) participants reported a complete change of sexual orientation. Spitzer argued that the lack of perfect success argued strongly for the reliability of his participants reports; a bias towards misrepresenting success would have, in his opinion, resulted in less ambiguous reports of progress. Similarly, Dreikorn (1998) reported that while eleven of his participants reported a reduced homosexual orientation and/or interests, only two said they had no residual same-sex attraction (the remaining two participants reported no change in their attractions).

The men in the present study therefore provided further evidence that a satisfying experience with SOCE does not appear to involve a complete change of sexual attractions. Rather, and consistent with other issues dealt with in psychotherapy, change

appeared to be a gradual process of diminished intensity of same-sex attractions and intermittent flashes of attraction to the opposite sex. Our 44-year-old participant, as noted, was the major exception to the gentle model of change that seemed to emerge.

**Grateful for the opportunity to undertake this therapy and have our voices heard.** The men expressed a profound gratefulness for the opportunity to engage in reparative therapy, while they acknowledged it had many challenges. Reparative therapy tore down the most basic assumptions one had about oneself, and challenged the development of a new sense of self. One man conceded this was a painful process, but also stated he did not know what he would have done had he not been able to undertake reparative therapy. He expressed concern for men undergoing similar struggles who did not live in an area where such services were offered. The 38-year-old participant talked about how his healing process was a constant undertaking that involved his whole life. He linked his ability to function as a father, businessman, and (emerging) religious believer to the ongoing work he did in reparative therapy.

Dreikorn (1998) noted that seven of his participants had made use of reparative therapy. All had indicated this was a helpful approach in assisting them with their therapeutic goals. The current study can be added to Dreikorn's research to suggest that for some men, the experience of reparative therapy has been seen as beneficial.

These men also expressed gratefulness that their voices would be heard. They were aware of the controversy surrounding reparative therapy, and wanted people to know that for them this had been the right choice. The men expressed the desire that the gay community as well as the wider culture accept their choices as legitimate, even if

they were not agreed with. These men were determined to proceed with their therapeutic journeys, even if meant that they would be subjected to ongoing misunderstanding.

The desire to have their voices heard is a trans-therapeutic theme that emerged in the present study and went beyond participant's discussion of their therapy experience. None of the research reviewed for this project (Dreikorn, 1998; Karten & Wade 2010; Spitzer, 2003) made reference to this desire on the part of SOCE clients. This would be expected, as the focus of those studies was not on this element of the SOCE experience (rather, those researchers enquired as to the nature of orientation change or on characteristics of persons undergoing SOCE treatments).

By contrast, the present study has sought to highlight the voices of men in reparative therapy for unwanted SSA. It can be seen as an academic extension of a venture that is starting to manifest on the internet with sites such as www.voices-of-change.org. Blog and "testimony" sites such as "voices of change" provide an important opportunity for individuals to tell their stories of being in SOCE, as other blogs allow individuals who have chosen to gay-identify (or who have had negative experiences with SOCE) to also tell of their experiences. That said, the testimonials presented in such forums typically consist of one to two-page accounts. As such, they are fairly "short-hand" condensations of journeys that have often been complex and lengthy. These stories can serve as an introduction to the experiences of individuals who have undertaken reparative therapy.

By contrast, this study has proceeded on the assumption that there is an additional value that can come from the kind of extended, meditative treatment that phenomenological analysis provides to experience. Engaging in extended reflection on

the stories our men have shared has led, to use Wertz's (2005) expression, to the "eidetic intuition" that reparative therapy is about the healing of masculine identity. The process of arriving at this insight (through derivation of meaning units and themes) tells us not just what reparative therapy for these men has involved but, in a more fundamental sense, what it has been for these men. This study therefore extends our knowledge of the experience of reparative therapy beyond the content provided in blog and "testimony" sites.

**Telling the Stories of Men in Reparative Therapy**

The closest published antecedent to the stories of the men in this project may well be Nicolosi's *Case studies in Reparative Therapy* (1993). In that book, Nicolosi presented eight case descriptions which were a composite of clients typical to his practice at that time. Nicolosi noted in the foreword to his book that he intended to provide concrete examples of the way he worked with men who experienced difficulties in their masculine identity.

By setting the stage for his case studies in this manner, Nicolosi reiterated his foundational premise that unwanted SSA originated from wounds and conflicts in masculine identity. Nicolosi elaborated on this point in a later chapter by asserting that, in his clinical experience, most men with unwanted SSA suffered from a sense of masculine identity deficit. This deficit was then projected onto other, idealized men and manifested as an erotic attraction. The core need, however, was not for sex, but for the healing of personal, and specifically masculine, identity.

As such, there is a strong common thread that has run through Nicolosi's theorizing and practice of reparative therapy. While *Case Studies* involved the use of

composites, and therefore did not refer to any one specific client, Nicolosi noted he attempted to portray representative aspects of the men in his practice. The men he presents in *Case Studies* struggled with fragile personality structures, anger, narcissism, integrity, and ambivalence.

The current project bears a strong parallel to *Case Studies*. The men in our research also described a process that was about healing in their masculine and personal identities. In telling their stories, they illustrated the continuing "heart" of the enterprise of reparative therapy, at least as practiced at the TA clinic. This study may be combined with *Case Studies* to form the nucleus of a qualitative research program focussed on the work at the TA clinic. Those who have found the current research engaging are encouraged to return to Nicolosi's earlier work.

Although this project illustrates clear continuity in reparative therapy and complements the material in *Case Studies*, it also makes some unique contributions. The stories from our men are not based on therapist reflections or retrospection on clinical notes, but proceeded directly from the men themselves. In that sense, our pattern of results provides closer access to actual clients in reparative therapy. We hear directly from them, rather than having their experiences mediated by a therapist.

Nicolosi's insights in *Case Studies* hold unquestionable value as coming from the originator of reparative therapy, but they, of necessity, only encompass one perspective in the dyadic encounter that is psychotherapy. There is also great value in hearing from "the other chair in the session room." The men in our study were speaking to an individual who had no professional affiliation with the TA clinic. The interviews afforded these clients a beneficial distance to reflect on and talk about their therapy experience.

The eighteen years that separates the current project from *Case Studies* also allows us to provide a snapshot of reparative therapy as it has evolved since the early 1990's. In particular, this research occurred after the publication of Nicolosi's *Shame and Attachment Loss* and reflects many of the additions and elaborations outlined in that 2009 volume, including Body Work and EMDR. Nicolosi added the concept of shame to his growing understanding of the origin and treatment of unwanted SSA; this focus is largely absent from his earlier works, including *Case Studies*. We have seen that shame manifested as an important theme in the stories our participants told us.

**Implications of a Positive Experience with Reparative Therapy**

This has been a study of one specific form of psychotherapy, one that assists individuals with issues relating to unwanted SSA. The stories of our participants indicate they found this psychotherapy helpful in meeting their chosen goals and improving the quality of their lives. Each of their stories was unique, and reflected the specific types of SSA-related concerns that brought them into the TA clinic. Their individuality pervaded their narratives; as such, we are not able to collapse their journeys into a single, cookie-cutter image of the process of doing reparative therapy.

Yet, these men were also united in focusing their change efforts through a single psychological clinic, and undertaking that journey with Dr. Nicolosi or therapists under his supervision. We have, therefore, a somewhat more focussed picture of an SOCE process than that obtained by Dreikorn (1998), who interviewed men from a variety of change therapies.

A primary implication of the present study is that these men reported a profound experience of healing through their ongoing journey in reparative therapy. Healing

consisted of various factors, and had different emphases from man to man. However, common experiences included a reduction in unwanted same-sex attractions, the lessening of shame, a healthier sense of masculine identity, improved relationships with other men, and a greater maturity. Healing for these men was about living a life consistent with their chosen values and the vision of who they wanted to be.

The men's stories provide for us a description of an empowering experience of psychotherapy. While all of them went into therapy for issues related to unwanted SSA, they were able to tailor their sessions towards personally relevant goals. Our 29-year-old noted he would encourage anyone entering this kind of therapy to "take control" and "say what he wanted from it". It appears that each of these five men were able to function as active agents in their own healing, both in choosing to enter the TA clinic, and throughout their therapy process.

In his review of SOCE research, Beckstead (2012) outlined a number of methodological errors. One of these was that "results are based on restricted, self-selected samples that represent a socially stigmatized population who affirmed heterocentric biases" (p. 124) In conceptualizing the population of men who present for treatment of unwanted SSA as "affirming heterocentric biases," Beckstead does not make room for those individuals whose personal value systems weighted heterosexual and homosexual behaviour differently. Such a perspective appears to devalue the experiences of the men in the current study, who provided detailed descriptions of their reasons for entering and continuing with reparative therapy. Those reasons engaged deeply held visions of personal identity. Ascribing what they have shared to nothing more than a "bias" would not do justice to the agency manifested in their stories.

Given the important role of client-report as an information-gathering method in psychology and psychotherapy research, the stories of the men in this study take their place alongside the results of Dreikorn (1998) and Spitzer (2003). Some men tell us, when given the opportunity, that they were satisfied with their experience of reparative therapy. Through the help they reported receiving from the TA clinic, they were able to live their lives more consistently with their goals, values and life priorities.

In sharing the stories of these men, the results from this study may have relevance to other persons who struggle with unwanted SSA, especially if they have undergone or are considering psychotherapy. Similarly, other persons who have some level of interest in this therapeutic approach may find it helpful to hear from persons who have recently been involved in reparative therapy. And scholars in the research community examining SOCE can draw on these results to help inform research programs, as can investigators exploring qualitative dimensions of psychotherapy more broadly. Our participants' stories do not offer a "definitive" picture of participating in reparative therapy, but in taking the risk of sharing their life experiences, these have shed some light on aspects of this therapeutic approach.

There continues to be great debate and uncertainty concerning the causes and psychological status of SSA. Reparative therapy has consistently seen the genesis of SSA as arising through gender-identity related wounds and deficits. In its more recent formulations, reparative therapy has construed SSA as the result of profound and early attachment wounds. For the men in this study, such an explanation appeared to resonate with their experience, and helped to clarify for them the painful and unwanted presence of SSA in their lives. One of the men was emphatic that making the connection between

his relationship with his father and his shame-based SSA was critical to catalyzing his healing process. This connection was afforded him at the TA clinic.

In light of the stories related by these men, future research that seeks to better understand the origins and nature of SSA may not want to abandon the insights that a theory such as that of Nicolosi's can offer. For at least the men in this small study, the model of reparative therapy appeared to offer a helpful framework for understanding their SSA (and related issues), and for helping them to move past it. Their stories suggest that healing from SSA may involve healing of masculine identity. The experiences of these men would seem to provide the impetus for larger-scale investigations to examine some of the causal factors which may be implicated in unwanted SSA.

There is a broad theoretical and empirical literature on masculine identity that has emerged (Levant, Hall & Rankin, 2013; Liu, Stinson, Hernandez, Shepard & Haag, 2009; Roberts-Douglas & Curtis-Boles, 2013; Vandello & Bosson, 2013; and Wade & Coughlin, 2012) in recent years. While most of this work has drawn on heterosexual samples, some research (Fischgrund, Halkitis & Carroll, 2011) has been with gay-identified men. Given the importance of masculine identity as it has emerged in the results of this study, future research on the experiences of men in reparative and related therapies will want to draw upon and integrate the insights of this broader literature.

The present study can contribute to existing SOCE research by providing a glimpse into the possible mechanisms of change for men with unwanted SSA who report a successful experience with psychotherapy. These mechanisms may involve addressing bodily-based experiences of shame, the healing of past experiences of abuse and rejection, increased insight into painful family dynamics, and development of non-erotic

but emotionally satisfying relationships with members of the same sex. Rather than narrowly focusing on the elimination of an unwanted attraction (SSA), effective therapy for the man distressed by his experience of SSA may well involve healing of his overall sense of masculine identity. This is the conclusion suggested by the stories these men have shared with us.

To what extent does the therapy reported by these men demonstrate fidelity to the principles of reparative therapy, as they are described in the works of Nicolosi? *Shame and Attachment Loss* (Nicolosi, 2009) was intended as a practical handbook to guide reparative therapy practitioners. It provided a number of specific treatment modalities that guided the work at the TA clinic. These treatment modalities consisted of intensive Body Work (BW), working through the preceding scenario for homosexual enactment, and EMDR for addressing past trauma. The men provided substantial material illustrating the use of these modalities. In terms of what happened in sessions, BW and EMDR constituted a large part of the process. There was extensive examination and processing of past memories of abuse and painful relationships through BW and EMDR. While there were preferences for one approach over the other expressed, the men reported these modalities allowed them to shift past historical material that had previously been a source of ongoing pain as well as SSA. The men were able to tailor these approaches to the material they presented and decide how they wanted to make use of them. But their stories evidenced an ongoing and substantive use of BW and EMDR in their treatment.

*Shame and Attachment Loss* offered an understanding of SSA as an attachment-based gender wound, one that can be healed as the client stays in his assertive self.

Assertion in this model has a number of aspects, but an important one is a fully conscious sense of being a gendered being, of fully identifying with the masculine. This understanding seemed to resonate with the men in this study. They spoke of a gradual improvement in the way they saw themselves as men, and posited a connection between this healing in masculine identity and a reduction in SSA.

It seems from their accounts, that there was a common approach taken to treatment at the TA clinic, and that this approach closely followed the protocols developed by Nicolosi. This is not a surprising conclusion, as most of the treatment given these men was implemented by Nicolosi and therapists under his supervision. Nonetheless, this study suggests that for individuals who, prospectively, have read Nicolosi's works and are considering consulting with the TA clinic, there appears to be fidelity between the theoretical outline and the practical application of reparative therapy.

Stanton Jones noted in his endorsement of *Shame and Attachment Loss* that the book offered "fruitful clinical hypotheses for exploration" (Nicolosi, 2009, endorsement, inside cover). The present study can be seen as an example of one such exploration. Our results strongly suggest a conceptual congruence between the experiences and understandings offered by clients at the TA clinic and Nicolosi's formulation of reparative therapy, most specifically in *Shame and Attachment Loss.*

This study may also speak to current controversies that are occurring within the mental health establishment(s) concerning the status and ethicality of SOCE. An important example of such controversy is the previously reviewed SB 1172, which proposes to ban SOCE attempts with minors. This legislation has been signed by the current governor of California and at the time of this writing appears to be on its way to

becoming law. One potential implication of such legislation could be an effort to introduce a similar ban for adults undertaking SOCE. In such a case, the men in the present research would not be able to continue their journeys with reparative therapy, nor could prospective clients begin such a process. At present, SOCE have not been banned, albeit they are looked at with increasing distrust within most mental health bodies. The results of this study suggest that such a development would cause considerable psychological distress to at least some individuals who experience unwanted SSA and desire assistance with overcoming it.

In its 2009 Task Force report, the APA noted that some of the benefits reported by clients in SOCE efforts were non-specific to sexual orientation change. They were benefits that could also be obtained from other kinds of therapies that did not seek to change sexual orientation. On that basis, in conjunction with the imputed lack of empirical evidence that SOCE efforts were successful, the APA recommended that clients with unwanted SSA be directed to affirmative therapies that assisted them to reduce the dissonance they experienced between their sexual attractions and, for example, their religious beliefs.

The current study has outlined the stories of a group of men who reported benefits from undertaking reparative therapy. Moreover, those benefits appear to have been intimately linked to the ability of reparative therapy to assist these men with understanding and reducing their unwanted SSA. Given the specificity of why these men came to the TA clinic, which was articulated in considerable detail, it is difficult to envisage how a more generic therapeutic approach would have been able to meet their

needs. Additionally, an affirming therapy, specifically one that encouraged these men to integrate their SSA into a gay identity, would be contrary to their desired goals.

The qualitative, open-ended interviewing protocol employed in this research may also speak to the integrity of the experiences these men shared. Spitzer (2012) expressed concern that there was no way to ascertain whether the participants from his 2003 study had been telling the truth. Spitzer (2012) also noted that he now found the reasons he had offered for trusting his participants' accounts in his earlier study unconvincing. Spitzer's change of interpretation highlights a major concern about the veracity of individuals who reported positive experiences with SOCE: namely, can they be trusted? Spitzer employed a structured interview format for his 2003 study, one that essentially asked participants to provide retrospective ratings on a number of sexual orientation-related scales. Whether or not one is in agreement with Spitzer's re-evaluation of his participants' truthfulness, his (2003) research design was one that would seem to allow individuals to fairly easily provide an overt success story; to do so, they only had to report appropriately high (or low) numbers on the relevant scales.

By contrast, the present study provided virtually no "scaffolding" for the experiences of men in reparative therapy. They were asked to merely talk about therapy. Over the course of one hour (or more), these men had to examine their journeys, and frame them for a neutral interviewer (i.e. one who had not asked for either "success" or "failure" accounts). In this regard, one of the participants expressed to the interviewer his surprise that they had not asked "whether he had changed". The format of these interviews made it, in the opinion of the research team, more difficult (though not impossible) for participants to falsely convey a positive experience with reparative

therapy. As is developed more fully in Appendix B, this interviewer came away from their experience convinced of the integrity of these men's accounts.

As such, this study lends some support to the calls of writers such as Yarhouse (2001) and Throckmorton (2002) to make SOCE approaches such as reparative therapy available for those clients who desire them. This is consistent with the ethical guidelines of all of the major mental health bodies (e.g., APA, Canadian Psychological Association, American Association of Marriage and Family Therapists) which stipulate that clients need to be able to choose the direction and goals of their therapy.

**Limitations and Future Research**

This study proceeded on the assumption that there were men engaged in reparative therapy who also wanted to talk to a researcher about their experiences. Fortunately for the researcher (and this project), that assumption proved to be correct. The five men interviewed have provided us with a rich description of their time in reparative therapy to date.

The present study is, therefore, focussed on the experiences of men engaged in reparative therapy who are ready and willing to talk about their journeys. Given the relatively low response rate to the study notice circulated at the TA clinic, it can be assumed that a large portion of the men at the TA clinic at the time this study began did not feel able or willing to discuss their experiences.

There are individuals trained by Nicolosi (for example, David Pickup, www.davidpickuplmft.com) who currently practice reparative therapy independently of the TA clinic. Additionally, the literature review discussed a number of other approaches that have been taken with respect to treating unwanted SSA. Studies similar to the

present one which focussed on client populations other than the TA clinic would also likely be limited to those men who are able to and willing to discuss their therapy.

In this respect, the present study shares the same limitation that all interview-based, qualitative research approaches have in common. The act of participating in an interview where one shares details of a very personal process such as psychotherapy requires self-confidence and a certain degree of ego strength (M. McDonald, personal communication, December 5, 2012). Not all persons in the midst of therapeutic journeys will possess these characteristics, and consequently be able to participate in qualitative research with a design similar to the present study.

Given that it is focussed on a specific therapy setting the present study is limited to those men who were receiving services from the TA clinic in the fall of 2011. The stories outlined here represent reparative therapy as it was practiced by Dr. Nicolosi and his team in that time period. This researcher has had the opportunity to attend a recent NARTH conference (2012) and in that context to consult with Dr. Nicolosi concerning his current clinic practices. It appears that Nicolosi has continued to expand and diversify his use of the EMDR protocol. He (Nicolosi, personal communication, November 3, 2012) stated that he has found the use of EMDR to be effective not only for the healing of past traumas but to further reduce sexual reactions to pornographic images through building up the assertive state in clients. As such, reparative therapy should not be seen as a static approach that is unchanging, but rather an evolving treatment that seeks to develop better and more rapid means for overcoming unwanted SSA. This project, consequently, needs to be viewed as a snapshot of several clients in treatment as they related their experiences in the fall of 2011. At the time of this writing, Nicolosi has

not published any further material outlining his treatment innovations, although at the NARTH 2012 conference he suggested it may be time to do so.

None of the men in this study had completed their therapy, but continued, at the time of their interviews, to attend sessions with Dr. Nicolosi and/or his colleagues. As such, this project can be seen as an example of *concurrent* psychotherapy research, as opposed to either *prospective* (interviewing clients about to begin therapy) or *retrospective* (interviews after therapy has concluded) research. This study is therefore focussed on the experiences of men who are in the midst of reparative therapy, as opposed to those who are beginning or who have ended their journeys.

An important limitation of the present study was a lack of independence from therapists with respect to recruitment. As noted, the researcher's physical distance from the TA clinic necessitated that therapists distribute study notices to clients. Although it was decided that this was a satisfactory method of study distribution, it was not ideal. The possibility existed that some clients may have experienced a desire to please their therapist by participating in the study. It is also possible that implicit criteria employed on the part of therapists may have influenced who they informed of the study. In this regard, the current project may have been less likely to catch clients who were not having a positive experience with reparative therapy. It would have been preferable to have clients notified of the study without any involvement or knowledge of their therapists. This aspect of the current study design remains an important limitation that, to some extent, weakens the research design.

Additionally, the requirement that participants have been in therapy for at least one year prior to the study also made it more likely they would have reported a positive

experience with therapy. Clients who did not find reparative therapy was meeting their needs would likely have come to such a conclusion within the first year of therapy. As such, they were more likely to have terminated before reaching the one year mark and, consequently, would not have been eligible for inclusion in the present research.

That said, the modification of the study design to include clients who had been in therapy for less than one year would have represented a fundamental and unacceptable change to the goals of this project. The researcher's aim was to talk with individuals who were "in process", in contrast to those in the beginning or ending stages of therapy. For that reason, a minimum of one year was seen as justifiable minimum time criterion for study inclusion. Further research targeting clients in the beginning as well as ending stages at the Thomas Aquinas Clinic is required to augment the information obtained in the present study.

With respect to the data analysis process, the fact that the primary researcher was a current client at the T.A. clinic also represents a potential design limitation. This pertains most closely to the "bracketing" process. In addition to possessing a philosophical sympathy with the goals of the men in this study, the researcher was also engaged in a similar (though not identical) process in reparative therapy. Although efforts were made to "bracket" this reality for the purpose of hearing these men's stories (in large measure through research team dialogue), it remains a possibility that the researcher's status as a current client may have, to some extent, impacted on the bracketing process.

There is, however, a "flip side" to the reality of the primary researcher being himself a client of reparative therapy. The process of immersion in both the process as

well as the theory of reparative therapy may have allowed the researcher a depth of sensitivity in hearing these men's stories that would likely be missing in someone without such a background. While efforts were made in both the study notice as well as the conduct of interviews to mask the researcher's identity as a client, this reality nonetheless may have better positioned the researcher to attune to these men's experiences. Consequently, the "researcher who is also a client" should be seen as a design strength as well as liability.

Future research could enrich the data obtained in the present study by conducting in-person interviews instead of by telephone (as was done by the present researcher). Face-to- face interactions could allow for richer data informed by paraverbal and non-verbal as well as verbal communication. This may be particularly relevant for ascertaining the extent to which elements such as internalized stigma may be operative in participants' accounts. Although the present study has undertaken an empowerment audit to review design strategies for addressing the possible presence of internalized stigma, an in-person interview environment would likely provide additional information to bolster a conclusion that internalized stigma is or is not relevant to participant stories.

Although follow-up interviews were considered, they were not conducted in the present study. Future research can enhance the design employed here by meeting or speaking again with research participants on more than one occasion. Follow-up data may serve to enhance participant narratives or, conversely, to challenge or enrich the analytic process.

**Anticipated Criticisms**

Of the limitations that have been thus far discussed, it is anticipated that some will figure more prominently for those who remain critical of this research project, notwithstanding the rationales given above. The largest point of contention will likely concern the shift of study design to have therapists, rather than a Thomas Aquinas (non-therapist) employee, distribute the study notices. It can be argued that such a decision showed weak fidelity to the original design. It can be argued that the Director's rationale that the employee was "too busy" provided an insufficient basis on which to change something so basic in the study design. The fact that the primary researcher was himself a client at the clinic with Nicolosi, with all the associated power imbalances, can cast further doubt on the legitimacy of this change in design.

A second anticipated criticism will likely revolve around the viability of the phenomenological analysis. It may be asserted that the researcher's status as a client held strong potential to "skew" the bracketing as well as data analysis. This concern could be stated even more strongly by those critics who assume that qualitative research is less defensible in controversial domains. Such critics tend to privilege generalizability standards over relevance criteria in evaluating research.

Research on individuals seeking to shift unwanted SSA often raises questions about the pervasiveness of internalized stigmatization in their therapy experiences. For some commentators, internalized stigmatization is seen as the primary motivation for engaging in therapy of this kind. Such critics may argue that this position is supported by the audit results (summarized in Appendix B) that failed to rule out the possibility of stigma influencing these men's accounts.

## Conclusion

The present study has conveyed something of the lived experience of men who have sought therapy for unwanted SSA. These men took the time to contact a researcher they did not know from another country to talk about an extremely intimate and painful part of their lives. Their stories illustrated the struggle to overcome a condition that for them was inimical to the persons they wanted to be and the lives they wanted to live. These are not perfect "before and after narratives," but portraits of struggle, change, and courage. Their voices add to our knowledge of what a fulfilling encounter with psychotherapy can look like. These men spoke of the anguish and pain they experienced as they became aware of SSA in their lives, and of the ways SSA conflicted with deeply held spiritual commitments, emotional health, and/or overall ability to function. Reparative therapy provided a way for them to understand their SSA, and to heal from the shame, past experiences of abuse, and relational deficits that they believed to be central to the development of their unwanted attractions. In their interviews, the men outlined a journey that involved a healing of their masculine identity.

This study has contributed to our understanding of the experiences of men in SOCE. More broadly, it has added to the growing qualitative knowledge of client experience in psychotherapy.

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# APPENDIX A: STUDY NOTICE

William E. Stanus

Telephone: (778) 878-4353
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8842 142A Street
Surrey, British Columbia,
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August 1, 2011

Dear Client:

I am a Master's student in the Counselling Psychology program at Trinity Western University in Langley, British Columbia (Canada). I am asking for your assistance with the completion of my Master's thesis. I am interested in understanding more about the experiences of men who are involved in reparative therapy to reduce unwanted same-sex attractions. There has been much controversy within the mental health field about the benefits and risks of this kind of therapy (as you learned about when you signed your informed consent to treatment form). I would like to give men who are currently in reparative therapy the chance to talk about their therapy experiences.

The format of this study will be phenomenological, and will involve participating in an interview of approximately one hour's length. During that time, you will be asked to talk about the reasons you initially chose to pursue reparative therapy, as well as your experiences in therapy so far. The interview format will be open-ended to allow you to share whatever you feel has been significant, positive, or negative, about your time in reparative therapy. All material you share during your interview will be kept strictly confidential.

If you are a male aged 21 or over, and have been in therapy for unwanted same-sex attractions for at least one year with either Dr. Nicolosi or one of his therapists, you are eligible for participation in this study. Neither Dr. Nicolosi nor any of the other therapists at the Aquinas Clinic will be made aware of your participation. You may, however, choose to inform your therapist of your involvement; this will not affect your ability to participate in the study. If you are interested in being a part of this study, or would like more information, please contact me by telephone or email (provided above) and I would be happy to discuss this project with you further.

Thank you for your time,

William E. Stanus

# APPENDIX B: EMPOWERMENT AUDIT

This appendix summarizes an empowerment audit protocol developed for this study and an audit report conducted by Chelsea Ohlman that examined the strengths and limitations of the present research process. Specifically, the audit addressed the possible presence and impact of internalized stigmatization in the experiences of participants as members of a sexual minority.

## Empowerment Audit Protocol

Many individuals within the mental health establishment as well as the wider culture continue to view the experiences of men who seek reparative therapy with suspicion. Many who critique SOCE assert that individuals undertake these therapies primarily as a result of internalized, homonegative stigma. Such stigma can be acquired through living with societal attitudes that devalue or villainize those who experience SSA, and especially those who wish to adopt a gay identity. Consequently, those men who present for treatments such as reparative therapy are sometimes assumed to be acting under the influence of pervasive, negative social pressures instead of enacting genuine agency (free choice) even when the men themselves claim agentic authenticity. A project such as the present study could not afford to ignore the very real possibility of internalized stigma as an operative element in the stories these men presented. Despite the considerable social advances gay persons in contemporary culture have made with respect to the acquisition of civil rights, it remains the case that SSA and same-sex sexual behaviour continues to be seen in a negative light in some sectors of society in Canada and the USA. These negative social attitudes are particularly true for what may be termed conservative religious traditions, in which several of the study participants

participated. As such, the research team felt it was incumbent to explore the possibility that internalized stigma was or could be present in our participant's narratives. The research team therefore undertook an empowerment audit conducted by another graduate student, Chelsea Ohlmann, with experience in anti-oppressive theory and research methods. The protocol for the empowerment audit was developed by the thesis supervisor for this project. The protocol outlined both the rationale for conducting an empowerment audit and procedures for (a) interviewing the research team (graduate student and supervisor), and (b) reviewing analysis procedures and preliminary results. The thesis student provided the consultant with copies of (a) the design chapter from the research proposal, (b) a 20% selection of meaning units across all five participants in this study, (c) preliminary descriptions from the theme analysis, and (d) a draft discussion of the presence of agency in the results.

Examples of questions from the audit included:

1) How does your research design allow for participants to notice and/or show oppressions faced by men experiencing same-sex attraction?
2) How does your study design allow participants to share their own voice?
3) Do any participants show evidence of being empowered to own their own voice/voices?
4) How might the experiences of participating in psychotherapy clarify or blur experiences of oppression, of personal empowerment, and of growth or decline in personal agency and understanding?
5) What difficulties have you encountered in distinguishing voices of stigma and voices of agency in the lives of participants in this study?

The consultant interviewed the researcher and the thesis supervisor in July 2012 and made an audio recording of the interview. This meeting provided a rich opportunity for the researcher to continue his immersion in the data, and, in a preliminary sense, communicate his results to an audience.

**Key Results of the Audit**

In part, the auditor concluded that:

> It appears that the data gathered provides an adequate basis for grasping the authentic voices of the research participants… It seems as though the participants did feel comfortable within the interview environment and were not hindered from sharing honestly and uninhibited about their experiences. … I am not convinced that the data provides a basis for gaining access to internalized stigma that may be impacting the lives of these men.

The auditor made several recommendations for the research team to consider. A central point made regarding the analytic strategy was to point out that the presence of agency does not, on its own, imply a lack of internalized stigmatization. Both can evidently be present in the same person at the same time. In this regard, the audit conclusions directly complemented a key premise of the present study that exposure to disempowering social environments does not, on its own, erase human capacities for agency, even when people are directly impacted by such oppressions.

In short, although the auditor did not evaluate the available evidence as indicating that interview participants were operating primarily from internalized stigma, the data set and analytic approach did not foreclose on the possibility that they were living with some element of internalized stigmatization. It needs to be acknowledged that internalized

stigma may well be operative in any research report of this kind, particularly with a population caught up in socially powerful controversies. This project has attempted to engage “due diligence” in terms of detecting the extent to which stigma had been operative in the stories of these men. The primary researcher is, on a personal level, convinced that internalized stigma was not present to an extent that would have impugned the validity their stories.