

**UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION**

ROBERT L. VAZZO, LMFT, individually and on behalf of his patients; DAVID H. PICKUP, LMFT, individually and on behalf of his patients; and SOLI DEO GLORIA INTERNATIONAL, INC., d/b/a NEW HEARTS OUTREACH TAMPA BAY, individually and on behalf of its members, constituents, and clients,

Plaintiffs,

v.

CITY OF TAMPA, FLORIDA;

Defendants.

No. 8:17-cv-02896-CEH-AAS

EQUALITY FLORIDA’S SUPPLEMENTAL AMICUS BRIEF

Amicus curiae Equality Florida Institute, Inc., submits this Supplemental Brief, as permitted by the Court.

I. CONVERSION THERAPY IS A SPECIFIC FORM OF MENTAL HEALTH TREATMENT, NOT A “CONVERSATION.”

Far from being a mere “conversation,” as Plaintiffs repeatedly characterized conversion therapy at the November 15 hearing, conversion therapy is a specific form of mental health treatment provided by licensed therapists to their clients in an attempt to “convert” their sexual orientation or gender identity. As its very name shows, “conversion therapy” is not an exchange of ideas or view points, but rather purports to be a legitimate therapeutic treatment to accomplish that change.

Indeed, conversion therapy is portrayed by its practitioners not as a mere “conversation,” but rather as a mental health “treatment” that should be performed in accordance with “practice guidelines” they have prepared. See Nat’l Ass’n for Research & Therapy of Homosexuality, *Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior*, 2 J. Hum. Sexuality 5 (2010) (attached hereto as Ex. 1). Plaintiff Pickup was part of the group preparing these “practice guidelines” for this “treatment.” See Ex. 1 at 38. The very fact that conversion therapists have developed a systemic protocol to guide the practice of conversion therapy belies Plaintiffs’ contention that it is simply a mere conversation.

Notably, although Guideline 2 acknowledges that conversion therapy is not the only possible therapeutic approach, the Guidelines present mental health practitioners who only provide conversion therapy as legitimate therapists. The Guidelines themselves exclusively address the practice of conversion therapy that purports to reduce or eliminate same-sex attraction and provide “guidelines” for how to provide it.

Simply put, conversion therapy is a specific form of therapy intended to try to change a person’s sexual orientation or gender identify, not to just have a talk about it. It proceeds on the baseline assumption that a young person having same-sex attraction can change his or her sexual orientation and that this mental health treatment by a licensed therapist can result in that conversion.

But, all of the leading medical and mental health professional organizations have concluded that conversion therapy is not only ineffective, it poses acute risks for children and adolescents. The sole purpose of Ordinance No. 2017-47 is to protect minors from the

serious harm posed by this discredited and dangerous mental health “treatment.” See Tampa, Fla., Code of Ordinances § 14-311 (prohibiting “any counseling, practice or treatment performed with the goal of changing individual’s sexual orientation or gender identity.”) (emphasis added). The Ordinance does not “[p]revent mental health providers from expressing their views to patients, whether children or adults, about [conversion therapy], homosexuality, or any other topic.” *Pickup v. Brown*, 740 F.3d 1208, 1223 (9th Cir. 2014).

Thus, unlike the statute at issue in *Nat’l Inst. of Family and Life Advocates (“NIFLA”) v. Becerra*, 138 S. Ct. 2361, 2374 (2018), the Ordinance does not regulate “speech as speech,” but rather is directly tied to a particular “procedure” for mental health treatment, which the statute in *NIFLA* was not. If Plaintiffs were having a mere “conversation” with their patients about this therapy, rather than performing a “treatment” intended to change their same-sex attraction, the Ordinance would not reach their speech.

Plaintiffs’ effort to frame this mental health therapy treatment as nothing more than pure speech for First Amendment purposes is meritless. If Plaintiffs were correct, all psychological counseling would be free from governmental regulation, including regulations to prevent harm to minors. Instead, there is widespread regulation of the mental health profession, which has long been held to lie squarely with the government’s power to protect the health and well-being of the public. See Cory Page *et al.*, Behav. Health Workforce Res. Ctr., Univ. of Mich., *National Assessment of Scopes of Practice for the Behavioral Health Workforce* (state-by-state overview of regulation of mental health profession) (attached hereto as Ex. 2). State and local governments do not violate the First Amendment by regulating mental health treatments that are both ineffective and dangerous.

The Supreme Court has explicitly recognized that many regulations designed to protect the public from specific harms may incidentally restrict some speech, but that does not render them subject to heightened First Amendment review. *See, e.g., Giboney v. Empire Storage & Ice Co.*, 336 U.S. 490, 502 (1949) (“[I]t has never been deemed an abridgement of freedom of speech or press to make a course of conduct illegal merely because the conduct was in part initiated, evidenced, or carried out by means of language, either spoken, written, or printed.”); *Ohralik v. Ohio State Bar Ass’n*, 436 U.S. 447, 456 (1978) (State bar could constitutionally regulate lawyers’ in-person solicitation of clients for pecuniary gain in circumstances likely to pose danger, as State does not lose power to regulate commercial activity deemed harmful to public merely because speech is a component of the activity).

In short: “That psychoanalysts employ speech to treat their clients does not entitle them, or their profession, to special First Amendment protection.” *Nat. Ass’n for the Advancement of Psychoanalysis v. California Bd. of Psychology*, 228 F.3d 1043, 1054 (9th Cir. 2000). *See also NIFLA*, 138 S. Ct. at 2373 (“[T]he First Amendment does not prevent restrictions directed at commerce or conduct from imposing incidental burdens on speech . . . , and professionals are no exception to this rule.”) (citation and internal quotation marks omitted).

II. RECENT STUDIES CONFIRM THE HARMS TO MINORS FROM CONVERSION THERAPY.

At the hearing, Plaintiffs claimed that the “state of the research today” is inconclusive as to the ineffectiveness and harm caused by conversion therapy. Hearing Trans. at 73:7-11, 75:5-15. To the contrary, the overwhelming weight of research performed over the years shows that attempts to change a person’s sexual orientation are not only futile, but pose

serious harms, including increased suicidal ideation and serious depression. The City of Tampa relied on that scientific consensus in passing this Ordinance and, since then, the evidence confirming that consensus has grown even stronger.

A recent article published in the *Journal of Homosexuality* found that young people who experienced parent-initiated conversion therapy experienced “depression, suicidal thoughts, suicide attempts” and other problems. See *Journal of Homosexuality, Parent-Initiated Sexual Orientation Change Efforts With LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment* (2018) (attached hereto as Ex. 3); see also Psychology Today, *Gay Conversion Therapy Associated with Suicide Risk*, <https://www.psychologytoday.com/us/blog/political-minds/201811/gay-conversion-therapy-associated-suicide-risk> (last visited Nov. 28, 2018) (discussing study).

The study found that being subjected to conversion therapy during adolescence had a lasting negative impact on “multiple domains of functioning that affect self-care, wellbeing, and adjustment.” *Id.* at 10. In particular, “attempts to change sexual orientation during adolescence were associated with elevated young adult depressive symptoms and suicidal behavior, and with lower levels of young adult life satisfaction, social support, and socioeconomic status.” *Id.*

Although this recent research was published after the City enacted the Ordinance, it is fully consistent with the numerous earlier studies relied on by the City. As such, it is highly relevant to the balancing test this Court must perform as part of its injunction analysis: the serious and inseparable harm to minors that would be caused by enjoining enforcement of the

Ordinance far outweighs any interest Plaintiffs have in performing this particular type of mental health treatment for minors.

Plaintiffs devoted a substantial portion of the hearing to hypotheticals involving gender fluidity and shifting sexual attractions. But the Ordinance does not prohibit therapy that seeks to assist minors in exploring or understanding their sexual orientation or gender identity, whether fluid or not. Conversion therapy does not seek to engage in such exploration of sexuality or gender identity; it seeks to change it.

That *a priori* commitment to the premise that gay or transgender youth can and should change their sexual orientation or gender identity is the hallmark of conversion therapy, but it has been rejected by the leading medical and mental health organizations. This professional consensus recognizes that “[i]nterventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation . . . are coercive, can be harmful, and should not be part of behavioral health treatments.” Substance Abuse & Mental Health Admin., *Ending Conversion Therapy: Support & Affirming LGBTQ Youth* 10 (2015) (emphasis supplied) (attached hereto as Ex. 4).

Just last month, the American Psychiatric Association stood by its 1998 position statement and reiterated its “strong opposition” to “any psychiatric treatment, such as ‘reparative’ or ‘conversion therapy,’ that is based on the assumption that homosexuality per se is a mental disorder is based on the a priori assumption that the patient should change his or her homosexual orientation.” See American Psychiatric Association, *APA Reiterates Strong Opposition to Conversion Therapy*, <https://www.psychiatry.org/newsroom/news-releases/apa-reiterates-strong-opposition-to-conversion-therapy> (last visited Dec. 3, 2018). It

plainly does not believe the evidence of the harm caused by conversion therapy is inconclusive.

Plaintiffs additionally relied heavily at the hearing on a highly limited 2003 study by one college professor. The authoritative research since that time, which was discussed in our initial papers, confirms the harm to minors from conversion therapy that was the basis for the prohibition of such therapy by mental health counselors that was addressed by the Eleventh Circuit in *Keeton v. Cobb County Ga*, 2009 WL 212097 (11th Cir. 2009), in 2011.

III. NARROW TAILORING WAS NOT REQUIRED HERE, BUT THE ORDINANCE IS NARROWLY TAILORED.

At the hearing, Plaintiffs asserted that the decision in *McCullen v. Oakley*, 134 S. Ct. 2518 (2014), required the City to consider “less restrictive” alternatives before passing the Ordinance and established that the Ordinance must be enjoined if no such evaluation was conducted. That decision has no relevance whatsoever to this case.

The regulation struck down in *McCullen* was a “time, place, and manner” restriction that substantially burdened protected First Amendment speech in public forum protests against abortion. The Court held that restriction on speech was subject to the three-part test outlined in *Ward v. Rock Against Racism*, 491 U.S. 781 (1989), including the requirement that it must be “narrowly tailored to serve a significant governmental interest.”

The record in *McCullen* established that although multiple states had passed measures aimed at controlling public protests of abortion at clinics, Massachusetts alone adopted no-protest “buffer zones” around abortion clinics. *Id.* at 2537. Since less restrictive alternatives were being used by other jurisdictions, the Supreme Court expressed “concern that the Commonwealth has too readily forgone options that could serve its interests just as well.” *Id.*

There, the law was not narrowly tailored because it burdened “substantially more speech than necessary to achieve the Commonwealth’s asserted interests.”

This Ordinance does not restrict speech in a public forum and is therefore not even subject to the *Ward* test, which itself involved time, place, or manner restrictions concerning speech in a public forum. In contrast to protests taking place on the public sidewalks in *McCullen*, the provision of professional mental health treatment is not done in a public forum. The purpose of a therapist’s speech in the context of this mental health treatment is not to express the therapist’s views publicly, but rather to provide that treatment in a private setting to their patients.

Because the speech is part of the provision of treatment, it is subject to reasonable regulation as professional conduct. *NIFLA*, 138 S. Ct. at 2373. Accordingly, the “narrow tailoring” requirement applied to the regulation of speech in public forums in *McCullen* has no applicability to this entirely different case.

It bears emphasis that, at the time the City adopted this Ordinance, other governments had adopted almost identical measures to protect minors from the serious harm of conversion therapy. Any lesser restriction would not have eliminated that harm. In fact, those measures had been squarely upheld against First Amendment challenges by two federal courts of appeals, which found the regulations narrowly tailored. See Ordinance, *supra*, at 4 (citing *King v. Governor, N.J.*, 767 F.3d 216 (3d Cir. 2014); *Pickup*, 740 F.3d at 1208). Even if a narrow tailoring requirement applied here—which it does not—the Ordinance would satisfy it.

Plaintiffs further claimed at the hearing that the Ordinance is “under-inclusive” because it does not prohibit conversion counseling by religious leaders. That claim is equally meritless. States and localities have the authority—and the responsibility—to regulate licensed professionals to protect their residents from harm. *See Locke v. Shore*, 634 F.3d 1185, 1196 (11th Cir. 2011) (“States have a compelling interest in the practice of professions within their boundaries, and ... they have broad power to establish standards for licensing practitioners and regulating the practice of professions.”) (quoting *Goldfarb v. Va. State Bar*, 421 U.S. 773, 792 (1975)).

By contrast, states and localities have much more limited constitutional authority to regulate the conduct of religious leaders and faith communities and have often exempted them from a wide variety of generally applicable laws. *See, e.g., Hobbie v. Unemp’t Appeals Comm’n of Fla.*, 480 U.S. 136, 144-45 (1987) (stating that the Supreme Court “has long recognized that the government may (and sometimes must) accommodate religious practices” and listing examples); *see also Hosanna-Tabor Evangelical Lutheran Church & Sch. v. EEOC*, 565 U.S. 171, 199-200 (2012) (holding that the First Amendment precludes the application of employment discrimination laws to disputes between religious organizations and their ministers).

In any event, “the First Amendment imposes no freestanding ‘underinclusiveness limitation.’” *Williams-Yulee v. Fla. Bar*, 135 S. Ct. 1656, 1668 (2015) (citing *R.A.V. v. St. Paul*, 505 U.S. 377, 387 (1992)). “A State need not address all aspects of a problem in one fell swoop; policymakers may focus on their most pressing concerns.” *Id.* Indeed, “even

under strict scrutiny,” the Supreme Court has upheld laws “that conceivably could have restricted even greater amounts of speech in service of their stated interests.” *Id.*

Finally, Plaintiffs argued strenuously at the hearing that the City could have accomplished its objectives by only banning “forced” conversion therapy for minors. But, such a limitation would leave many minors vulnerable, undermining the City’s goal of protecting all youth from the serious harms caused by conversion therapy. Research shows that children and teenagers may “agree” to enter conversion therapy to please their parents or avoid family rejection. *See* Am. Psychological Ass’n, *Appropriate Therapeutic Responses to Sexual Orientation* 91 (2009) (“APA Report”) at 45-46, 50-51 (attached hereto as Ex. 5). These minors may then become distraught when they are unable to change their sexual orientation—suffering the very harms the Ordinance seeks to prevent. *See id.*

Thus, the purpose of the Ordinance would be defeated by creating an exception for youth who “voluntarily” agree to undergo these practices. As the American Psychological Association has noted, therapy that attempts to change sexual orientation provides no benefits, while putting patients at risk of harm. As such, it would be inappropriate to apply an “informed consent” framework to permit conversion therapy for minors, just as it would be inappropriate to do so for a medication that provides no benefits, while causing serious potential harms.

CONCLUSION

Amicus Curiae Equality Florida respectfully ask that the Court grant the City’s motion to dismiss Plaintiffs’ amended complaint with prejudice and deny Plaintiffs’ amended motion for a preliminary injunction.

Respectfully submitted,

/s/ Sylvia Walbolt

Sylvia H. Walbolt
Florida Bar No. 0033604
swalbolt@carltonfields.com
Brian C. Porter
Florida Bar No. 0120282
bporter@carltonfields.com
CARLTON FIELDS JORDEN BURT,
P.A.
4221 W. Boy Scout Boulevard
Tampa, FL 33607-5780
Telephone: (813) 223-7000
Facsimile: (813) 229-4133

Shannon Minter
sminter@nclrights.org
Christopher Stoll
cstoll@nclrights.org
NATIONAL CENTER FOR
LESBIAN RIGHTS
870 Market Street
Suite 370
San Francisco, CA 94102
Telephone: (415) 392-6257

Scott D. McCoy
Florida Bar No. 1004965
scott.mccoy@splcenter.org
David C. Dinielli
david.dinielli@splcenter.org
J. Tyler Clemons
tyler.clemons@splcenter.org
SOUTHERN POVERTY LAW
CENTER
106 East College Avenue
Tallahassee, FL 32301
Telephone: (850) 521-3042

*Attorneys for Amicus Curiae Equality
Florida Institute Inc.*

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on December 3, 2018, the foregoing was electronically filed with the Clerk of Court by using the CM/ECF system, which will also send a notice of electronic filing to all counsel of record.

/s/ Sylvia Walbolt
Attorney

Introduction

Clinical intervention for those who desire to change their unwanted same-sex attractions and behavior is an increasingly controversial subject. Within the sociopolitical environment that currently dominates mental health associations (Cummings, O'Donahue, & Cummings, 2009; Redding, 2001; Wright & Cummings, 2005), individuals who pursue and/or report greater heterosexual functioning through psychotherapy may have their experiences of change marginalized or invalidated.

One possible reason for such marginalization is the increasing number of resolutions, position statements, and practice guidelines produced by professional psychological associations that are related to therapeutic approaches to sexual orientation (e.g., American Psychological Association, 2000, 2009). While these documents contain much helpful information with which clinicians should be familiar, they are nonetheless limited by their lack of diverse professional perspectives (Yarhouse, 2009). Specifically, they often appear to be produced by partisan committees whose members do not generally share the goals, values, or worldviews of many clients who seek assistance in changing unwanted same-sex attractions and associated feelings, fantasies, and behaviors.

This document is intended to provide educational and treatment guidance to clinicians who affirm the right of clients to pursue change of unwanted same-sex behavior and attractions. The specific goals of these guidelines are twofold: (1) to promote professional practice that maximizes positive outcomes and reduces the potential for harm among clients who seek change-oriented intervention for unwanted same-sex attractions and behavior, and (2) to provide information that corrects stereotypes or mischaracterizations of change-oriented intervention and those who seek it.

The very right of clients to pursue change-oriented intervention continues to be questioned within mental health associations (American Psychological Association, 2009; Kaplan et al., 2009; Yarhouse & Throckmorton, 2001, 2002). As a result, the National Association for Research and Therapy of Homosexuality (NARTH) Board and

Scientific Advisory Committee concluded that the development of guidelines by and for clinicians who actually engage in this practice is urgently needed. A practice guideline task force was subsequently formed to develop this document. An initial draft document was sent for review to the NARTH board and the association's professional membership; all feedback was considered and, where deemed beneficial, incorporated into the final version of the practice guidelines.

The term *guidelines* refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for clinicians. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. By contrast, guidelines are aspirational in intent and are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by clinicians. Because practice guidelines are not mandatory, exhaustive, or applicable to every professional and clinical situation, they should be used to supplement accepted principles of psychotherapy, not to replace them.

The guidelines outlined in this document are not intended to serve as a standard of clinical care. Instead, they simply reflect the state of the art in the practice of psychotherapy with same-sex-attracted clients who want to decrease homosexual functioning and/or increase heterosexual functioning. These guidelines are organized into three sections: (a) attitudes toward clients who seek change, (b) treatment considerations, and (c) education.

Attitudes Toward Clients Who Seek Change

Guideline 1. Clinicians are encouraged to recognize the complexity and limitations in understanding the etiology of same-sex attractions.

The standard opinion among behavioral scientists is that the causes of human behavior are multifactorial (Rutter, 2006). There is also general consensus that the

etiology of homosexuality is multifactorial (e.g., Gallagher, McFalls, & Vreeland, 1993; Otis & Skinner, 2004), as are the reasons that cause some to view their same-sex attractions and behaviors as unwanted (cf. Guideline 3).

Over time, there have been vastly different theories about etiology, and a broad variety of approaches to intervention have been used. Theories about the origin of same-sex attraction have often been adopted when a particular approach proved adequate—leading a counselor, therapist, or client to draw a particular conclusion about what “caused” the attraction. The strongest childhood correlate of an adult same-sex orientation is that of clinical Gender Identity Disorder, which has been associated with subsequent homosexuality in 50 percent or more of cases in longitudinal studies (e.g., Zucker & Bradley, 1995). However, the low prevalence of full-fledged Gender Identity Disorder among those who experience same-sex attractions means that this explanation likely applies in only a minority of cases, although subclinical gender identity concerns may be more common.

Sociological research has not shown any one environmental, familial, or social factor as a predominant factor in same-sex attractions for the majority of gay and lesbian people. The exhaustive work of Bell, Weinberg, and Hammersmith (1981) considered all known factors to that date and concluded that each could only be numerically responsible for a small fraction of the causation. This was confirmed by the work of Van Wyk and Geist (1984). Biological research does not show one predominant cause; in fact, most influences have been numerically minor, though many individual correlations have achieved statistical significance (Bogaert, 2007; James, 2006; Lalumiere, Blanchard, & Zucker, 2000; Martin & Nguyen, 2004; Meyer-Bahlburg, Dolezal, Baker, & New, 2008; Rahman, Kumari, & Wilson, 2003). The degree of concordance of sexual orientation in twins is the result of multiple influences, whether known to researchers or not, and twin studies suggest that multiple individual responses predominate to a degree that had not been expected (Bailey, Dunne, & Martin, 2000; Bearman & Bruckner, 2002; Hershberger, 1997; Langstrom, Rahman, Carlstrom, & Lichtenstein, 2008; Santtila et al., 2008).

Therefore, clinicians need to take client histories seriously and not impose on all clients any particular etiological theories, even if those theories have been clearly applicable in other cases. On the other hand, a client may for psychological reasons deny events or processes that to the clinician are obvious causes; in such cases, it may be legitimate to address this with the client. A balance must be struck between taking client histories very seriously and retaining therapeutic objectivity. It is also important to consult peers and to increase understanding by collating influences that clients have found important.

Although no overwhelmingly predominant factors are likely to be found, several broad themes are already known to potentially lead to same-sex attraction and behavior. In no particular order, these include but are not limited to sexual abuse (James, 2005; Wilson & Widom, 2010), relationships with parents (Francis, 2008), relationships with same-sex peers (Bem, 1996), political solidarity (Rosenbluth, 1997; Whisman, 1996), and atypical mental or physical/biological gender characteristics (Zucker & Bradley, 1995).

Discretion is necessary in exploring the etiology of same-sex attractions in any particular client, as is suggested by the fact that leading mental health organizations are noncommittal about etiology (American Psychological Association, 2008a). Nevertheless, a broad but unified understanding of these diverse influences might be found in viewing same-sex attractions and behavior as a developmental adaptation to less-than-optimal biological and/or psychosocial environments, possibly in conjunction with a weak and indirect genetic predisposition.³ Such an adaptation and the resulting same-sex attraction may distress some people either because it violates their values and/or because the subsequent behaviors may place them at risk for mental illness and physical disease (cf. Guidelines 7 and 11).

Given the complexity of this topic, clinicians who work with clients who have unwanted same-sex attractions and behavior must be even more concerned about and committed to contributing data for research, subject to the usual confidentiality

requirements. These contributions would help broaden everyone's understanding of the etiology of same-sex attractions and behaviors.

Guideline 2. Clinicians are encouraged to understand how their values, attitudes, and knowledge about homosexuality affect their assessment of and intervention with clients who present with unwanted same-sex attractions and behavior.

When individuals enter into psychotherapy and express conflicted feelings, thoughts, or values about their same-sex attractions (or any other issues), clinicians are impacted by their own values and biases as they engage these clients. A clinician's values and biases help determine the theories, techniques, and attitudes used to help these clients explore their presenting issues (Jones, 1994; Meehl, 1993; Midgley, 1992; O'Donohue, 1989; Redding, 2001).

Professional mental health associations have historically recognized this principle in their ethical guidelines, which call on clinicians to be aware of their own belief systems, values, needs, and limitations and how these factors affect their work (e.g., American Association of Marriage and Family Therapy, 2001; American Psychological Association, 2002). More recently, clinicians have been encouraged to exercise reasonable judgment and "take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices" (American Psychological Association, 2002, Ethical Principles, Principle D, pp. 1062–1063). Mental health associations have also recognized that sexuality and religiosity are important aspects of personality (American Psychological Association, 2008b)—and clinicians are encouraged to be aware of and respect cultural and individual differences, including those pertaining to religion and sexual orientation, when working with clients for whom these dimensions are particularly salient (American Psychological Association, 2002; cf. Guideline 3).

A client whose presenting problem is a need to clarify conflicted attitudes toward same-sex attractions represents a microcosm of the moral, legal, and psychological

conflicts regarding homosexuality in our society. Clinicians need to be aware that, historically, same-sex attractions and behavior were considered as a moral issue (sin) by theologians and laypersons, as a legal problem (crime) by legislators, and only later as a psychological phenomenon (psychic disturbance) by clinicians and others (Katz, 1976). Same-sex attractions and behaviors were—and to a significantly lesser extent still are—seen or experienced in our culture as moral failures to be judged (Gallup, 1998; Schmalz, 1993); criminal acts to be prosecuted (Posner & Silbaugh, 1996; Rubenstein, 1996); behaviors to be stigmatized and discriminated against (Rubenstein, 1996; Eskridge & Hunter, 1997); and, until 1974, disorders in and of themselves that needed to be treated (American Psychiatric Association, 1972).

The last few decades have brought about significant changes in the moral valuation, legal status, and psychological description of homosexuality. The change in description was reflected when in 1973 the American Psychiatric Association removed homosexuality in and of itself as a pathological condition from the DSM (Diagnostic and Statistical Manual of Mental Disorders). At this time the legitimacy, effectiveness, and ethicality of change-oriented interventions also came into question. This in turn led to most mental health associations asserting that homosexual orientation and/or attractions could never be modified (e.g. American Psychological Association, 2000, 2008a). Within this exclusively gay-affirmative position, the presumed and prescribed optimal outcome of therapy for clients ambivalent about their attractions to the same gender is developing and achieving acceptance of and identification with their sexual desires.

Clinicians who continue to practice change-oriented counseling believe change is possible and available for many highly motivated clients who want to lessen their same-sex attraction, develop and increase their opposite-sex attractions and identification, or achieve stability within an abstinence-based life (Byrd & Nicolosi, 2002; NARTH, 2009).

Other clinicians can identify with both of these positions. When counseling a client with ambivalence about same-sex attractions, these clinicians look at both the goals

of change and the goals of the gay-affirmative stance as possible and ethical without an exclusive value commitment to either one (Throckmorton & Yarhouse, 2006).

As clinicians approach the task of assessment, informed consent, and goal setting, they need to consider the complexities of sexual orientation and its development (cf Guideline 1). Many social scientists share an interactionist perspective that sexual orientation is shaped for most people through the complex interaction of biological, psychological, and social factors (cf. Guideline 1). There is a lack of consensus about how to best measure sexual orientation and what constitutes its central dimensions, be they attractions, behavior, fantasies, identification, or some combination of these elements (Kinnish, Strassberg, & Turner, 2005; Moradi, Mohr, Worthington, & Fassinger, 2009; Sell, 1997; Throckmorton & Yarhouse, 2006). This leads to further problems with estimating prevalence rates and measuring the reliability of sexual orientation (Byne, 1995; Laumann, Gagnon, Michael, & Michaels, 1994; Stein, 1999). In addition, after December 1973, when homosexuality in and of itself was no longer categorized as a disorder, research on the possibility of changing unwanted same-sex attractions became much less prevalent in the professional literature (Jones & Yarhouse, 2007).

Along with considering the above, clinicians are encouraged to reflect on some specific potential biases they may encounter when they start exploring a client's issues. Clinicians who have adopted a primarily gay-affirming stance tend to focus on research literature that emphasizes a lack of difference in pathology between individuals with same-sex attractions and the rest of the population—research that attributes differences between the two populations to internalized homophobia and external stressors (Gonsiorek, 1991). They may ignore the possible etiological significance of social and developmental factors, such as a higher incidence of childhood sexual abuse, particularly for men (Eskin, Kaynak-Demir, & Demir, 2005; Fields, Malebranche, & Feist-Price, 2008; James, 2005; Stoddard, Dibble, & Fineman, 2009; Tomeo, Templer, Anderson, & Kotler, 2001; Wilson & Widom, 2010). They might also emphasize the

methodological limitations in the research literature that indicate the possible efficacy of change intervention (American Psychological Association, 2009; Gonsiorek, 1991), even though there appears to be no satisfactory measure of sexual orientation (or its change) in the literature (Jones & Yarhouse, 2007; Moradi et al, 2009). They are likely to dismiss the research into psychodynamic and other theories that can be used to support change interventions (American Psychological Association, 2009; Bell et al., 1981) based on methodological limitations—ignoring the fact that the quality of these studies, although not impressive by contemporary standards, was nevertheless “state of the art” and good enough to merit publication in respected professional journals. Moreover, the early research that supported the possibility of change is comparable to other studies on homosexuality in the literature of the time that are still held in good repute (Jones & Yarhouse, 2007) and referenced uncritically in contemporary discussions about change-oriented treatment (cf. American Psychological Association, 2009), probably because they support a favored sociopolitical point of view.

Furthermore, clinicians with a strong gay-affirming position may tend to emphasize clinical literature that describes examples of harm—such as disappointment in not achieving complete sexual reorientation—in the course of change-oriented therapy and may decide that conducting such therapy is clearly unethical and harmful (Gonsiorek, 2004; Murphy, 1992; Tozer & McClanahan, 1999; Worthington, 2004). They may maintain this view even when clients explicitly say they want to change their unwanted same-sex attractions and/or behavior (Gonsiorek, 2004). These clinicians may believe that clients cannot establish realistic therapeutic goals for themselves nor make a truly voluntary decision to develop their heterosexual potential, assuming that clients want to change only because they have been oppressed and discriminated against by society (Tozer & McClanahan, 1999). They may discount the reality that many clients who want to explore the possibility of change experience significant conflict between their religious beliefs and their same-sex attraction (Beckstead & Morrow, 2004; Haldeman, 1994,

2004; Yarhouse & Tan, 2004), and that religious affiliation may be the most stable aspect of a client's identity (Johnson, 1995; Koenig, 1993). Some clinicians have even equated agreeing to help someone develop their heterosexual potential as analogous to agreeing to help an anorexic lose weight (Green, 2003). They may tend to espouse the immutability of sexual orientation, basing this conclusion on unsubstantiated biological research—a conclusion that remains premature (Garnets & Peplau, 2001; James, 2005; Stein, 1999; Yarhouse & Throckmorton, 2002).

Biases may impact clinicians on the other side of the issue as well. Clinicians who practice a primarily change-oriented intervention approach to unwanted same-sex attractions may overly interpret the likelihood and extent of probable change, oversimplifying or overselling the process of change according to their preferred (often psychodynamic) theory. They may not take into sufficient account the uniqueness of a particular client's history of same-sex or opposite-sex interest/arousal/behavioral patterns, and they may underestimate the possible therapeutic harm that may result from such oversimplification (Buxton, 2004), such as causing clients to feel misunderstood and misrepresented (Beckstead, 2001; Haldeman, 2002; Shildo & Schroeder, 2002; Shildo, Schroeder, & Drescher, 2001). They may be tempted to ignore the reality that only a minority of clients with unwanted same-sex attractions achieve complete change toward heterosexual capacity and functioning, even though they face enormous social sanctions throughout their lives (Green, 2003).

Change-oriented clinicians might also tend to minimize the research on the effect of social pressures and internalized societal attitudes toward homosexuality as possible factors contributing to a client's symptoms (DiPlacido, 1998; Maylon, 1982; Mays & Cochran, 2001; Meyer & Dean, 1998; Shildo, 1994). They might also minimize research suggesting that homosexual men and women who report lower internalized homophobia generally have fewer related problems (Meyer & Dean, 1998). Some clinicians who practice primarily change-oriented intervention might automatically assume that outside

pressure to move away from unwanted same-sex attractions is congruent with clients' value systems and should be honored, and might as a result neglect a deeper exploration of the issues (Green, 2003; cf. Guideline 8). Some of these clinicians may suggest to clients that change in unwanted same-sex attractions would be potential relief from a pathological condition when it would be more helpful to look at it as a "clinical problem" (Engelhardt, 1996)—especially for clients who are leaning toward integrating a gay identity and who find a focus on pathology unhelpful (Liddle, 1996) or harmful (Shildo & Schroeder, 2002), or for clients who have been made vulnerable by repetitive, traumatic anti-gay experiences (Haldeman, 2002).

There are also biases that affect both gay-affirmative and change-oriented clinicians. Both—especially if they are actively involved in the cultural debate surrounding the moral, legal, and psychological aspects of homosexuality in society—may dismiss the need to refer clients. This may be a risk particularly when, during the goal-setting process, it becomes clear that the value position of the counselor is in clear conflict with the client's goals (Haldeman, 2004; Liszez & Yarhouse, 2005). Clinicians may need to refer if they are unable to identify with religiously based identity outcomes (Throckmorton & Welton, 2005) or with the less sexually monogamous norms of a significant portion of the gay culture (Bepko & Johnson, 2000; Bonello & Cross, 2010; Laumann et al., 1994; Martell & Prince, 2005; Mercer, Hart, Johnson, & Cassell, 2009; Prestage et al., 2008; Shernoff, 1999, 2006; Spitalnick & McNair, 2005). A clinician may also find it objectionable to refer clients to a needed supportive community whose values the clinician does not accept (Yarhouse & Brooke, 2005).

Clinicians who adopt a primarily more flexible position than either gay-affirmative or change-oriented clinicians are less likely to be impacted by these sorts of biases during the initial phase of assessment, informed consent, and goal setting (Throckmorton & Yarhouse, 2006). Yet these therapists may tend to wait too long to encourage a client to move out of contemplative ambivalence, thus losing opportunities

to help a client experiment with new behaviors, attitudes, and adaptations (Buxton, 2004). This could be due to a clinician's own ambivalences toward the possibility of change or to the clinician not being able to fully identify with the sexual value system of the gay or conservative religious subcultures (Bepko & Johnson, 2000; Rosik, 2003a).

Clinicians who do not exclusively offer change-oriented intervention may not fully appreciate the experience of clinicians who do and who often find that effective working alliances can come into play only when the counselor and client both view unwanted same-sex attractions from similar value positions. From this perspective, their more flexible position of addressing the therapeutic needs of both change-seeking and gay-affirmative clients can dilute the power of the alliance and leave the client feeling incompletely understood and incompletely supported (Nicolosi, Byrd, & Potts, 2000; Rosik, 2003a, 2003b). In addition to the above considerations, gay-affirmative and change-oriented clinicians working with adolescents may need to exercise extra caution: at this developmental stage, the experience of sexual identification is more fluid, and adolescents may experience pressure toward resolution as unhelpful (Cates, 2007; McConaghy, 1993; Remafedi, Resnick, Blum, & Harris, 1992; Savin-Williams, 2005; cf. Guideline 9).

Mental health professionals are in conflict on how best to help individuals who enter psychotherapy expressing conflicted feelings, thoughts, or values about their same-sex attractions and behavior. Since conservative and traditional views are presently underrepresented in the mental health profession (Redding, 2001), there is serious risk that a counselor's response will be negative toward a client who is leaning toward change. Because of that, it is important for clinicians to become familiar with a range of therapeutic options for clients who experience religious and sexual identity conflicts, including options that validate a client's decision to develop heterosexual potential (Beckstead & Morrow, 2004; Haldeman, 2004; Rosik, 2003a; Throckmorton & Yarhouse, 2006). It is recommended that clinicians consider these options as part of a reflective, ethical practice.

Guideline 3. Clinicians are encouraged to respect the value of clients' religious faith and refrain from making disparaging assumptions about their motivations for pursuing change-oriented interventions.

Research indicates that the majority of people who present to clinicians with unwanted same-sex attractions are motivated in part by deeply held religious values (Jones & Yarhouse, 2007; Nicolosi et al., 2000; Spitzer, 2003). However, studies consistently report that mental health professionals are less religious than the general population across several dimensions of participation and belief (Bergin & Jensen, 1990; Delaney, Miller, & Bisono, 2007; Neeleman & King, 1993). A lack of familiarity with religious beliefs and values in general—and those of the client in particular—can negatively affect the course and outcome of interventions with clients whose faith motivates the pursuit of change in same-sex behaviors and attractions. Respect for religion as a dimension of diversity within psychology underscores the need for attention to this risk (Benoit, 2005; Buxton, 2004; Yarhouse & Burkett, 2002; Yarhouse & VanOrman, 1999).

Religious motivations should not be immune from scrutiny in psychotherapy, but clinicians need to be extremely cautious about pathologizing religious values that may prompt a client to attempt to modify unwanted same-sex attractions and behavior. A lack of conservative and religious representation among mental health professionals compared to the general population (Delaney et al., 2007; Redding, 2001) suggests a considerable danger of clinicians misinterpreting or invalidating the motives of religious and conservative clients. One way in which that occurs is when religious beliefs that motivate clients to modify their unwanted same-sex attractions are too quickly and uniformly labeled as internalized homophobia (such as Herek, Gillis, & Cogan, 2009). Differences in moral values between therapists, counselors, and their religiously identified clients concerning sexuality can easily become the object of clinical suspicion, with the tacit and inappropriate assumption that the counselor's values are superior to and should override

those of the client (Haidt & Hersh, 2001; Kendler, 1999; Miller, 2001; O'Donahue & Caselles, 2005; Rosik, 2003a, 2003b, 2007a, 2007b).

Clinicians can benefit by examining the role that worldview similarity—particularly with regard to moral epistemology—plays in their attitudes toward clients who ask for help developing their heterosexual potential. For example, five domains of moral concerns have been identified across cultures: 1) concerns for the suffering of others; 2) concerns about unfair treatment, inequality, and justice; 3) concerns related to obligations of group membership (such as religious identification); 4) concerns related to social cohesion and respect for tradition and authority; and 5) concerns related to physical and spiritual purity and the sacred (Graham, Haidt, & Nosek, 2009; Haidt & Graham, 2007, 2009; McAdams et al., 2008). The first two moral domains focus on the individual as the center of moral value, with an aim of protecting the individual directly and teaching respect for individual rights. The other three domains emphasize the value of groups and institutions in binding individuals into roles and duties for the good of society.

The research of Haidt and his colleagues (2001, 2007, 2009) has indicated that conservative people tend to utilize all five of these domains in their moral thinking, while liberal people tend to rely much more on the first two concerns. These differences can lead liberal people to misunderstand the moral concerns of conservative individuals more than conservatives misconstrue the concerns of liberals. Furthermore, the moral concerns of conservative individuals regarding group loyalty, respect for authority and tradition, and purity/sacredness tend to be rejected by liberal individuals (including many mental health professionals)—who, in fact, consider those concerns immoral if they seem to be in conflict with their own emphasis on harm, rights, and justice. Respectful awareness of such differences can promote a positive therapeutic environment for clients who, for religious or other morally motivated reasons, pursue change in their unwanted same-sex attractions and behavior.

Another means of marginalizing religious belief within the general practice of psychology has been to completely separate psychology and religion—to deem religiously motivated psychotherapeutic attempts to change unwanted same-sex attractions and behavior as essentially religious pursuits that have no place in a science-based clinical practice (American Psychological Association, 2009; Silverstein, 2003). This perspective creates a strict demarcation that is not supportable given the enormous overlap between psychology and religion in their philosophical and anthropological areas of inquiry, such as theories of human nature (Auger, 2004; Bain, Kashima, & Haslam, 2006; Jones, 1994; O'Donahue, 1989). This perspective can also represent some degree of philosophical naïveté or professional hubris, since the empirical methods of psychology contain their own “innate” values and are also influenced by the value assumptions of researchers (Fife & Whiting, 2007; Slife, 2006, 2008; Slife & Reber, 2009). These methods are not theologically or philosophically neutral, nor do they enable research to proceed without the application of interpretive biases of some sort—particularly when investigating value-laden subjects such as change-oriented interventions. Conversely, established religious and theological traditions are not bereft of a degree of objective and empirical validation; when they have not become corrupted by power, they have been valid and useful for understanding and directing human behavior for hundreds, if not thousands, of years (Stark, 2005).

A professional stance that endorses dialogue between religion and psychology is to be preferred over one that situates them in opposition to one another in order to place certain religiously motivated therapeutic goals outside the domain of mental health practice (Gregory, Pomerantz, Pettibone, & Segrist, 2008). Clinicians are therefore encouraged to utilize the insights from social science to inform and guide—rather than to obstruct and proscribe—their clinical practice with religiously identified clients who pursue change-oriented intervention.

Guideline 4. Clinicians strive to respect the dignity and self-determination of all their clients, including those who seek to change unwanted same-sex attractions and behavior.

Professional clinicians ascribe to the general ethical principle of individual autonomy and self-determination (e.g., Principle E: Respect for People's Rights and Dignity; American Psychological Association, 2002). Clinicians are encouraged to avoid viewing individuals who seek to change their unwanted same-sex attractions, sexual orientation, or sexual identity as an exception to this general ethical principle. Likewise, professionals strive to view clients as fully capable of pursuing self-determination or able to respond in an autonomous manner to the source of their distress (Byrd, 2008). In harmony with that attitude, clinicians act in an ethical and humane manner and provide a valued service to clients when they respect a client's right to self-determination and autonomy when the client seeks change interventions for unwanted same-sex attractions and behavior (Benoit, 2005).

A focus on self-determination and autonomy does not elevate this ethical consideration above others in addressing the provision of change-oriented interventions (American Psychological Association, 2009). However, this ethical issue is often stressed in the change-oriented literature precisely because it is the ethical guideline most directly impacted by the threat of professional restrictions on such care. Restricting client self-determination to pursue change-oriented intervention on the basis of a lack of empirical efficacy, even if accurate, should in fairness make clinicians stop using many other experimental and unsupported treatment modalities that are currently practiced. Nor does the limiting of client autonomy appear to be warranted by the potential for harm in change-oriented interventions. No harm has been definitively linked to such interventions as a whole (American Psychological Association, 2009), and potential harm can likely be resolved by suitable precautions such as those offered in these guidelines.

Clients enter therapy with values that guide their goals for therapy. Whether religious or personal, such values may lead individuals to seek change interventions

for unwanted same-sex attractions and behavior. In treatment settings, professionals respect the autonomy and right of self-determination of individuals who seek change interventions for unwanted same-sex attractions and behavior, as well as those individuals who do not desire such interventions. Clinicians are encouraged to refrain from persuading clients to select interventions that are contrary to their personal values (American Psychological Association, 2008a; Haldeman, 2004).

Professionals support the principle that individuals are capable of making their own choices in response to same-sex attractions and promote autonomy and self-determination by: (a) acknowledging a client's choice or desire to seek intervention for unwanted same-sex attractions and behavior; (b) exploring why these attractions and behaviors are distressing to the client (Jones & Yarhouse, 2007); (c) addressing the cultural and political pressures surrounding choice in response to same-sex attractions; (d) discussing the available range of professional therapies and resources (Jones & Yarhouse, 2007); (e) providing understandable information on outcome research related to change interventions (NARTH, 2009); and (f) obtaining informed consent for treatment (Rosik, 2003a; Yarhouse, 1998a; cf. Guideline 5).

Value conflicts with the broader culture are more likely to be experienced by clients who opt for gay-affirmative interventions. However, the more sociopolitically liberal and secular worldview of licensed clinicians heightens the probability that value conflicts in the clinical setting are more likely to occur among clients who pursue change-oriented interventions. The clinician's commitment to respecting client autonomy and self-determination may be especially tested when working with people reporting unwanted same-sex attractions and behavior. Clinicians risk violating the client's right to autonomy and self-determination when they attempt to deny a client the opportunity to engage in change interventions, view the client as incapable of making choices among intervention options, or withhold information about a full range of therapeutic choices. Such violations of client rights may risk harm to the client (Byrd, 2008).

Treatment Considerations

Guideline 5. At the outset of treatment, clinicians strive to provide clients with information on change-oriented processes and intervention outcomes that is both accurate and sufficient for informed consent.

Clinicians from all of the mental health professions provide clients with informed consent at the beginning of treatment (e.g., American Psychological Association, 2002, Ethical Standards 3.10 & 10.01; American Association for Marriage and Family Therapy, 2001, Ethical Standard 1.2; National Association of Social Workers, 2000). Ethically, those who serve clients with unwanted same-sex feelings and behaviors—or any psychological, behavioral, or relational concerns—offer accurate information both about the process of change and the kinds and likelihood of changes that are possible.

Adequate informed consent is an important part of therapeutic “beneficence and nonmaleficence” through which clinicians “strive to benefit those with whom they work and take care to do no harm . . . [and] seek to safeguard the welfare and rights of those with whom they interact professionally” (American Psychological Association, 2002, General Principle A, p. 1062). Informed consent also encourages and expresses clinical “competence,” through which clinicians “provide services . . . with populations and in areas only within the boundaries of their competence.” Clinicians inform their clients about the clinical “education, training, supervised experience, consultation, study, or professional experience” that contributed to their competence (American Psychological Association, 2002, Ethical Standard 2.01, p. 1063).

Since 1973, homosexuality itself has no longer been formally considered to be pathological (American Psychiatric Association, 1973; American Psychological Association, 1975). But distress concerning sexual orientation is still a diagnosable, treatable condition under the category *Sexual Disorder Not Otherwise Specified* (American Psychiatric Association, 2000), and some instances of unwanted same-sex

attractions may fall under this category. As even gay-identified scholars have asserted, developmental issues that contribute to a person's distress about her or his sexual orientation are valid topics for research (Morin & Rothblum, 1991).

This also holds true when considering intervention for unwanted same-sex attractions and behavior. Contrary to current attitudes explicit or implicit in the professional and lay media, "regardless of pathology, cultural trends, or current political rhetoric, mental health issues for homosexuals remain clinically significant and, like all others, must be addressed by the clinician with competence" (Monachello, 2006, p. 56). Clinicians who help clients distressed about their same-sex attractions and behavior are being ethically responsible, respecting "the dignity and worth of all people, and the rights of individuals to . . . self-determination" (American Psychological Association, 2002, General Principles, Principle E, p. 1063).

In helping clients resolve unwanted same-sex behavior and attraction, clinicians are mindful that the phenomena of male and female homosexuality and the related concept of "sexual orientation"—the gender(s) of the persons to whom one is sexually and/or affectionately attracted and with whom one experiences love and/or sexual arousal—are not universally defined, fixed, discrete, one-dimensional constructs (Weinrich & Klein, 2002; Worthington & Reynolds, 2009). A person's perceived or self-declared sexual orientation may or may not be consistent with actual sexual behaviors, thoughts, or fantasies (Schneider, Brown, & Glassgold, 2002). Moreover, clients' responses to unwanted same-sex experiences may vary from obsessive anxiety that they—or a dependent family member—may develop same-gender sexual attractions, to feeling but never having acted upon such attractions, to having gratified them in a single, occasional, habitual, or even addictive manner.

Clinicians will assess the nature of their clients' actual experience of unwanted same-sex feelings, thoughts, and behaviors as part of informing the clients of possible treatment outcomes and developing a mutually agreed-upon plan for intervention.

Such assessment will explore the possible presence of many co-occurring medical, psychological, behavioral, and relational difficulties that either contribute to and/or may be consequences of a client's unwanted same-sex attractions or behaviors (cf. Guideline 9). Clinicians also will assess the nature of their clients' spiritual and religious involvement and motivation in order to respect their clients' rights, dignity, and need for self-determination (cf. Guidelines 3 and 4). Appropriate referrals for allied medical, mental, and/or pastoral health care may be an appropriate component of informed consent and goal setting (cf. Guideline 8).

When discussing the possibilities for change, it is important to explain that, as with any intensive course of intervention, achievement of significant change(s) of unwanted same-sex attractions and/or behaviors requires sufficient motivation, hard work, and patience, with no guarantees of "success" (Haldeman, 1991, 1994, 2001). But when discussing the possibilities of successful changes, it is heartening to note that successful intervention has been reported in the clinical and scientific literature for the past 125 years. More than 150 reports spanning the end of the nineteenth century through the beginning of the twenty-first have documented successful change(s) in sexual attractions, thoughts, fantasy, and/or behaviors from same-sex to opposite-sex (Byrd & Nicolosi, 2002; NARTH, 2009; Throckmorton, 2002).

While not an exhaustive list, reports of change range in size from single-client case studies to group studies involving hundreds of clients. The various therapeutic paradigms used have included psychoanalysis (Bieber, Dain, Dince, Drellich, & Grand, 1962; MacIntosh, 1994) and experiential or other psychodynamic approaches (Berger, 1994; Nicolosi, 2009); hypnosis; behavior and cognitive therapies (Bancroft, 1974; Birk, Huddleston, Miller, & Cohler, 1971; Throckmorton, 1998); sex therapies (Masters & Johnson, 1979; Pomeroy, 1972; Schwartz & Masters, 1984); group therapies; religiously mediated interventions (Jones & Yarhouse, 2007); and various combinations of therapies (Karten & Wade, 2010), among others. Non-theory-driven, serendipitous change has also

been reported in response to psychotropic medication and brain injury (Golwyn & Sevlie, 1993; Jawad, Sidebothams, Sequira, & Jamil, 2009). A number of meta-analyses have demonstrated that intended change in feelings and behaviors is a realistic goal for many persons with unwanted attractions to the same sex (Byrd & Nicolosi, 2002; Clippinger, 1974; James, 1978; Jones & Yarhouse, 2000). See NARTH (2009) for a comprehensive list of reports for each paradigm.

While no approach to therapy for any presenting concern—including unwanted same-sex attraction or behavior—has been shown to enable clients to meet all of their therapeutic goals, the clinical and scientific literature to date has shown the potential for change to varying degrees. Many—but not all—clients have either been observed by their therapists or have reported themselves to have experienced desired changes in “sexual orientation” and related presenting concerns (NARTH, 2009).

Clients who report a significant transition and/or who are assessed as having made a significant transition from same-sex to opposite-sex attraction, cognition, fantasy, and behavior not uncommonly re-experience same-sex feelings or thoughts, though at a less intense level than before intervention. Of course, there may be exceptions. Even when clients do not achieve all they had hoped to when beginning therapy, many report satisfaction with what they have achieved (Nicolosi et al., 2000, 2008; Spitzer, 2003), and some clients who describe their therapy experiences as “harmful” may also characterize those experiences as “helpful” (Shildo & Schroeder, 2002). As with therapy in general (Lambert & Ogles, 2004), documented intervention success is often accompanied by some recidivism during or following the treatment of compulsive or addictive sexual and/or other disorders co-occurring with unwanted same-sex attractions (cf. Guidelines 6 and 10).

Critics of the clinical and scientific literature documenting successful therapeutic outcomes—or the lack thereof—accurately point out the absence of truly randomized outcome studies (American Psychological Association, 2009). Another criticism

of the literature is the lack of clear definition of terms such as *sexual orientation*, *homosexuality*, *heterosexuality*, and *change*. As noted previously, there has been much less research focusing on the development of and interventions for unwanted same-sex attractions since the American Psychiatric Association's 1973 decision to no longer diagnose homosexuality as a mental disorder

Such criticism does not negate that, for more than a century, clinical and scientific evidence has persistently demonstrated that unwanted same-sex attractions and behaviors are often treatable and that clients who seek intervention are not invariably harmed when receiving intervention. A substantial number of people who have sought help from professionals representing various theoretical paradigms and psychotherapeutic approaches have diminished the frequency and strength of same-sex attractions, reduced or eliminated same-sex behaviors, and enhanced their experience of opposite-gender sexual attractions (Nicolosi et al., 2000; Spitzer, 2003). While some clients may report change in sexual orientation identity only—labeling themselves as ex-gay without an accompanying change in the direction or intensity of sexual attractions (American Psychological Association, 2009)—research does support the occurrence of change in the behaviors, attractions, and fantasies associated with sexual orientation per se (Jones & Yarhouse, 2007; Spitzer, 2003). Since the question of change in sexual orientation identity versus sexual orientation is definitionally complex and does not lend itself to an either/or dichotomy, clinicians are encouraged to be cognizant of this issue without adopting a dogmatic all-or-nothing approach.

Doubt that same-sex attractions and behavior can change has arisen in part because of the desertion of psychological and clinical principles in favor of sociological surveys. This constitutes a significant methodological problem. The traditional psychological treatments arose in a discipline where individual change was monitored and interpreted and taken as an indicator of ways therapy could be improved. Change that was satisfactory to the client was the criterion. However, in a situation (germane to

many interventions) in which a minority of clients experience significant change, some experience minimal change, and some experience no change, the illegitimate sociological average would say the therapy does not work.

To illustrate this point, imagine an intervention that helps only 10 percent of clients, but for that 10 percent the intervention is brilliantly successful. The intervention fails for the other 90 percent. The sociological average of all these cases would indicate that the intervention has no effect at all. That conclusion is false and neglects the traditional prime role of the individual.

It may be that many of those who say change is impossible have been unable to change themselves—so they assume their experience is like that of all who pursue change. This would be invalid reasoning, but it may contribute to attempts by professional organizations to explicitly or implicitly discredit change-oriented interventions or otherwise discourage their use (American Psychological Association, 2009).

Lambert & Ogles (2004) observed that “helping others deal with depression, inadequacy, anxiety, and inner conflicts, as well as helping them form viable relationships and meaningful directions for their lives, can be greatly facilitated in a therapeutic relationship characterized by trust, warmth, understanding, acceptance, kindness and human wisdom” (pp. 180–181). As with therapy for all presenting concerns, giving satisfactory informed consent when beginning to counsel those who want to resolve unwanted same-sex attractions and behavior is not only ethical but also may be expected to facilitate the development of more effective, therapeutic relationships.

Guideline 6. Clinicians are encouraged to utilize accepted psychological approaches to psychotherapeutic interventions that minimize the risk of harm when applied to clients with unwanted same-sex attractions.

Every counselor uses psychotherapeutic approaches that may be reasonably expected to offer clients help in dealing with their presenting problems (beneficence) and

to avoid or minimize potential harm (nonmaleficence). Professional clinicians who work with clients to resolve unwanted same-sex attractions and behaviors are trained in one or more of the theoretical approaches and techniques currently practiced in the mental health professions. Clinicians use accepted psychological approaches to help clients deal with common co-presenting problems, including depression, anxiety, shame, unresolved distress originating from family of origin, sexual and emotional abuse, relationship difficulties, lack of assertiveness, and compulsive and addictive habits. Clinicians also seek supervision and additional training as dictated by their clients' needs and professional development (cf. Guideline 11).

It has been suggested by critics that one possible outcome of counseling for unwanted same-sex attraction has been the development of a negative attitude toward homosexuality or homosexuals (e.g., Haldeman, 1991, 1994). This caution about potential harm or criticism of reported harm must be understood in the context of any therapeutic process. Such intervention often leads a client to become more aware of depression, anxiety, and other emotions left over from the recent or distant past. In the short term, as clients are helped to practice sexual or other (such as substance use) sobriety, they may experience an increase in their "feeling" of depression, anxiety, and other problems.

An increase in unpleasant feelings may not be an indication of "harm," but an opportunity to deal with feelings formerly numbed by mood-altering behaviors (such as sexual gratification), substances (such as alcohol or drugs), or other paraphernalia (such as pornography). Clients who terminate any therapy before effectively resolving any underlying emotional issues or compulsive behavior patterns will undoubtedly feel worse than when they began therapy. Also, to the extent that persons with same-sex desires are engaged in sexual compulsions or experience other psychological or relational difficulties, a high recidivism rate may not be unrealistic—similar to what is found when treating substance abuse and other habits.

In general, interventions for unwanted same-sex attractions and behavior have been shown to help a number of clients and have not been shown to be invariably harmful (Throckmorton, 1998, 2002). Even authors who clearly oppose such intervention and who caution that it may be harmful nonetheless recognize that it is not always so (Haldeman, 2001; Schroeder & Shildo, 2002; Shildo & Schroeder, 2002). Even clients who are disappointed by failure to change their same-sex thoughts, feelings, fantasies, and/or behaviors as much as they had hoped have reported satisfaction with the changes they did achieve, and they regard the counseling process as at least somewhat helpful (e.g., Nicolosi et al., 2000; Shildo & Schroeder, 2002; Spitzer, 2003; Throckmorton, 2002). While a client's dissatisfaction is a possible and unfortunate consequence of any therapy, such dissatisfaction is not inherently "harmful" and may be minimized by the responsible practice of timely and accurate informed consent (cf. Guideline 5).

Regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences appear to be unavoidable for a small percentage of clients, especially those who begin therapy with a severe "initial level of disturbance," such as borderline personality disorder (Lambert & Ogles, 2004, p. 177). Clients who experience significant negative countertransference or whose clinicians may lack empathy or underestimate the severity of their problem may also be at greater risk for deterioration (Mohr, 1995).

Finally, in light of current research and professional ethics, some interventions for unwanted same-sex attractions and behavior are not recommended. These include shock therapy and other aversive techniques, so-called reparenting therapies, and coercive forms of religious prayer.

Overall, research to date has shown that clients participating in efforts to change unwanted same-sex attractions or behaviors are not invariably harmed by doing so. Any negative consequences attributed to experiencing change-oriented interventions have not been shown to outweigh the benefits claimed by those who have found the interventions helpful.

Guideline 7. Clinicians are encouraged to be knowledgeable about the psychological and behavioral conditions that often accompany same-sex attractions and to offer or refer clients to relevant treatment services to help clients manage these issues.

When treating clients with unwanted same-sex attractions and behavior, it is strongly encouraged that clinicians do a complete assessment that includes a detailed history and examination. Clinicians should be particularly alert to the potential of associated psychopathological conditions. While often limited by restricted samples, lack of controls, and/or indeterminate causal pathways, studies of mental health morbidity among adults reporting same-sex partners consistently suggest that lesbians, gay men, and bisexual individuals may experience higher risk for some mental disorders when compared to heterosexual adults (Cochran & Mays, 2009; King et al., 2008). Cochran, Sullivan, and Mays (2003) found that gay and bisexual men showed higher prevalence of depression, panic attacks, and psychological distress than heterosexual men; lesbian and bisexual women showed greater prevalence of generalized anxiety disorder than heterosexual women in the same study. This excessive risk of co-occurring psychopathology needs to be at the forefront of a clinician's mind when working with individuals who report same-sex attractions, whether wanted or not.

A key issue in health care is risk assessment and management; in mental health terms, it is important to assess the risk of self-harm or suicide. Research has demonstrated a strong association between suicide risk and same-sex attractions and behavior (Eskin et al., 2005; King et al., 2008; Ploderl & Fartacek, 2005; Remafedi, French, Story, Resnick, & Blum, 1998). Data from the National Comorbidity Survey found that people with same-sex partners have consistently greater odds of experiencing psychiatric and suicidal symptoms compared with their heterosexual peers (Gilman et al., 2001). This finding has been consistent in studies of both young people (Russell & Joyner, 2001) and adults (Remafedi et al., 1998). Such suicidal feelings may not be only the result of prejudice or societal pressures; even in Holland, a country with a comparatively tolerant attitude to

homosexuality, men with same-sex attractions and behaviors are at a much higher risk for suicidality than heterosexual men (de Graaf, Sandfort, & ten Have, 2006).

Sex addiction often co-occurs with same-sex behavior (Dodge et al., 2008; Guigliamo, 2006; Kelly, Bimbi, Nanin, Izienicki, & Parsons, 2009; Parsons et al., 2008; Quadland & Shattls, 1987). Instead of “enjoying sex as a self affirming source of physical pleasure, the addict has learned to rely on sex for comfort from pain, for nurturing or relief from stress” (Carnes, 1992, p. 34). This type of addiction often has roots in childhood and adolescence; as many as 60 percent of people who seek treatment for sex addiction were sexually abused before reaching adulthood (Griffin-Shelley, 1997). Clients with same-sex attractions commonly report other addictive behaviors as well, including pathological gambling (Granta & Potenzab, 2006) and substance abuse of prescribed, illicit, and over-the-counter medications. A thorough history should include assessment for these and other common addictive behaviors.

Individuals reporting same-sex attractions and behavior also appear to have suffered a higher prevalence of sexual abuse (Doll, Joy, Bartholow, & Harrison, 1992; Eskin et al., 2005; Paul, Catania, Pollack, & Stall, 2001; Tomeo et al., 2001; Wilson & Widom, 2010). It is therefore imperative that clinicians take a full and detailed history from each client.

While clinicians should complete a full assessment to screen for active psychopathology, they must also take care not to practice in a clinical area where they are not competent (American Psychological Association, 2002). If active psychopathology is detected, it should be addressed through multidisciplinary consultation or by referral to an appropriate service where clinically necessary (cf. Guideline 11).

Guideline 8. Clinicians strive to consider and understand the difficult pressures from culture, religion, and family that are confronted by clients with unwanted same-sex attractions.

The societal pressures that surround people with unwanted same-sex attractions cannot be understated. Careful appraisal of the multiple contexts from which these clients come and the normative attitudes toward homosexuality found in each milieu will benefit clinical intervention.

One pervasive dimension is culture, which includes ethnic heritage and the varying perspectives on homosexuality common to each ethnicity. For example, clients coming from African-American or Hispanic backgrounds often live in communities that have traditional and more uniformly negative views of homosexuality (Greene, 1998; Herek & Gonzalez-Rivera, 2006; Martinez & Sullivan, 1998; Schulte & Battle, 2004; Vincent, Peterson, & Parrott, 2009).

Another critical dimension is the religious background of these clients, since many who seek interventions for unwanted same-sex attractions and behavior often come from conservative faith communities (Haldeman, 2002, 2004; Nicolosi et al., 2000; Rosik, 2003a; Schulte & Battle, 2004; Spitzer, 2003). Most of these individuals will have previously adopted from their religious background a value framework that considers homosexual behavior as immoral. Some religiously conservative clients will have grown up hearing homosexuality condemned by religious authorities who may—or may appear to—lack compassion for their struggle.

A third dimension worthy of careful evaluation is the family context of clients (Yarhouse, 1998b). The attitude of parents and heterosexual spouses toward clients' same-sex attractions is the factor that can likely exert the most immediate influence on the mind-set of those seeking change. The extent to which clients have disclosed their unwanted same-sex attractions to family members will also affect clients' clarity concerning how their loved ones might respond. Clients may receive a variety of messages from family members, ranging from gay affirmation to loving disapproval to outright rejection and distancing (Freedman, 2008).

The effects of ethnicity and religious identity can overlap with family considerations and may intensify a sense of reluctance to acknowledge, explore, and seek

therapy for unwanted same-sex attractions. An important factor is client proximity to these contexts; clients coming immediately from nonaffirming backgrounds may not have been as reflective about their decision to pursue change as clients who report having once lived a gay identity but who now wish to change that identity.

The early assessment of these contexts is important in determining how ready a client may be for interventions oriented toward change. Clients from ethnic, religious, and family backgrounds that do not affirm homosexuality need to be assessed carefully to make sure they are acting in a reasonably self-determined manner as they seek intervention. This important precaution is not to assert, as some have done (Davison, 2001; Murphy, 1992), that clients from these backgrounds can never autonomously enter into therapy with the goal of attempting to change unwanted same-sex attractions and behaviors. But while people do make rational and free choices to identify with the moral values and behavioral codes of conduct for sexual expression inherent in homosexually nonaffirming contexts (Yarhouse & Burkett, 2002), it cannot be assumed that this is always the case. Therefore, it is essential to explore with clients the attitudes and beliefs toward same-sex attractions and behavior that dominate their particular cultural and family situation as part of evaluating the extent to which they have genuinely taken ownership of their decision to pursue change.

Guideline 9. Clinicians are encouraged to recognize the special difficulties and risks that exist for youth who experience same-sex attractions.

Research suggests that in 50 percent of the population, first attraction to the same or opposite sex has occurred by age ten (Hamer, Hu, Magnuson, Hu, & Pattatucci, 1993; Whitam & Mathy, 1986)—but there is an unusually wide age range during which those first feelings of attraction occur. Some are still essentially asexual until their late teens in spite of the highly sexualized cultural climate in the West.

Even when experiences with attraction occur, they may not be “reliable.” Neurology—including that of the brain—continues to develop throughout adolescence

(Sisk & Zehr, 2005), so teens generally lack mature judgment, even though they are at or near their physical peak in their late teens. Many use the late teen years to explore what mature possibilities may exist for them and to then evolve an identity by experimenting with a wide range of experiences. Sexual initiation usually occurs during this time (Floyd & Bakeman, 2006).

A mature estimate of risk does not conform to reality during adolescence. Teens tend to underestimate familiar risks and overestimate the possibility of remote risk. The risk of HIV is clearly underestimated by mature people, but adolescents' estimation of risk is less realistic still, even though their risk of infection is not much less than that of adults (Lock & Steiner, 1999). Unfortunately, teenagers may also be reluctant to listen to input about such risks. Consequently, responsible clinicians will offer more directive guidance to youth than to more mature clients, particularly when a client's estimate of risk is unrealistic. This type of guidance may involve more mentoring than for a mature client or referral to someone who can mentor the client.

Statistical surveys show that adolescents participate in considerable sexual experimentation, much of which is not followed up on in adulthood—and, therefore, those types of experimentation can be considered far from definitive (Laumann et al., 1994). Changes of various types continue to take place even during adulthood (Kinnish et al., 2005). Consequently, adolescents may prematurely decide they have a particular sexual orientation, and hence should be warned against hasty conclusions. A very significant proportion of young women are most comfortable with the “unlabeled” sexual orientation category (Diamond, 2008); conversely, they might be told that, with strong motivation, change may be easier during adolescence than during adulthood.

Each year, about 42 percent of youth are exposed, either willingly or unwillingly, to Internet pornography; over the period of a few years, almost all youth get exposed (Wolok, Ybarra, Mitchell, & Finkelhor, 2007), so the effects of such pornography should be monitored. Youth may absorb quite unrealistic ideals as a result, and may even draw

incorrect conclusions; for example, compulsive or addictive use of gay pornography may lead a young person to assume that he is gay when he is merely compelled or addicted to sexual gratification.

Surveys show that adolescents who reach a conclusion about their sexuality and who are distraught about its perceived consequences are at highest risk of suicide immediately before they disclose their “secret” to anyone (Paul et al., 2002). Therapists should be particularly aware of the fragility of such clients, who tend to be those without social support. Suicide risk among youth with same-sex attractions decreases 20 percent each year they delay labeling themselves as gay (Remafedi, Farrow, & Deisher, 1991). Although causal links are not clear, it is prudent to encourage teens to wait for some time and maturity to take place before they label themselves as gay.

Clinicians should also consider carefully whether disclosure of the client’s struggle to unaware family and friends is in the client’s best interests (Rosario, Schrimshaw, & Hunter, 2009; cf. Guideline 8). Many who disclose their homosexuality to unsympathetic family join the ranks of the homeless and then become at risk for drug use, prostitution, and violence (Tyler, Whitbeck, Hoyt, & Cauce, 2004). The reactions of peers at this age can be brutal—brutality tends to peak in the adolescent years, probably because teens have less empathy than younger or older people. Brutality can also occur because there is still intense pressure from peers to conform to stereotypical gender roles during adolescence.

Male adolescents will probably report rejection and discrimination by others much more than female adolescents will (Hershberger & D’Augelli, 1995). Such rejection may be more perceived than actual but can have real effects for clients. The literature suggests that, in some cases, emotional and avoidance coping styles may account for perceived rejection more than the actual circumstances do (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2009). Therefore, it is wise to examine an individual’s coping style.

Co-occurrence of standard DSM conditions is much higher for such clients than others (Fergusson, Horwood, & Beautrais, 1999), so clients should be checked for, among others,

substance abuse (Sandfort, de Graaf, Bijl, & Schnabel, 2001; Trocki, Drabble, & Midanik, 2009), antisocial behavior (Fergusson et al., 1999), depression (Cochran et al., 2003), compulsivity (Dodge et al., 2008), and borderline personality disorder (Sandfort et al., 2001).

Education

Guideline 10. Clinicians are encouraged to make reasonable efforts to familiarize themselves with relevant medical, mental health, spiritual, and religious resources that can support clients in their pursuit of change.

Unwanted same-sex attractions and behaviors often co-occur with formally diagnosable or otherwise evident medical, psychological, behavioral, and relational difficulties (cf. Guideline 7). Therefore, clinicians should make reasonable efforts to familiarize themselves with relevant approaches to health care that address applicable areas of difficulty.

It is essential for clinicians to keep current about health psychology and related behavioral health issues and to refer clients to specialists when care is outside their scope of practice. These health issues include, but are not limited to, how to improve general health habits (such as diet, exercise, relaxation, and sleep), the use of relevant psychotropic medications and understanding of their interactive effectiveness with psychotherapy, ways to enhance compliance with medical directives, and how to determine when partial and inpatient hospitalization is indicated (Creer, Holroyd, Glasgow, & Smith, 2004; Thase & Jindal, 2004).

Addressing clients' co-occurring medical or psychiatric difficulties may sometimes have greater priority than helping them resolve unwanted same-sex attractions or behaviors; psychological care may become an important support to enable clients to comply with other medical directives. At other times, treating medical or psychiatric difficulties may enable clients to engage in psychological and spiritual interventions more effectively. Additional adjunctive interventions may include referring for

psychoeducation (such as individual or group substance abuse counseling) or referring to couples therapy, family therapy, group therapy, or peer-support groups when clients need and are able to benefit from therapeutic relational and group interaction. Referrals also may help clients successfully deal with co-occurring sexual abuse, substance abuse, eating disorders, or other compulsive or addictive behaviors (Lambert & Ogles, 2004).

Parents who are concerned about children with Gender Identity Disorder or unwanted same-sex attractions might be referred for parent education and family therapy (Lundy & Rekers, 1995; Rekers, 1995; Zucker & Bradley, 1995). Clinicians are encouraged to be prepared to make referrals to other health-care professionals so clients can receive primary, sequential, alternative, combined, or adjunct medical or mental health assistance in a timely way.

In addition, clinicians serving clients who seek to resolve unwanted same-sex attractions and behaviors are also encouraged to be prepared to offer their clients pastoral care, either directly or by referral. Religious or spiritual beliefs, practices, and social interactions can offer motivation and support for a client's desired changes (cf. Guidelines 3 and 4). Clinicians should therefore make reasonable efforts to assess their clients' religious beliefs, moral values, and spiritual practices and be prepared to support clients' utilization of appropriate spiritual and religiously oriented resources to achieve intended changes (Richards & Bergin, 2000).

Clinicians should wisely recognize that, in general, religion can be beneficial to psychological and interpersonal health, more "intrinsic" ways of being religious appear to be healthier, and clients who are more religiously devout tend to "prefer and trust clinicians with similar beliefs and values" (Gregory et al., 2008; Richards & Bergin, 2005, p. 307). Also, the use of spiritual or religiously inspired aides such as prayer, forgiveness, meditation, and twelve-step groups based on spiritual principles have been shown to be therapeutically effective as part of or as an adjunct to clinical intervention (Benson, 1996; Enright & Fitzgibbons, 2000; Richards & Bergin, 2004, 2005).

Studies of clients with unwanted same-sex attractions and behavior who have used spiritual aides, religious activities, and pastoral counseling—whether as adjuncts to psychotherapy or separate from therapy—report positive results (Jones & Yarhouse, 2007). Even when clients did not change as they had intended, some asserted that the process was helpful, even when the research was designed to elicit reports of intervention failure, harm, or dissatisfaction from religiously mediated efforts to change (Shildo & Schroeder, 2002). When the research was designed to elicit reports of success or satisfaction with their participation, substantially more were favorable (Nicolosi et al., 2000, 2008; Spitzer, 2003). The more rigorous the research design, the more clearly results have shown that spiritual/religious/pastoral counseling approaches by themselves have been able to reduce or eliminate unwanted same-sex attractions and behaviors (Jones & Yarhouse, 2007; Yarhouse, Burkett, & Kreeft, 2002).

Guideline 11. Clinicians are encouraged to increase their knowledge and understanding of the literature relevant to clients who seek change, and to seek continuing education, training, supervision, and consultation that will improve their clinical work in this area.

The literature on homosexuality is at first glance an academic field like any other, even though it might be considered slightly more active because new references accumulate almost every day. That view is deceptive, though: Same-sex attraction is not an isolated clinical entity. A very wide range of conditions occur with it, and clinicians need to have a reasonable knowledge of these conditions—or at the very least be able to recognize those conditions readily and refer clients to others as necessary (cf. Guideline 7). This greatly increases the responsibility of clinicians to keep current with the literature.

Research has generally shown that people reporting same-sex attractions and behavior (mainly the men who have been studied) have much greater prevalence of

pathology than the general population. The consistency of these findings counterbalances to some degree the methodological limitations. These differences in prevalence have been reported or can be inferred in several areas: suicidal risk-taking in unprotected sex (van Kesteren, Hospers, & Kok, 2007); violence (Coxell, King, Mezey, & Gordon, 1999; Owen & Burke, 2004); antisocial behavior (Fergusson et al., 1999); substance abuse (Rhodes, McCoy, Wilkin, & Wolfson, 2009; Sandfort et al., 2001; Trocki et al., 2009); suicidality (de Graaf et al., 2006; King et al., 2008); more sexual partners (Laumann et al., 1994; Mercer et al., 2009; Rhodes et al., 2009); paraphilias, or so-called fisting (Crosby & Mettey, 2004); being paid for sex (Schrimshaw et al., 2006); sexual addiction (Dodge, Reece, Cole, & Sandfort, 2004; Parsons et al., 2008; Satinsky et al., 2008); personality disorders (Zubenko, George, Soloff, & Schulz, 1987); and psychopathology (Sandfort et al., 2001). It is difficult to find a group of comparable size in society with such intense and variable co-occurring pathology.

As a rule of thumb, many of these characteristics have prevalence rates about three times those reported in the general population, sometimes much more. A check of any medical database shows that there are many more articles—generally ten times as many—dealing with conditions that co-occur with homosexuality than articles restricted to homosexuality alone. It is not enough to read about homosexuality alone, then, but it is essential to read the much greater number of co-associated articles and to benefit from the understanding these articles make possible.

References to HIV are extensive in the literature, and it is quite possible this condition will co-occur with same-sex behaviors. Even if HIV infection is under control, the prevalence of various cancers in AIDS patients is about twenty times greater than in the general population (Galceran et al., 2007). A clinician may well encounter clients with these kinds of medical needs and will need to address appropriate treatment issues.

Psychotherapeutic intervention for unwanted same-sex attractions and behavior is controversial in a way that is seldom experienced today for other conditions. As a result,

clinicians face the risk of unanticipated legal consequences (Hermann & Herlihy, 2006), deal with more complex therapy, and have a greater-than-average need to stay current in the field and be aware of the latest implications of research and good practice.

This kind of intervention is also exceptionally complex. Clinicians need to understand the consequences to the client's psyche of having an associated medical condition or suffering strong rejection because of attitudes toward homosexuality.

The varieties of change-oriented counseling are numerous, and there is no consensus on the best approach. This requires clinicians to be aware of other intervention strategies and theoretical approaches and to be willing to adopt useful insights and previously successful techniques (cf. Guideline 6). Alongside this, the variety of experiences among clients is significantly diverse (Otis & Skinner, 2004), which demands a greater versatility of response from the clinician and greater familiarity with the research literature.

Much of the literature pertaining to homosexuality is at risk of being irrelevant because it is associated with the political aspects of the topic. The remainder of the relevant literature involves many widespread fields, including genetics, physiology, sociology, urban anthropology, and psychotherapy. Thus, clinicians must strive to locate relevant material in unusually diverse fields. Clinicians also need to be prepared for the fact that clients often read this same material and want to discuss it. It is probably worthwhile that clinicians use a service on the Internet—such as PubMed—to alert them when relevant new material is published.

Focused events such as seminars and conferences are more important than usual because change-oriented interventions for unwanted same-sex attractions and behavior are not as widely known and practiced as counseling for other conditions; as a result, collegial consultation becomes more important. Finally, it goes without saying that clinicians must attempt to keep current in the psychological disciplines in general, with the usual accompanying need for continuing education.

Applications and Conclusion

These guidelines were developed with multiple purposes in mind and ideally will have many applications. First, the guidelines are intended to address the needs of clinicians and provide specific guidance from experienced clinicians to colleagues who are currently practicing or who are considering the use of change-oriented interventions for unwanted same-sex attractions and behavior. As such, these guidelines encourage excellence in practice that, when followed, should limit the risk of harm and expand the probability of favorable outcomes for clients seeking some measure of change. The guidelines also serve to educate clinicians by providing an entry point into aspects of the professional literature that may be underreported by national mental health associations.

Second, these guidelines inform consumers who are receiving or considering therapeutic intervention to change their unwanted same-sex attractions and behaviors. The guidelines provide a broad evaluative framework that helps these clients determine if the clinical services they receive are being provided in a sufficiently professional and ethical manner. Consumers of change-oriented intervention may find value in discussing these guidelines with their clinicians. Discussing them early in treatment as part of the informed consent process may facilitate planning of both short-term and long-range goals.

Periodically and at the end of a course of treatment, clinicians may also use these guidelines to assess the therapeutic progress that has been achieved by clients and to review and renegotiate any remaining goals. As is true for all approaches to psychological care for any problem, the most effective therapeutic alliance occurs when there is initial and ongoing clarity of purpose and goals shared by clients seeking change and their clinicians.

The social, scientific, and medical information made available through these guidelines may also benefit consumers as they weigh the benefits and risks of pursuing change-oriented intervention in comparison to therapeutic approaches that endorse or embrace a gay or lesbian identity. In this way, these guidelines can contribute to a more fully informed and autonomous decision-making process by clients who want to know

what clinical approach—if any—they want to use for their unwanted same-sex attractions and behavior.

Finally, these guidelines can help mental health associations and graduate training programs facilitate a balanced and informed discussion about change-oriented intervention. The guidelines complement the existing professional literature pertaining to psychological care for those with unwanted same-sex attractions and behavior by their nondismissive focus on change-oriented intervention. The guidelines may thus encourage more individuals within these associations and universities to engage in valuable dialogue, education, and research about the place such interventions have in the array of therapeutic responses to unwanted same-sex attraction and behavior. The guidelines also may provide interested clinicians and students an opportunity to become educated about the professional practices of responsible change-oriented clinicians.

Mental health associations have emphasized the importance of client autonomy and self-determination within a therapeutic environment that honors diversity. This respect for diversity should oblige clinicians to give as much weight to religious belief and traditional values as to sexual identity (Benoit, 2005). Within the contemporary milieu of psychological practice, this especially needs to be emphasized when addressing the choices clients make about how to approach their unwanted same-sex attractions and behavior. When conducted in a manner consistent with these guidelines, change-oriented intervention deserves to be made available to clients who seek it.

Footnotes

¹ These guidelines were adopted by the National Association for Research and Therapy of Homosexuality's Board of Directors on October 25, 2008, and reaffirmed upon subsequent revisions prior to publication.

² These guidelines were developed by the NARTH Practice Guidelines Task Force (PGTF). The PGTF chair was Christopher H. Rosik, Ph.D.* (Link Care Center/Fresno Pacific University). The PGTF members included Marc Dillworth, Ph.D. (independent practice, Bradenton, FL); Floyd Godfrey, M.A., L.P.C. (Family Strategies & Coaching, LLC, Mesa, AZ); Paul Miller, M.D., D.M.H., M.R.C.Psych.* (ABEO, Belfast, Northern Ireland); David Pickup, M.A. (Thomas Aquinas Psychological Clinic, Encino, CA); Paul Popper, Ph.D.* (independent practice, San Francisco, CA); and Philip Sutton, Ph.D.* (independent practice, South Bend, IN). Others who contributed to the development of these guidelines were A. Dean Byrd, Ph.D., M.P.H. (University of Utah, Salt Lake City, UT); Neil Whitehead, Ph.D.* (research scientist, Lower Hutt, New Zealand); and David Wood, Ph.D.* (LDS Family Services, Chicago, IL). Individuals who made primary contributions to the authorship of these guidelines are identified by the symbol *.

Requests for copies of these guidelines should be addressed to the National Association for Research and Therapy of Homosexuality, 307 West 200 South—Suite 3001, Salt Lake City, UT 84101; they can be ordered by phone at 1-888-364-4744 or online at <http://narth.com>

³ An example of such genetic predisposition occurs when a girl, through her genetic inheritance, is attractive to boys and hence more likely to become pregnant as a teenager. This is a weak and indirect effect because many other cultural and situational factors are involved in determining whether she has early sexual intercourse, and those influences usually predominate.

References

- American Association for Marriage and Family Therapy. (2001). *Code of ethics*. Washington, DC.
- American Psychiatric Association. (1972). *Diagnostic and statistical manual* (DSM-II) (2nd ed.). Baltimore, MD.
- American Psychiatric Association. (1973). *Diagnostic and statistical manual* (DSM-II) (2nd ed., 6th printing). Baltimore, MD.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (DSM-IV) (4th ed., text rev.). Washington, DC.
- American Psychological Association. (1975). Minutes of the council of representatives. *American Psychologist*, 30, 633.
- American Psychological Association. (2000). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist*, 55, 1440–1451.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060–1073.
- American Psychological Association. (2008a). *Answers to your questions for a better understanding of sexual orientation and homosexuality*. Washington, DC.
Retrieved from <http://www.apa.org/topics/orientation.pdf>
- American Psychological Association. (2008b). Resolution on religious, religion-related and/or religion-derived prejudice. *American Psychologist*, 63, 431–434.
- American Psychological Association. (2009). *Report of the task force on appropriate therapeutic responses to sexual orientation*. Washington, DC.
- Auger, R. W. (2004). What we don't know CAN hurt us: Mental health clinicians' implicit assumptions about human nature. *Journal of Mental Health Counseling*, 26, 13–24.
- Bailey, J. M., Dunne, M. P., & Martin, N. G. (2000). Genetic and environmental influences on sexual orientation and its correlates in an Australian twin sample. *Journal of Personality and Social Psychology*, 78, 524–536.

- Bain, P. G., Kashima, Y., & Haslam, N. (2006). Conceptual beliefs about human values and their implications: Human nature beliefs predict value importance, value trade-offs, and responses to value-laden rhetoric. *Journal of Personality and Social Psychology, 91*, 351–367.
- Bancroft, J. (1974). *Deviant sexual behaviour: Modification and assessment*. Oxford, England: Clarendon.
- Bearman, P. S., & Bruckner, H. (2002). Opposite-sex twins and adolescent same-sex attraction. *American Journal of Sociology, 107*, 1179–1205.
- Beckstead, A. L. (2001). Cures versus choices: Agendas in sexual reorientation therapy. *Journal of Gay and Lesbian Psychotherapy, 5*, 87–115.
- Beckstead, A. L., & Morrow, S. L. (2004). Mormon clients' experiences of conversion therapy: The need for a new treatment approach. *Consulting Psychologist, 32*, 651–690.
- Bell, A. P., Weinberg, M. S., & Hammersmith, S. K. (1981). *Sexual Preference: Its development in men and women*. Bloomington, IN: Indiana University Press.
- Bem, D. J. (1996). Exotic become erotic: A developmental theory of sexual orientation. *Psychological Review, 103*, 320–325.
- Benoit, M. (2005). Conflict between religious commitment and same-sex attraction: Possibilities for a virtuous response. *Ethics and Behavior, 15*, 309–325.
- Benson, H. (1996). *Timeless healing: The power and biology of belief*. New York, NY: Scribner.
- Bepko, C., & Johnson, T. (2000). Gay and lesbian couples in therapy: Perspectives for the contemporary family therapist. *Journal of Marital and Family Therapy, 26*, 409–419.
- Berger, J. (1994). The psychotherapeutic treatment of male homosexuality. *American Journal of Psychotherapy, 48*, 251–261.
- Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy, 27*, 3–7.

- Bieber, I., Dain, H., Dince, P., Drellich, M., & Grand, H. (1962). *Homosexuality: A psychoanalytic study*. New York, NY: Basic Books.
- Birk, L., Huddleston, W., Miller, E., & Cohler, B. (1971). Avoidance conditioning for homosexuality. *Archives of General Psychiatry*, 25, 314–323.
- Bogaert, A. F. (2007). Extreme right-handedness, older brothers, and sexual orientation in men. *Neuropsychology*, 21, 141–148.
- Bonello, K., & Cross, M. C. (2010). Gay monogamy: I love you but I can't have sex with only you. *Journal of Homosexuality*, 57, 117–139.
- Buxton, M. S. (2004). *Ethical treatment for people who present with unwanted homoerotic attractions: Guidelines for therapists*. BYU Counseling and Career Center. Retrieved from <http://www.narth.com/docs/buxton.html>
- Byne, W. (1995). Science and belief: Psychobiological research on sexual orientation. *Journal of Homosexuality*, 28, 303–344.
- Byne, W., & Parsons, B. (1993). Human sexual orientation: The biologic theories reappraised. *Archives of General Psychiatry*, 50, 228–239.
- Byrd, A. D. (2008). *Former APA president supports NARTH's mission statement, assails APA's intolerance of differing views*. Retrieved from <http://www.narth.com/docs/perloff.html>
- Byrd, A. D., & Nicolosi, J. (2002). A meta-analytic review of treatment of homosexuality. *Psychological Reports*, 90, 1139–1152.
- Carnes, P. (1992). *Don't call it love*. New York, NY: Bantam Doubleday Dell Publishing Group.
- Cates, J. A. (2007). Identity in crisis: spirituality and homosexuality in adolescence. *Child and Adolescent Social Work Journal*, 24, 369–383.
- Clippinger, J. A. (1974). Homosexuality can be cured. *Corrective and Social Psychiatry and Journal of Behavioral Technology, Methods, and Therapy*, 20, 15–28.
- Cochran, S. D., & Mays, V. M. (2009). Burden of psychiatric morbidity among lesbian, gay, and bisexual individuals in the California Quality of Life Survey. *Journal of Abnormal Psychology*, 118, 647–658.

- Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*, 53–61.
- Coxell, A., King, M., Mezey, G., & Gordon, D. (1999, March 27). Lifetime prevalence, characteristics, and associated problems of non-consensual sex in men: Cross sectional survey. *British Medical Journal, 318*, 846–850.
- Creer, T. L., Holroyd, K. A., Glasgow, R. E., & Smith, T. W. (2004). Health psychology. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 697–742). New York, NY: Wiley.
- Crosby, R., & Mettey, A. (2004). A descriptive analysis of HIV risk behavior among men having sex with men attending a large sex resort. *Journal of Acquired Immune Deficiency Syndrome, 37*, 1496–1499.
- Cummings, N., O'Donohue, W., & Cummings, J. (2009). *Psychology's war on religion*. Phoenix, AZ: Zeig, Tucker, & Theisen.
- Davison, G. C. (2001). Conceptual and ethical issues in therapy for the psychological problems of gay men, lesbians, and bisexuals. *Journal of Clinical Psychology, 57*, 695–704.
- de Graaf, R., Sandfort, T. G. M., & ten Have, M. (2006). Suicidality and sexual orientation: Differences between men and women in a general population-based sample from the Netherlands. *Archives of Sexual Behavior, 35*, 253–262.
- Delaney, H. D., Miller, W. R., & Bisono, A. M. (2007). Religiosity and spirituality among psychologists: a survey of clinician members of the American Psychological Association. *Professional Psychology: Research and Practice, 38*, 538–546.
- Diamond, L. M. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology, 44*, 5–14.
- DiPlacido, J. (1998). Minority stress among lesbians, gay men, and bisexuals. In G. H. Hereck (Ed.), *Stigma and sexual orientation: understanding prejudice against lesbians, gay men and bisexuals* (pp. 138–159). Thousand Oaks, CA: Sage.

- Dodge, B., Reece, M., Cole, S. L., & Sandfort, T. G. M. (2004). Serial compulsivity among heterosexual college students. *Journal of Sex Research, 41*, 343–350.
- Dodge, B., Reece, M., Herbenick, D., Fisher, C., Satinsky, S., & Stupiansky, N. (2008, August 1). Relations between sexually transmitted infection diagnosis and sexual compulsivity in a community-based sample of men who have sex with men (MSM). *Sexually Transmitted Infections, 84*, 324–327.
- Doll, L. S., Joy, D., Bartholows, B. N., & Harrison, J. S. (1992). Self-reported childhood and adolescent sexual abuse among adult homosexual and bisexual men. *Child Abuse and Neglect, 16*, 855–864.
- Engelhardt, H. T., Jr. (1996). *The foundations of bioethics* (2nd ed.). New York, NY: Oxford University Press.
- Enright, R. D., & Fitzgibbons, R. P. (2000). *Helping clients forgive*. Washington, DC: American Psychological Association.
- Eskin, M., Kaynak-Demir, H., & Demir, S. (2005). Same-sex sexual orientation, childhood sexual abuse, and suicidal behavior in university students in Turkey. *Archives of Sexual Behavior, 34*, 185–195.
- Eskridge, W., Jr., & Hunter, N. (Eds.) (1997). *Sexuality, gender and the law*. Westbury, NY: Foundation Press.
- Fergusson, D. M., Horwood, L. J., & Beautrais, A. L. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry, 56*, 876–880.
- Fields, S. D., Malebranche, D., & Feist-Price, S. (2008). Childhood sexual abuse in black men who have sex with men: Results from three qualitative studies. *Cultural Diversity and Ethnic Minority Psychology, 14*, 385–390.
- Fife, S. T., & Whiting, J. B. (2007). Values in family therapy practice and research: An invitation for reflection. *Contemporary Family Therapy, 29*, 71–86.

- Floyd, F. J., & Bakeman, R. (2006). Coming-out across the life course: Implications of age and historical context. *Archives of Sexual Behavior, 35*, 287–296.
- Francis, A. M. (2008). Family and sexual orientation: The family-demographic correlates of homosexuality in men and women. *Journal of Sex Research, 45*, 371–377.
- Freedman, L. (2008). Accepting the unacceptable: Religious parents and adult gay and lesbian children. *Families in Society, 89*, 237–244.
- Galceran, J., Marcos-Gragera, R., Soler, M., Romaguera, A., Ameijide, A., . . . Casabona, J. (2007). Cancer incidence in AIDS patients in Catalonia, Spain. *European Journal of Cancer, 43*, 1085–1091.
- Gallagher, B. J., McFalls, J. A., & Vreeland, C. N. (1993). Preliminary results from a national survey of psychiatrists concerning the etiology of male homosexuality. *Psychology: A Journal of Human Behavior, 30*, 1–3.
- Gallup, G., Jr. (1998). *The Gallup poll: Public opinion 1997*. Wilmington, DE: Scholarly Resources.
- Garnets, L. D., & Peplau, L. A. (2001). A new paradigm for women's sexual orientation: Implications for therapy. *Women and Therapy, 24*, 111–121.
- Gilman, S. E., Cochran, S. D., Mays, V. M., Hughes, M., Ostrow, D., & Kessler, R. C. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the national comorbidity survey. *American Journal of Public Health, 91*, 933–939.
- Golwyn, D. H., & Sevlie, C. P. (1993). Adventitious change in homosexual behavior during treatment of social phobia with phenelzine [Letter to the editor]. *Journal of Clinical Psychiatry, 54*, 39–40.
- Gonsiorek, J. C. (1991). The empirical basis for the demise of the illness model of homosexuality. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 115–136). Thousand Oaks, CA: Sage.
- Gonsiorek, J. C. (2004). Reflections from the conversion therapy battlefield. *The Counseling Psychologist, 32*, 750–759.

Graham, J., Haidt, J., & Nosek, B. A. (2009). Liberals and conservatives rely on different sets of moral foundations. *Journal of Personality and Social Psychology*, 96, 1029–1046.

Granta, J. E., & Potenzab, M. N. (2006). Sexual orientation of men with pathological gambling: Prevalence and psychiatric comorbidity in a treatment-seeking sample. *Comprehensive Psychiatry*, 47, 515–518.

Green, R. J. (2003). When therapists do not want their clients to be homosexual: A response to Rosik's article. *Journal of Marriage and Family Therapy*, 29, 31–40.

Greene, B. (1998). Family, ethnic identity, and sexual orientation: African American lesbians and gay men. In C. J. Patterson & A. R. D'Augelli (Eds.), *Lesbian, gay, and bisexual identities in families: Psychological perspectives* (pp. 40–52). New York, NY: Oxford University Press.

Gregory, C., Pomerantz, A. M., Pettibone, J. C., & Segrist, D. J. (2008). The effect of psychologists' disclosure of personal religious background on prospective clients. *Mental Health, Religion, and Culture*, 11, 369–373.

Griffin-Shelley, E. (1997). *Sex and love: Addiction, treatment, and recovery*. Westport, CT: Praeger.

Guigliamo, J. (2006). Out of control sexual behavior: A qualitative investigation. *Sexual Addiction and Compulsivity*, 13, 361–375.

Haidt, J., & Graham, J. (2007). When morality opposes justice: Conservatives have moral intuitions that liberals may not recognize. *Social Justice Research*, 20, 98–116.

Haidt, J., & Graham, J. (2009). Planet of the Durkheimians, where community, authority, and sacredness are foundations of morality. In J. Jost, A. C. Kay, & H. Thorisdottir (Eds.), *Social and psychological bases of ideology and system justification* (pp. 371–401). New York, NY: Oxford University Press.

Haidt, J., & Hersh, M. A. (2001). Sexual morality: The cultures and emotions of conservatives and liberals. *Journal of Applied Social Psychology*, 31, 191–221.

- Haldeman, D. C. (1991). Sexual orientation conversion therapy for gay men and lesbians: A scientific examination. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 149–160). Newbury Park, CA: Sage.
- Haldeman, D. C. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Consulting and Clinical Psychology*, 62, 221–227.
- Haldeman, D. C. (2001). Therapeutic antidotes: Helping gay and bisexual men recover from conversion therapies. In A. Shildo, M. Schroeder, & J. Drescher (Eds.), *Sexual conversion therapy: Ethical, clinical, and research perspectives* (pp. 117–130). Binghamton, NY: Haworth.
- Haldeman, D. C. (2002). Gay rights, patient rights: The implications of sexual orientation conversion therapy. *Professional Psychology: Research and Practice*, 33, 260–264.
- Haldeman, D. C. (2004). When sexual and religious orientation collide: Considerations in working with conflicted same-sex attracted male clients. *Counseling Psychologist*, 32, 691–715.
- Hamer, D. H., Hu, S., Magnuson, V. L., Hu, N., & Pattatucci, A. M. L. (1993). A linkage between DNA markers on the X-chromosome and male sexual orientation. *Science*, 261, 321–327.
- Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social science perspective. *Journal of Counseling Psychology*, 56, 32–43.
- Herek, G. M., & Gonzalez-Rivera, M. (2006). Attitudes toward homosexuality among U.S. residents of Mexican descent. *Journal of Sex Research*, 43, 122–135.
- Hermann, M. A., & Herlihy, B. R. (2006). Legal and ethical implications of refusing to counsel homosexual clients. *Journal of Counseling and Development*, 84, 414–418.
- Hershberger, S. L. (1997). A twin registry study of male and female sexual orientation. *Journal of Sex Research*, 34, 212–222.

- Hershberger, S. L., & D'Augelli, A. R. (1995). The impact of victimization in the mental health and suicidality of lesbian gay and bisexual youths. *Developmental Psychology, 31*, 65–74.
- James, E. C. (1978). Treatment of homosexuality: A reanalysis and synthesis of outcome studies (Unpublished doctoral dissertation). Brigham Young University, Provo, UT.
- James, W. H. (2005). Two hypotheses on the causes of male homosexuality and paedophilia. *Journal of Biosocial Science, 38*, 745–761.
- Jawad, S., Sidebothams, C., Sequira, R., & Jamil, N. (2009). Case report [Letter to the editor]. *Journal of Neuropsychiatry and Clinical Neuroscience, 21*, 354.
- Johnson, T. R. (1995). The significance of religion for aging well. *American Behavioral Scientist, 39*, 186–208.
- Jones, S. L. (1994). A constructive relationship for religion with the science and profession of psychology. *American Psychologist, 49*, 184–199.
- Jones, S. L., & Yarhouse, M. A. (2000). *Homosexuality: The use of scientific research in the church's moral debate*. Downers Grove, IL: InterVarsity Press.
- Jones, S. L., & Yarhouse, M. A. (2007) *Ex-gays?: A longitudinal study of religiously mediated change in sexual orientation*. Downers Grove, IL: InterVarsity Press.
- Kaplan, D. M., Kocet, M. M., Cottone, R. R., Glosoff, H. L., Miranti, J. G., . . . Tarvydas, V. M. (2009, March). New mandates and imperatives in the revised *ACA Code of Ethics*. *Journal of Counseling and Development, 87*, 241–252.
- Karten, E. Y., & Wade, J. C. (2010). Sexual orientation changes efforts in men: A client perspective. *Journal of Men's Studies, 18*, 84–102.
- Katz, J. (1976). *Gay American history: Lesbians and gay men in the U.S.A.* New York, NY: Crowell.
- Kelly, B. C., Bimbi, D. S., Nanin, J. E., Izienicki, H., & Parsons, J. T. (2009). Sexual compulsivity and sexual behaviors among gay and bisexual men and lesbian and bisexual women. *Journal of Sex Research, 46*, 301–308.

- Kendler, H. H. (1999). The role of value in the world of psychology. *American Psychologist*, 54, 828–835.
- King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., Nazareth, I. (2008, August). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay, and bisexual people. *BMC Psychiatry*, 8, Special Section pp. 1–17. Retrieved from <http://www.biomedcentral.com/1471-244X/8/70>
- Kinnish, K. K., Strassberg, D. S., & Turner, C. W. (2005). Sex differences in the flexibility of sexual orientation: A multidimensional retrospective assessment. *Archives of Sexual Behavior*, 34, 175–183.
- Koenig, H. G. (1993). Religion and aging. *Reviews in Clinical Gerontology*, 3, 195–203.
- Lalumiere, M. L., Blanchard, R., & Zucker, K. L. (2000). Sexual orientation and handedness in men and women: A meta-analysis. *Psychological Bulletin*, 126, 575–592.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change*, (5th ed., pp. 139–193). New York, NY: Wiley.
- Langstrom, N., Rahman, Q., Carlstrom, E., & Lichtenstein, P. (2008). Genetic and environmental effects on same-sex sexual behavior: A population study of twins in Sweden. *Archives of Sexual Behavior*. Retrieved from <http://dx.doi.org/10.1007/s10508-008-9386-1>
- Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality*. Chicago, IL: University of Chicago Press.
- Liddle, B. J. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to ratings of helpfulness by gay and lesbian clients. *Journal of Counseling Psychology*, 43, 394–401.
- Liszez, A. M., & Yarhouse, M. A. (2005). Same-sex attraction: A survey regarding client-directed treatment goals. *Psychotherapy: Theory, Research, Practice, Training*, 42, 111–115.

- Lock, J., & Steiner, H. (1999). Gay, lesbian, and bisexual youth risks for emotional, physical, and social problems: Results from a community-based survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 297–304.
- Lundy, M. S., & Rekers, G.A. (1995). Homosexuality in adolescence: Interventions and ethical considerations. In G. A. Rekers (Ed.), *Handbook of child and adolescent sexual problems* (pp. 341–377). New York, NY: Lexington Books.
- MacIntosh, H. (1994). Attitudes and experiences of psychoanalysis in analyzing homosexual patients. *Journal of the American Psychoanalytic Association*, 42, 1183–1207.
- Martell, C. R., & Prince, S. E. (2005). Treating infidelity in same-sex couples. *Journal of Clinical Psychology*, 61, 1429–1438.
- Martin, J. T., & Nguyen, D. H. (2004). Anthropometric analysis of homosexuals and heterosexuals: Implications for early hormone exposure. *Hormones and Behavior*, 45, 31–39.
- Martinez, D. G., & Sullivan, S. C. (1998). African American gay men and lesbians: Examining the complexity of gay identity development. *Journal of Human Behavior in the Social Environment*, 1, 243–264.
- Masters, W., & Johnson, V. (1979). *Homosexuality in perspective*. Boston, MA: Little, Brown.
- Maylon, A. K. (1982). Psychotherapeutic implications of internalized homophobia in gay men. In J. C. Gonsiorek (Ed.), *Homosexuality and psychotherapy: A practitioner's handbook of affirmative models* (pp. 59–69). New York, NY: Haworth.
- Mays, V. M., & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbians, gay, and bisexual adults in the United States. *American Journal of Public Health*, 91, 1869–1876.
- McAdams, D. P., Albaugh, M., Farber, E., Daniels, J., Logan, R. L., & Olson, B. (2008). Family metaphors and moral intuitions: How conservatives and liberals narrate their lives. *Journal of Personality and Social Psychology*, 95, 978–990.

- McConaghy, N. (1993). *Sexual behavior: Problems and management*. New York, NY: Plenum.
- Meehl, P. E. (1993). Philosophy of science: Help or hindrance. *Psychological Reports*, 72, 702–734.
- Mercer, C. H., Hart, G. J., Johnson, A. M., & Cassell, J. A. (2009). Behaviorally bisexual men as a bridge population for HIV and sexually transmitted infections? Evidence from a national probability survey. *International Journal of STD and AIDS*, 20, 87–94.
- Meyer, I. H., & Dean, L. (1998). Internalized homophobia, intimacy and sexual behavior among gay and bisexual men. In G. M. Herek (Ed.), *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals* (pp. 160–186). Thousand Oaks, CA: Sage.
- Meyer-Bahlburg, H. F., Dolezal, C., Baker, S. W., & New, M. I. (2008). Sexual orientation in women with classical or non-classical congenital adrenal hyperplasia as a function of degree of prenatal androgen excess. *Archives of Sexual Behavior*, 37, 85–99.
- Midgley, M. (1992). *Science and salvation: A modern myth and its meaning*. London, England: Rutledge.
- Miller, R. B. (2001). Scientific vs. clinical-based knowledge in psychology: A concealed moral conflict. *American Journal of Psychotherapy*, 55, 344–356.
- Mohr, D. C. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology: Science and Practice*, 2, 1–27.
- Monachello, R. J. (2006). The father and son relationship in homosexual identity development: A phenomenological study (Unpublished doctoral dissertation). St. Mary's University, San Antonio, TX.
- Moradi, B., Mohr, J. J., Worthington, R. L., & Fassinger, R. E. (2009). Counseling psychology research on sexual (orientation) minority issues: Conceptual and

- methodological challenges and opportunities. *Journal of Counseling Psychology*, 56(1), 5–22.
- Morin, G., & Rothblum, G. (1991). Removing the stigma: Fifteen years of progress. *American Psychologist*, 46, 947–949.
- Murphy, T. F. (1992). Redirecting sexual orientation: Techniques and justifications. *Journal of Sex Research*, 29, 501–523.
- National Association for Research and Therapy of Homosexuality (NARTH) Scientific Advisory Committee. (2009). What research shows: NARTH's response to the APA claims on homosexuality. *Journal of Human Sexuality*, 1, 1–121.
- National Association of Social Workers. (2000). *Code of ethics of the National Association of Social Workers*. Washington, DC.
- Neeleman, J., & King, M. B. (1993). Psychiatrists' religious attitudes in relation to their clinical practice: A survey of 231 psychiatrists. *Acta Psychiatrica Scandinavica*, 88, 420–424.
- Nicolosi, J. (2009). *Shame and attachment loss: The practical work of reparative therapy*. Downers Grove, IL: InterVarsity Press.
- Nicolosi, J., Byrd, A. D., & Potts, R. W. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports*, 86, 1071–1088.
- Nicolosi, J., Byrd, A. D., & Potts, R. W. (2008). Clients' perceptions of how reorientation therapy and self-help can promote change in sexual orientation. *Psychological Reports*, 102, 3–28.
- O'Donahue, W. T. (1989). The (even) bolder model: The clinical psychologist as metaphysician-scientist-practitioner. *American Psychologist*, 44, 1460–1468.
- O'Donahue, W. T., & Caselles, C. E. (2005). Homophobia: Conceptual, definitional, and value issues. In R. H. Wright & N. A. Cummings (Eds.), *Destructive trends in mental health: The well-intentioned path to harm* (pp. 65–83). New York, NY: Routledge.

- Otis, M. D., & Skinner, W. F. (2004). An exploratory study of differences in views of factors affecting sexual orientation for a sample of lesbians and gay men. *Psychological Reports, 94*, 1173–1179.
- Owen, S., & Burke, T. W. (2004). An exploration of the prevalence of domestic violence in same-sex relationships. *Psychological Reports, 95*, 129–132.
- Parsons, J. T., Kelly, B. C., Bimbi, D. S., DiMaria, L., Wainberg, M. L., & Morgenstern, J. (2008). Explanations for the origins of sexual compulsivity among gay and bisexual men. *Archives of Sexual Behavior, 37*, 817–826.
- Paul, J. P., Catania, J., Pollack, L., Moskowitz, J., Canchola, J., . . . Mills, T. (2002). Suicide attempts among gay and bisexual men: Lifetime prevalence and antecedents. *American Journal of Public Health, 92*, 1338–1345.
- Paul, J. P., Catania, J., Pollack, L., & Stall, R. (2001). Understanding childhood sexual abuse as a predictor of sexual risk-taking among men who have sex with men: The urban men's health study. *Child Abuse and Neglect, 25*, 557–584.
- Ploderl, M., & Fartacek, R. (2005). Suicidality and associated risk factors among lesbian, gay, and bisexual compared to heterosexual Austrian adults. *Suicide and Life-Threatening Behavior, 35*, 661–670.
- Pomeroy, W. B. (1972). *Dr. Kinsey and the institute for sex research*. New York, NY: Harper & Row.
- Posner, R. A. (1992). *Sex and reason*. Cambridge, MA: Harvard University Press.
- Posner, R. A., & Silbaugh, K. B. (1996). *A guide to sex laws in the United States*. Chicago, IL: University of Chicago Press.
- Prestage, G., Jin, F., J., Zablotska, I., Grulich, A., Imrie, J., . . . Kaldor, J. (2008). Trends in agreements between regular partners among gay men in Sydney, Melbourne and Brisbane, Australia. *AIDS Behavior, 12*, 513–520.
- Quadland, M. C., & Shattls, W. D. (1987). AIDS, sexuality, and sexual control. *Journal of Homosexuality, 14*, 277–298.

- Rahman, Q., Kumari, V., & Wilson, G. D. (2003). Sexual orientation-related differences in prepulse inhibition of the human startle response. *Behavioral Neuroscience*, 117, 1096–1102.
- Redding, R. E. (2001). Sociopolitical diversity in psychology. *American Psychologist*, 56, 205–215.
- Rekers, G. A. (1995). Assessment and treatment methods of gender identity disorder and transvestism. In G. A. Rekers (Ed.), *Handbook of child and adolescent sexual problems* (pp. 272–289). New York, NY: Lexington Books.
- Remafedi, G., Farrow, J., & Deisher, R. (1991). Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics*, 87, 869–875.
- Remafedi, G., French, S., Story, M., Resnick, M., & Blum, R. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health*, 88, 57–60.
- Remafedi, G., Resnick, M., Blum, R., & Harris, L. (1992). Demography of sexual orientation in adolescents. *Pediatrics*, 89, 714–722.
- Rhodes, S. D., McCoy, T. P., Wilkin, A. M., & Wolfson, M. (2009). Behavioral risk disparities in a random sample of self-identifying gay and non-gay male university students. *Journal of Homosexuality*, 56, 1083–1100.
- Richards, P. S., & Bergin, A. E. (2000). *Handbook of psychotherapy and religious diversity*. Washington, DC: American Psychological Association.
- Richards, P. S., & Bergin, A. E. (2004). *Casebook for a spiritual strategy in counseling and psychotherapy*. Washington, DC: American Psychological Association.
- Richards, P. S. & Bergin, A. E. (2005). *Spiritual strategy for counseling and Psychotherapy* (2nd ed.). Washington, DC: American Psychological Association.
- Rosario, M., Schrimshaw, E. W., & Hunter, J. (2009). Disclosure of sexual orientation and subsequent substance use and abuse among lesbian, gay, and bisexual youths: Critical role of disclosure reactions. *Psychology of Addictive Behavior*, 23, 175–184.

- Rosenbluth, S. (1997). Is sexual orientation a matter of choice? *Psychology of Women Quarterly*, 21, 595–610.
- Rosik, C. H. (2003a). Motivational, ethical, and epistemological foundations in the treatment of unwanted homoerotic attraction. *Journal of Marital and Family Therapy*, 29, 13–28.
- Rosik, C. H. (2003b). When therapists do not acknowledge their moral values: Green's response as a case study. *Journal of Marital and Family Therapy*, 29, 39–45.
- Rosik, C. H. (2007a). Ideological concerns in the operationalization of homophobia, Part 1: An analysis of Herek's ATLG-R scale. *Journal of Theology and Psychology*, 35, 132–144.
- Rosik, C. H. (2007b). Ideological concerns in the operationalization of homophobia, Part 2: The need for interpretive sensitivity with conservatively religious persons. *Journal of Psychology and Theology*, 35, 145–152.
- Rubenstein, W. (Ed.) (1996). *Cases and materials on sexual orientation and the law* (2nd ed.). St. Paul, MN: West.
- Russell, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health*, 91, 1276–1281.
- Rutter, M. (2006). *Genes and behavior*. Malden, MD: Blackwell.
- Sandfort, T. G., Bakker, F., Schellevis, F., & Vanwesenbeeck, I. (2009). Coping styles as mediator of sexual orientation-related health differences. *Archives of Sexual Behavior*, 38, 253–263.
- Sandfort, T. G. M., de Graaf, R., Bijl, R. V., & Schnabel, P. (2001). Same-sex sexual behavior and psychiatric disorders. *Archives of General Psychiatry*, 58, 85–91.
- Santtila, P., Sandnabba, N. K., Harlaar, N., Varjonen, M., Alanko, K., & von der Pahlen, B. (2008). Potential for homosexual response is prevalent and genetic. *Biological Psychology*, 77, 102–105.

- Satinsky, S., Fisher, C., Stupiansky, N., Dodge, B., Alexander, A., Herbenick, D., & Reece, M. (2008, July). Sexual compulsivity among men in a decentralized MSM community of the Midwestern United States. *AIDS Patient Care and STDs*, 22(7), 553–560.
- Savin-Williams, R. (2005). *The new gay teenager*. Cambridge, MA: Harvard University Press.
- Schmalz, J. (1993, March 5). Poll finds even split on homosexuality's cause. *New York Times*, p. A14.
- Schneider, M. S., Brown, L. S., & Glassgold, J. M. (2002). Implementing the resolution on appropriate therapeutic responses to sexual orientation: A guide for the perplexed. *Professional Psychology: Research and Practice*, 33, 265–276.
- Schrimshaw, E., Rosario, M., Meyer-Bahlburg, H., Scharf-Matlick, A., Langstrom, N., & Hanson, R. K. (2006). Test-retest reliability of self-reported sexual behavior, sexual orientation, and psychosexual milestones among gay, lesbian, and bisexual youths: High rates of sexual behavior in the general population: Correlates and predictors. *Archives of Sexual Behavior*, 35, 225–234.
- Schroeder, M., & Shildo, A., (2002). Ethical issues in sexual orientation conversion therapies. In A. Shildo, M. Schroeder, & J. Drescher (Eds.), *Sexual conversion therapy: Ethical, clinical, and research perspectives* (pp. 131–166). New York, NY: Haworth.
- Schulte, L. J., & Battle, J. (2004). The relative importance of ethnicity and religion in predicting attitudes toward gays and lesbians. *Journal of Homosexuality*, 47, 127–141.
- Schwartz, M. F., & Masters, W. H. (1984). The Masters and Johnson treatment program for dissatisfied homosexual men. *American Journal of Psychiatry*, 141, 173–181.
- Sell, R. L (1997). Defining and measuring sexual orientation: A review. *Archives of Sexual Behavior*, 26, 643–658.

- Shernoff, M. (1999). Monogamy and gay men. *Family Networker*, 23, 63–71.
- Shernoff, M. (2006). Negotiated nonmonogamy and male couples. *Family Process*, 45, 407–418.
- Shildo, A. (1994). Internalized homophobia: Conceptual and empirical issues in measurement. In R. J. Green & G. M. Herek (Eds.), *Lesbian and gay psychology: Theory, research, and clinical applications* (pp. 176–205). Thousand Oaks, CA; Sage.
- Shildo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumer's report. *Professional Psychology: Research and Practice*, 33, 249–259.
- Shildo, A., Schroeder, M. & Drescher, J. (Eds.). (2001). *Sexual conversion therapy: Ethical, clinical and research perspectives*. New York, NY: Haworth.
- Silverstein, C. (2003). The religious conversion of homosexuals: Subject selection is the *voir dire* of psychological research. *Journal of Gay and Lesbian Psychotherapy*, 7, 31–53.
- Sisk, C. L., & Zehr, J. L. (2005). Pubertal hormones organize the adolescent brain and behavior. *Frontiers of Neuroendocrinology*, 26, 163–174.
- Slife, B. D. (2006). Are psychology's main methods biased against the worldview of many religious people? *Journal of Psychology and Theology*, 34, 217–231.
- Slife, B. D. (2008). A primer of the values implicit in counseling research methods. *Counseling and Values*, 53, 7–21.
- Slife, B. D., & Reber, J. S. (2009). Is there a pervasive implicit bias against theism in psychology? *Journal of Theoretical and Philosophical Psychology*, 29, 63–79.
- Spitalnick, J., & McNair, L. D. (2005). Couples therapy with gay and lesbian clients: An analysis of important clinical issues. *Journal of Sex and Marital Therapy*, 31, 43–56.
- Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior*, 32, 403–417.

Stark, R. (2005). *The victory of reason: How Christianity led to freedom, capitalism, and western success*. New York, NY: Random House.

Stein, E. (1999). *The mismeasure of desire: The science, theory and ethics of sexual orientation*. London, England: Oxford University Press.

Stoddard, J. P., Dibble, S. L., & Fineman, N. (2009). Sexual and physical abuse: A comparison between lesbians and their heterosexual sisters. *Journal of Homosexuality, 56*, 407–420.

Thase, M. E., & Jindal, R. D. (2004). Combining psychotherapy and psychopharmacology for treatment of mental disorders. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 743–766). New York, NY: Wiley.

Throckmorton, W. (1998). Attempts to modify sexual orientation: A review of outcome literature and ethical issues. *Journal of Mental Health Counseling, 20*, 283–304.

Throckmorton, W. (2002). Initial empirical and clinical findings concerning the change process for ex-gays. *Professional Psychology: Research and Practice, 33*, 242–248.

Throckmorton, W., & Welton, G. (2005). Counseling practices as they relate to ratings of helpfulness by consumers of sexual reorientation therapy. *Journal of Psychology and Christianity, 24*, 332–342.

Throckmorton, W., & Yarhouse, M. A. (2006). *Sexual identity therapy: Practice guidelines for managing sexual identity conflicts*. Retrieved from <http://www.drthrockmorton.com/article.asp?id=187>

Tomeo, M. E., Templar, D. L., Anderson, S., & Kotler, D. (2001). Comparative data of childhood and adolescent molestation in heterosexual and homosexual persons. *Archives of Sexual Behavior, 30*, 535–541.

Tozer, E. E., & McClanahan, M. K. (1999). Treating the purple menace: Ethical considerations of conversion therapy and affirmative alternatives. *Counseling Psychologist, 27*, 722–742.

- Trocki, K. F., Drabble, L. A., & Midanik, L. T. (2009). Tobacco, marijuana, and sensation seeking: Comparisons across gay, lesbian, bisexual, and heterosexual groups. *Psychology of Addictive Behaviors, 23*, 620–631.
- Tyler, K. A., Whitbeck, L. B., Hoyt, D. R., & Cauce, A. M. (2004). Risk factors for sexual victimization among male and female homeless and runaway youth. *Journal of Interpersonal Violence, 19*, 503–520.
- van Kesteren, N. M., Hospers, H. J., & Kok, G. (2007). Sexual risk behavior among HIV-positive men who have sex with men: A literature review. *Patient Education and Counseling, 65*, 5–20.
- Van Wyk, P. H., & Geist, C. S. (1984). Psychosocial development of heterosexual, bisexual, and homosexual behavior. *Archives of Sexual Behavior, 13*, 505–544.
- Vincent, W., Peterson, J. L., & Parrott, D. J. (2009). Differences in African American and white women's attitudes toward lesbians and gay men. *Sex Roles, 61*, 599–606.
- Weinrich, J. D., & Klein, F. (2002). Bi-gay, bi-straight, and bi-bi: Three bisexual subgroups identified using cluster analysis of the Klein Sexual Orientation Grid. *Journal of Bisexuality, 2*, 109–140.
- Whisman, V. (1996). *Queer by choice: Lesbians, gay men, and the politics of identity*. New York, NY: Routledge.
- Whitam, F. L., & Mathy, R. M. (1986). *Male homosexuality in four societies: Brazil, Guatemala, the Philippines, and the United States*. New York, NY: Praeger.
- Wilson, H. W., & Widom, C. S. (2010). Does physical abuse, sexual abuse, or neglect in childhood increase the likelihood of same-sex sexual relationships and cohabitation? A prospective 30-year follow up. *Archives of Sexual Behavior, 39*, 63–74.
- Wolok, J., Ybarra, M. L., Mitchell, K., & Finkelhor, D. (2007). Current research knowledge about adolescent victimization via the Internet. *Adolescent Medicine: State of the Art Reviews, 18*, 325–341.

- Worthington, R. L. (2004). Sexual identity, sexual orientation, religious identity, and change: Is it possible to depolarize the debate? *Counseling Psychologist, 32*, 741–749.
- Worthington, R. L., & Reynolds, A. L. (2009). Within-group differences in sexual orientation and identity. *Journal of Counseling Psychology, 56*, 44–55.
- Wright, R. H., & Cummings, N. A. (Eds.). (2005). *Destructive trends in mental health: The well-intentioned path to harm*. New York, NY: Routledge.
- Yarhouse, M. A. (1998a). When clients seek treatment for same-sex attraction: Ethical issues in the “right to choose” debate. *Psychotherapy, 35*, 234–259.
- Yarhouse, M. A. (1998b). When families present with concerns about an adolescent’s experience of same-sex attraction. *American Journal of Family Therapy, 26*, 321–330.
- Yarhouse, M. A. (2009). The battle regarding sexuality. In N. Cummings, W. O’Donohue, & J. Cummings (Eds.), *Psychology’s war on religion* (pp. 63–93). Phoenix, AZ: Zeig, Tucker, & Theisen.
- Yarhouse, M. A., & Brooke, H. L. (2005). *Running a sexual identity therapy group*. Poster presented at the annual convention of the American Psychological Association, Washington, DC.
- Yarhouse, M. A., & Burkett, L. A. (2002). An inclusive response to LGB and conservative religious persons: The case of same-sex attraction and behavior. *Professional Psychology: Research and Practice, 33*, 235–241.
- Yarhouse, M. A., Burkett, L. A., & Kreeft, E. M. (2002). Paraprofessional Christian ministries for sexual behavior and same-sex identity conflicts. *Journal of Psychology and Theology, 30*, 209–227.
- Yarhouse, M. A., & Tan, E. S. N. (2004). *Sexual identity synthesis: Attributions, meaning making, and the search for congruence*. Lanham, MD: University Press of America.

Yarhouse, M. A., & Throckmorton, W. (2001). Ethical issues in attempts to ban reorientation therapies. In P. A. Bigaler (Chair), *Clinical issues and ethical concerns regarding attempts to change sexual orientation: An update*. Paper presented at the Annual Meeting of the American Psychiatric Association, New Orleans, LA.

Yarhouse, M. A., & Throckmorton, W. (2002). Ethical issues in attempts to ban reorientation therapies. *Psychotherapy: Theory, Research, Practice, Training*, 39, 66–75.

Yarhouse, M. A., & VanOrman, B. T. (1999). When psychologists work with religious clients: Applications of the general principles of ethical conduct. *Professional Psychology: Research and Practice*, 30, 557–562.

Zubenko, G. S., George, A. W., Soloff, P. H., & Schulz, P. (1987). Sexual practices among patients with borderline personality disorder. *American Journal of Psychiatry*, 144, 748–752.

Zucker, K. J., & Bradley, S. J. (1995). *Gender Identity Disorder and psychosexual problems in children and adolescents*. New York, NY: Guilford.



National Assessment of Scopes of Practice for the Behavioral Health Workforce

April 2017

Cory Page MPH, MPP, Angela J. Beck, PhD, MPH, Jessica Buche, MPH, MA, Phillip M. Singer, MHSA, Christian Vazquez, Brian Perron, PhD

KEY FINDINGS

Scopes of practice (SOPs) define which services a state or territory allows a licensed or certified professional to perform. These essential constructs can vary by state, potentially leading to service coverage gaps on a national scale. The same statutes and administrative rules that contain SOP information also include other vital licensing information, such as educational and experience requirements.

The Behavioral Health Workforce Research Center extracted SOP information from online statutes and administrative rules for ten behavioral health occupations from all 50 states and Washington D.C. The purpose of the study was to: 1) create a database to serve as an updateable index of online statutes and administrative codes for the nation's behavioral health workforce; and 2) summarize descriptive information about behavioral health licensing, certification, and regulation across the country for multiple occupations.

Variables were grouped into three main categories: regulatory information, licensure and certification requirements, and authorized services. These data were then analyzed for descriptive trends. The results of this study showed that SOPs lack standardization across states and professions nationally. There is a great deal of variation in the detail provided in state SOPs. Peer and paraprofessionals, in particular, often lack formal SOPs, as many states have not codified the parameters of service authority or regulatory requirements. Telehealth was notably absent from SOP language in many cases, although Medicaid reimburses for this service in nearly every state.

Overall, more uniform definitions and requirements in SOPs would promote standardization and could aid reciprocity and endorsement procedures across states. Future research should look at SOP variability across states and professions and determine whether enhanced SOPs are associated with better access to care and health outcomes for those with behavioral health conditions.

CONTENTS:

Key Findings.....	1
Background.....	2
Methods.....	3
Results.....	4
Conclusion and Policy Considerations.....	25
References.....	28
Appendix.....	29



BACKGROUND

The Affordable Care Act¹ and the Mental Health Parity and Addiction Equity Act² have increased the need for behavioral healthcare workers,^{3,4} and challenged policymakers to regulate behavioral healthcare practice in such a way that maximizes the use of practitioners to deliver care to patients.⁵ As demand for greater and more diverse behavioral healthcare services increases, expansion of occupational SOPs has been suggested as one mechanism for enhancing workforce capacity.^{6,7,8,9} SOPs, while varied across states,¹⁰ attempt to define the services and functions permitted by different levels of a specific profession.

The term “SOP” often has different meanings across health professions: it can refer to standards of practice or professional competencies,^{10,11} the legal base of practice,^{8,9,12} or clinical parameters of practice.¹³ These guidelines are informed by the professionals themselves,^{14,15} typically through larger professional associations or accrediting bodies; some are codified in state statute and administrative rules for licensing purposes.¹⁰ State statutes, for example, tend to provide basic language to empower a state licensing board to vet and approve applicants for licensure. State regulation serves the purpose of protecting the public from unqualified professionals by removing information asymmetry – once a professional is licensed, the consumer can be sure that s/he has met certain training criteria.¹⁴ Administrative rules are drafted by state licensing boards to clarify the licensing process.^{10,13} These administrative rules will sometimes offer further detail about SOPs and also include specific requirements (e.g. education, experience) an applicant must meet in order to become a licensed or certified professional.^{7,16,17} SOPs that are uniform for a given occupation across states, and complementary across behavioral health occupations, may help ensure that a full range of mental health and substance use disorder services are authorized and easily accessible for patients.⁷

No system currently exists to track SOP content and modifications at the national level.^{7,18} Consequently, policymakers have limited opportunity to systematically assess the potential strengths and gaps in behavioral health professions across the country. This knowledge is essential for building and monitoring the capacity of the behavioral health workforce. To address this knowledge gap, the Behavioral Health Workforce Research Center (BHWRC) at the University of Michigan School of Public Health gathered and comprehensively analyzed state statutes and administrative rules for ten behavioral health occupations from all 50 states and the District of Columbia (D.C.).

The project had two aims:

- 1) To create a database to serve as an updateable index of online statutes and administrative codes for the nation’s behavioral health workforce.
- 2) To summarize descriptive information about behavioral health licensing, certification, and regulation across the country for multiple occupations.

The findings of this study are intended to aid research and policymakers in decisions about whether behavioral health workers are practicing to the full extent of their education and training and inform policies for modifying SOPs to enhance workforce capacity.

METHODS

We chose ten occupations for this study, which includes the core licensed behavioral health professions, as well as professions that provide support services: psychiatrists, psychologists, advanced practice psychiatric nurses (PMH-APRNs), licensed professional counselors (LPCs), marriage and family therapists (MFTs), addiction counselors, social workers, prevention specialists, psychiatric rehabilitation specialists, and psychiatric aides.

Data gathering was restricted to online sources for two reasons: first, all states have digitized their statutes and administrative rules to some extent and most are publicly accessible online for inquiring licensing boards and professionals. Second, the use of URL links permits the database to be a living resource, capable of being updated as statutes and administrative codes are amended. Online searches were conducted to find the appropriate professional licensing boards in each state. Often, state statutes and rules were available from central hubs; LexisNexis™ or an individual state's Secretary of State website were the most common online repositories. State licensing boards would often collate the most current versions of the statutes/rules and offer supplementary information in the form of Frequently Asked Questions.

For many of the professions providing support services, certification was used for regulatory purposes, rather than licensure. Information from state-approved (though not necessarily state-run) certification boards that acted similarly to state licensing boards was utilized. These certification boards posted "candidate guides" instead of administrative rules. These guides, when statutes or rules were not available, were gathered, coded, and analyzed alongside licensing materials.

Data Extraction and Study Variables

The raw data exhibited considerable heterogeneity in the type and structure of the documents; therefore, the research team constructed a standardized coding system that was used to extract comparable data. A single rater performed the initial data extraction, which was subsequently reviewed by a second rater. Rating discrepancies were resolved through discussions with the research team. Spreadsheets were developed to summarize information from statutes, administrative rules, and candidate guides into three categories: Regulatory Information, Licensure and Certification Requirements, and Service Authorization. Definitions for all variables used in this study are available in Appendix Table 1.

Regulatory Information: These data included broad information about relevant laws and rules, such as year the statute/rule was enacted, year the statute/rule was last updated, name of body that confers the license or

certification, whether that licensing body focuses on a single occupation or is part of a consolidated board, whether or not the professional title is protected by law, web address for the source of the SOP, and the exact language of the SOP.

Licensure and Certification Requirements: These variables include: the number of education hours required for initial licensure eligibility; minimum number of post-degree practice hours (i.e., hours performed under the direction of a supervisor, but the supervisor is not required to be present) required before obtaining license/certification; post-degree supervision hours required for license/certification (i.e., hours requiring direct supervision); minimum number of continuing education hours required to maintain license/certification, as well as required continuing education content; minimum amount of time in which the practice and/or supervision hours can be completed from time of application to licensure/certification; and the number of months the license/certification is valid until renewal is required. In addition, data were collected on licensure and certification through reciprocity or endorsement. Reciprocity refers to being able to apply for a license in one state based almost solely on having a comparable, active license in another state. Endorsement refers to being able to apply for a license in one state based on having comparable experience and education from another state. Reciprocity laws tend to be a “rubber stamp”, in that an incoming professional needs to do very little, outside of paying a fee and taking a jurisprudence examination, to get a new license. Endorsement laws, on the other hand, tend to require more examinations, practice, and verification.

Authorized Services: These data summarized whether the following services were legally authorized by the SOP for each occupation: assessment, diagnosis, psychotherapy, crisis intervention, and telehealth.

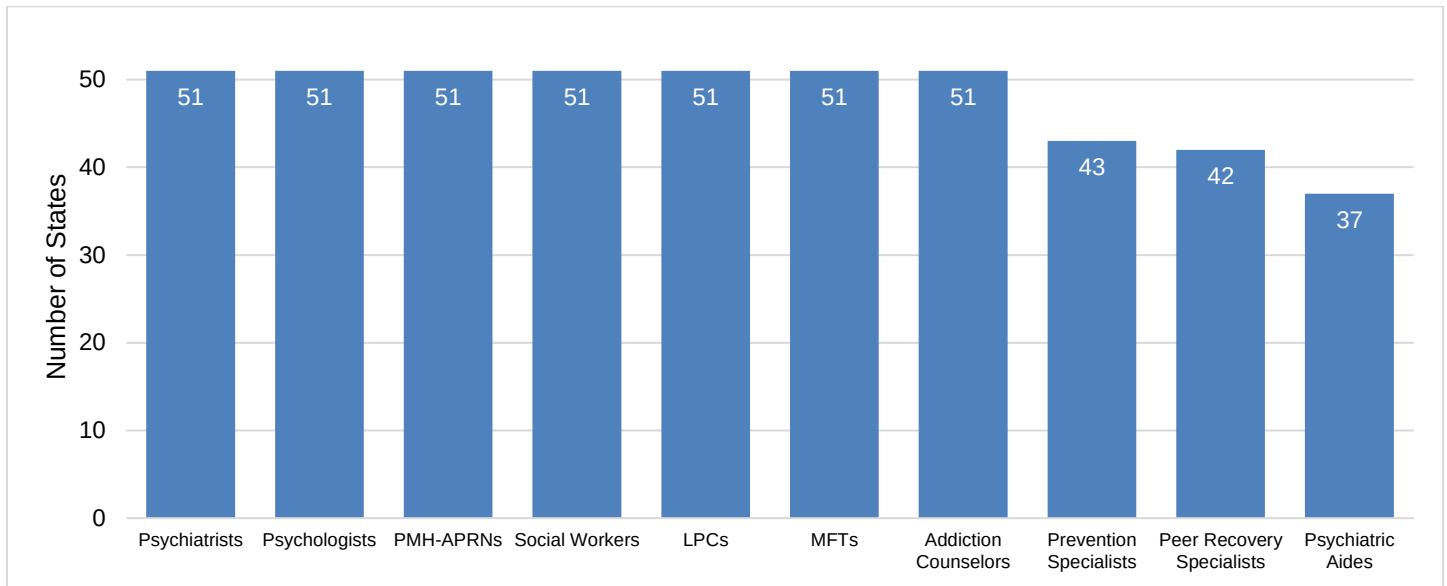
Data Analysis

All document sources and coded data were saved in a database. Quantitative descriptive statistics were generated for several of the Licensure/Certification Requirement variables such as educational hours, practice hours, supervised hours, and continuing education hours. Other variables included qualitative data for which themed summaries were generated. Summary results are presented for all SOP data, followed by profession-specific result profiles.

RESULTS

Regulatory Information

All states and D.C. have SOP language available for licensed behavioral health professionals; however, SOP availability for paraprofessional and peer occupations varies. Psychiatric aides have an SOP in the fewest states (37 states), followed by psychiatric rehabilitation specialists (42 states), and prevention specialists (43 states) (Figure 1).

Figure 1. Number of states with identified scopes of practice by occupation

PMH-APRNs= Advanced Practice Psychiatric Nurses; LPC=Licensed Professional Counselors; MFTs=Marriage and Family Therapists

Entities regulating licensure for physicians, nurses, and psychologists tend to be independent. However, many states use composite boards for regulating licensure of mental health counselors and MFTs (14 states); an additional 10 states also include social workers. Thirteen states use one regulatory body to oversee addiction counselors, prevention specialists, and peer recovery specialists. Psychiatric aides, if part of a composite regulatory unit, are regulated by the same board as either psychologists (2 states), PMH-APRNs (3 states), or as part of a combined board for addiction counselors, prevention specialists, and psychiatric rehabilitation specialists (1 state) (Table 1). A full listing of regulatory board composition by state is found in Appendix Table 2.

Table 1. Number of states regulating behavioral health professions through a composite board

Professions Regulated by a Composite Board	No. of States	Professions Regulated by a Composite Board	No. of States
- Marriage and Family Therapists - Licensed Professional Counselor	14	- Psychologist - Psychiatric Aide	2
- Addiction Counselor - Certified Prevention Specialist - Peer Recovery Specialist	13	- Addiction Counselor - Peer Recovery Specialist	2
- Marriage and Family Therapists - Licensed Professional Counselor - Social Workers	10	- Psychologist - Addiction Counselor - Certified Peer Specialist	1
- Addiction Counselor - Certified Prevention Specialist	8	- Licensed Professional Counselor - Addiction Counselor	1
- Certified Prevention Specialist - Peer Recovery Specialist	4	- Licensed Professional Counselor - Peer Recovery Specialist	1
- Advanced Practice Psychiatric Nurse - Psychiatric Aide	4	- Social Worker - Addiction Counselor	1
- Marriage and Family Therapist - Licensed Professional Counselor - Social Worker - Addiction Counselor	3	- Addiction Counselor - Certified Prevention Specialist - Peer Recovery Specialist - Psychiatric Aide	1
- Marriage and Family Therapist - Licensed Professional Counselor - Addiction Counselor	3	- Marriage and Family Therapist - Licensed Professional Counselor - Peer Recovery Specialist	1
- Psychiatrist - Psychologist - Advanced Practice Psychiatric Nurse - Marriage and Family Therapist - Licensed Professional Counselor - Social Worker - Addiction Counselor	3	- Psychologist - Marriage and Family Therapist - Licensed Professional Counselor - Social Worker - Addiction Counselor	1
- Psychiatrist - Psychologist - Advanced Practice Psychiatric Nurse - Marriage and Family Therapist - Licensed Professional Counselor - Social Worker	3	- Marriage and Family Therapist - Social Worker	1

Licensure and Certification Requirements

Licensure and certification requirements were most frequently specified for the core licensed behavioral health professions, although requirements across states varied for each occupation and some states did not detail all elements of licensure requirements in the SOP (Table 1). Licenses/certifications typically were valid for either 12 or 24 months, with rare exceptions. Psychiatrist licenses were more likely to be valid longer than 24 months compared with other license types. National examinations were required for professional licensure in all states. Paraprofessional licensure/certification required passing state-specific examinations in 11 instances. Content requirements for

continuing education hours were most likely to be outlined in SOPs for MFTs (49 states), LPCs (48 states), and addiction counselors (48 states). Although content varied across occupations, approximately 75% of continuing education content requirements included an ethics component. Detailed data summaries by state are available in Appendix Tables 3 and 4.

Table 2. Frequencies for licensure and certification requirements identified in state Scopes of Practice by occupation (n=51)

		Practice Hours	Supervision Hours	Completion Time (Months)	Continuing Education Hours	Renewal Time (Months)
Psychiatrist	n	49		49	46	51
	Mean	1.7 years		20	58	24
	Mode	1 year	N/A	12	40	24
	Range	1-3 years		12-36	20-200	12-48
Psychologist	n	46	40	40	48	51
	Mean	2001	115	17	31	21
	Mode	1500	100	12	40	24
	Range	1500-4500	24-400	10-60	6-60	12-36
Advanced Practice Psychiatric Nurse	n	22		1	41	50
	Mean	874		24	31	24
	Mode	500	N/A	N/A	30	24
	Range	384-3000		No range	8-90	12-48
Social Worker	n	50	43	50	51	51
	Mean	3224	107	25	34	24
	Mode	3000	100	24	30	24
	Range	1500-5760	20-200	24-36	15-48	12-36
Licensed Professional Counselor	n	48	44	34	50	51
	Mean	2820	126	25	32	22
	Mode	3000	100	24	40	24
	Range	1000-4000	50-400	12-48	10-55	12-36
Marriage and Family Therapist	n	49	46	36	50	51
	Mean	2387	169	24	32	22
	Mode	3000	200	24	40	24
	Range	1000-4000	52-360	12-36	15-55	12-48
Addiction Counselor (licensed)	n	25	21	10	25	25
	Mean	3568	210	24	36	22
	Mode	2000	300	36	40	24
	Range	1000-6000	24-500	6-36	15-60	12-36
Addiction Counselor (certified)	n	24	25	4	26	26
	Mean	4562	246	29	38	23
	Mode	6000	300	36	40	24
	Range	1000-6000	100-500	18-36	20-60	12-36
Prevention Specialist	N	40	39		39	40
	Mean	2388	138		36	22
	Mode	2000	120	N/A	40	24
	Range	2000-6000	120-300		12-60	12-26
Peer Recovery Specialist	N	22	20	3	35	35
	Mean	1034	48	36	20	20
	Mode	500	25	24	20	24
	Range	250-4500	24-300	24-60	5-40	12-36
Psychiatric Aide	N	9	4	13	6	6
	Mean	1606	42	16	23	20
	Mode	1000	N/A	12	10	24
	Range	500-4000	10-85	6-36	10-40	12-24

Authorized Services

Most states have authorizing language in the SOP to permit licensed behavioral health professionals to engage in assessment, psychotherapy, and crisis intervention services. Many licensed behavioral health professionals were also authorized to engage in diagnosis, though this service was sometimes reserved for psychiatrists as being part of the practice of medicine. Peer and paraprofessional workers tend not to have authority to diagnose patients, and many states provide no reference to service provision in the SOPs for prevention specialists, peer recovery specialists, and psychiatric aides. While many states do not mention diagnosis in their service authorization language, some states explicitly deny authority to diagnose patients for some licensed behavioral health professionals: addiction counselors in Tennessee and Utah; MFTs in Indiana; and licensed professional counselors in Indiana, Maine, and Texas. Similarly, Louisiana's SOP for psychiatric aides prohibits psychotherapy. Telehealth authority is most often granted to psychiatrists (31 states), followed by psychologists (21 states), and social workers (21 states). Telehealth is never explicitly authorized in SOPs for paraprofessional occupations. Diagnosis is most commonly authorized for psychiatrists (47 states), followed by psychologists (46 states), and social workers (45 states) (Table 3). SOP service authorities by state are summarized in Appendix Table 5.

Table 3. Number of states authorizing service provision in the Scope of Practice by occupation (n=51)

	Assessment	Diagnosis	Psychotherapy	Crisis Intervention	Telehealth
Psychiatrist	47	47	47	45	31
Psychologist	51	46	51	51	21
Advanced Practice Psychiatric Nurse	48	40	49	48	17
Social Worker	51	45	50	15	21
Licensed Professional Counselor	51	32	51	51	14
Marriage and Family Therapist	50	34	51	51	13
Addiction Counselor	51	14	51	51	9
Prevention Specialist	0	0	0	0	0
Peer Recovery Specialist	2	0	1*	26	0
Psychiatric Aide	32	0	22*	24	0

*For psychiatric aides and peer recovery specialists, “psychotherapy” does not refer to individual provision of this service, but indicates that the SOP permits assistance with therapy or treatment.

Note: States not included in these counts did not address provision of these services in the occupational SOP with the exception of 7 states that prohibit diagnosis (TN and UT: addiction counselors; IN: MFTs and LPCs; KS: LPCs; ME: LPCs; TX: LPCs), and LA, which prohibits psychiatric aides from engaging in psychotherapy.

Licensed Behavioral Health Professionals

The following occupations included in this section: psychiatrists, psychologists, advanced practice psychiatric nurses (PMH-APRNs), social workers, licensed professional counselors (LPCs), addiction counselors, and marriage and family therapists (MFTs).

Psychiatrists

Regulatory Information

The regulatory boards overseeing psychiatrists are uniformly under the jurisdiction of a state's physician Board of Examiners with the exception of Nebraska, Connecticut, Illinois, New York, Rhode Island, and Utah, which license physicians along with other professionals as a composite licensing body. No states define "psychiatrist" or "the practice of psychiatry" in their statutes because doctors first become licensed as allopathic physicians (M.D.s) or osteopaths (D.O.s) and then later go on to specialize in psychiatry. Twenty states, however, do define "physician" and all but 1 (South Dakota) define "the practice of medicine" which serves as the M.D.'s service authorization. Thirty-one states and D.C. include title protection in the SOP for psychiatrists, ensuring that licensure is necessary to advertise or practice as a psychiatrist. There is a great variability in the region, population size, and political composition among the 19 states that do not offer title protection, with 6 of the states coming from the southern U.S., 5 in the Midwest, and 3 in the Mid-Atlantic region.

Licensure Requirements

Overall, there is some variability in psychiatrist SOPs across states, both in terms of licensure requirements, as well as the level of detail outlined in the SOP.

Education: All regulatory bodies require psychiatrists to be a licensed physician with a medical degree. Only 5 states (Missouri, New York, Ohio, Oklahoma, and Texas) have specified the number of required hours of education prior to licensure, each at 60 credit hours. Only 4 states describe the types of courses that they require psychiatrists to have taken to receive licensure. All 50 states and D.C. require psychiatrists to pass the United States Medical Licensing Examination as part of their licensure requirements.

Practice, Supervision, and Continuing Education Requirements: Unlike the general education requirements, most state SOPs include requirements for continuing education, completion time, and renewal time. However, there is no specific delineation of required practice or supervision hours for licensure in state SOPs. Although practice hours are undefined, states do outline requirements for post-graduate residency programs, with 25 states requiring one year of post-graduate residency training, 16 requiring two years, and 8 requiring three years. Two states (North Dakota and South Carolina) do not define the required length of time for residency training.

Once licensed, all but 5 states have continuing education requirements for psychiatrists. The minimum number of required hours of continuing education is 40 hours in most states, but ranges substantially from 20 hours (Arkansas, Kentucky, Louisiana, North Carolina, Oklahoma, and Wyoming) to 200 hours (Washington state), with 58 hours being the average across the country.

Renewal, Reciprocity, and Endorsement: In most states, psychiatrists are required to renew their licensure every two years, with a range between 12 months (10 states) and 48 months (Washington). Only 13 states offer license reciprocity; however, 31 states and D.C. offer licensure by endorsement for psychiatrists.

Authorized Services

The specific services which psychiatrists are permitted to perform across the states are fairly uniform, across the series of services we collected. Forty-seven states SOPs permit psychiatrists to complete assessments, diagnosis, and psychotherapy. The remaining four states, Illinois, Missouri, Ohio, and South Dakota, did not include any delineation of allowable services under their licensure. Forty-five state SOPs permit crisis intervention, with Arkansas and California, in addition to the four states mentioned previously, not referencing this service as part of their SOP. Lastly, SOPs in 31 states and D.C. permit psychiatrists to provide telehealth services. More states might allow psychiatrists to perform telehealth services, but those provisions were not available in the SOP language.

Psychologists

Regulatory Information

The analysis of SOPs for psychologists across the 50 states and D.C. yielded thorough information on licensure requirements and service authorization. The regulatory bodies issuing licenses in each state vary in specialty, with nearly all states having a Board of Examiners specifically for the profession of psychology; only 10 states have regulatory bodies that oversee psychology and at least one other behavioral health profession and/or a composite board for licensing multiple professions.

SOPs in 46 states provide professional definitions of “psychology”, “psychologist”, and/or the “practice of psychology”, while 5 state SOPs do not include any specific language for defining the profession. However, all states and D.C. define the clinical scope for psychologists. Forty-six states have title protection for psychologists, meaning that a state license is required to self-advertise as a psychologist or perform psychological services. SOPs for psychologists in Nevada, New Mexico, Utah, Virginia, and Wyoming do not include title protection.

Licensure Requirements

Across the states, we found standardization with regard to education requirements and variability in practice, supervision, and continuing education requirements.

Education: All state regulatory bodies require psychologists to have a Master of Psychology degree and to pass the Association of State and Provincial Psychology Boards' Examination for Professional Practice of Psychology (EPPP) to obtain licensure.

Practice, Supervision, and Continuing Education Requirements: Some standardization exists across states with regard to practice requirements. The 46 state SOPs which specify practice requirements most commonly require 1500 hours (mean: 2001 hours; range: 1500-4500 hours). Alabama, Ohio, South Carolina, South Dakota, and West Virginia do not outline required practice hours in their SOP. States have varying activity requirements for practice hours, with most states requiring at least 100 hours of face-to-face clinical activities, and averaging 115 hours of activities (i.e. assessment, diagnosis, psychotherapy, etc.) to be eligible for licensure. Forty states explicitly mention whether and how many practice hours must be supervised prior to licensure.

Once licensed, nearly every state requires continuing education hours for licensure renewal; however, the number of hours required and specification of course content varies. For example, the number of required continuing education hours for licensure renewal ranges from 6 (South Dakota) to 60 (Vermont) (average: 31 hours; mode: 40). Thirty-two states have continuing education content designations; of these, 24 explicitly require "ethics" as part of their continuing education provisions.

Completion Time and Renewal: Of the 40 states that require supervised hours, 5 states require completion of hours in at least 10 months and 11 states require a minimum of 24 months; most other states (22) require licensees to complete these hours in no less than 12 months. North Carolina requires 36 months and West Virginia requires at least 60 months to complete all practice hours. The majority of states (35) require license renewal at 24 months, while 15 states require renewal at 12 months. Only one state (Kentucky) requires renewal at 36 months.

Reciprocity and Endorsement: For psychology, 19 states (37%) have reciprocity provisions in their SOP language, and 25 states (49%) have endorsement provisions. Of these states, 7 offer both reciprocity and endorsement (California, Indiana, Iowa, Kentucky, Massachusetts, Missouri, and Texas).

Authorized Services

Psychologists are permitted to perform assessments in all state SOPs and to diagnose patients in 46 state SOPs. Alaska, D.C., Illinois, Pennsylvania, and West Virginia do not specify in the SOP whether diagnosis is permitted. SOPs in all states and D.C. permit psychologists to perform psychotherapy and crisis intervention services. Language permitting psychologists to engage in telehealth was found for 21 states; the remaining 29 states and D.C. do not include language specifying telehealth rules or regulations within the psychologist SOP.

Advanced Practice Psychiatric Nurses

Regulatory Information

Three states (Maryland, Massachusetts, and Rhode Island) specifically include regulations for psychiatric nurses (i.e. clinical nurse specialist or psychiatric nurse practitioner) in their SOPs. For the remaining states, we used SOPs for Advanced Practice Registered Nurses (APRNs) or nurse practitioners to assess licensure requirements and service authority for Advanced Practice Psychiatric Nurses (PMH-APRNs. All 50 states and D.C. place APRNs under the governance of a state nursing board. For 44 of the states and D.C., this profession is licensed by a board specific to nursing; Connecticut, Illinois, Nebraska, New York, Rhode Island, and Utah provide licensing through broader licensing bodies. . All but four states (New Hampshire, New York, Utah, and Wyoming) provide a definition for “advanced practice registered nurse”. Forty-five states and D.C. include title protection in their SOP for APRNs; Alabama, Alaska, Arizona, Nevada, New Jersey, and Utah do not address title protection in their SOPs.

Licensure and Certification Requirements

Education: All governing bodies require PMH-APRNs to be licensed as either an advanced practice nurse or nurse practitioner and to have received a nursing degree. However, within the required education for APRNs, there is some variation. For example, only five states, California, Kansas, New Jersey, North Carolina, and Wisconsin, specify the number of hours of education required for the profession. Of those 5 states, there is a range of required hours from 30 credit hours (California) to 400 clock hours (North Carolina). Twenty-three states do not include any specification for the curriculum or any required domains of study which must be covered for PMH-APRNs. All 50 states and D.C. require passage of the National Council Licensing Examination for Registered Nurses before practicing.

Practice, Supervision, and Continuing Education Requirement: Twenty-two states include information about practice hour requirements for PMH-APRNs before they are licensed. States most frequently require 500 hours (mean: 874 hours; mode: 384-3000 hours). Supervisory hour requirements are not addressed in state SOPs. Once licensed, all but eight states (Georgia, Maryland, Missouri, New York, South Dakota, Utah, Vermont, and Virginia) require or delineate specific continuing education for PMH-APRNs. Most of those states require 30 hours of continuing education (mean: 31 hours; range: 8-90 hours).

Renewal, Reciprocity, and Endorsement: In most states, PMH-APRNs are required to renew their licensure every two years (mean: 24 months; range: 12-48 months). There are limited options for license reciprocity, with only 19 states offering the option. However, 38 states and D.C. provide endorsement with their SOP. Many of the states that allow reciprocity or endorsement participate in the Nurse Licensure Compact, which allows for the issuance of multistate licenses.

Authorized Services

The majority of state SOPs permit a variety of services to be performed by PMH-APRNs. All states except Alaska permit psychotherapy services; 48 states and D.C. include assessment and crisis intervention functions as part of their SOP (exceptions are Michigan and West Virginia); and 40 states address diagnosis as a service provided by PMH-APRNs. However, only 17 states have SOPs that include provision of services through telehealth.

Social Workers

Regulatory Information

Although SOPs tend to broadly cover different types of social workers, clinical social workers were the primary focus for this analysis, as they are more likely to be providing behavioral health services than non-clinical social workers. The regulatory bodies issuing licenses in each state vary in specialty, with 29 states having a licensing board solely for the profession of social work and the other 22 states having governing bodies that oversee social work and at least one other behavioral health profession, which most frequently included MFTs and/or LPCs (15 states).

Forty-one state SOPs include a professional definition for “social worker” and 13 of those SOPs specifically reference clinical social work. Forty-eight states have title protection for social workers, meaning that a state license is required to self-advertise as social worker or perform social work services. Title protection is not addressed in social work SOPs in Idaho, Michigan, and Nebraska.

Licensure Requirements

Across the states, we found standardization with regard to education requirements and variability in practice, supervision, and continuing education requirements.

Education: All regulatory bodies require clinical social workers to have a Master of Social Work degree for licensure. Unlike other behavioral health professions captured in our research, states eschew the option of listing specific credit hours and required classes for social workers and instead permit any degrees obtained from programs approved by the Council for Social Work Education to count for licensure.

Practice, Supervision, and Continuing Education Requirements: Little consistency exists across states with regard to practice requirements. The mean number of required hours of postgraduate practice for social work licensure is 3224 (mode: 3000; range: 1500-5760 hours). Approximately half of states require at least 1000 hours of face-to-face clinical activities (e.g. assessment, diagnosis, psychotherapy) to be eligible for licensure. Forty-three states include direct supervision requirements, and most require 100 hours of direct supervision before licensure (mean: 107; range: 50-200).

Once licensed, every state requires continuing education hours for licensure renewal; however, the number of hours required and specification of course content varies. Most states require 30 hours of continuing education for licensure renewal (range: 15-48 hours). Forty states require “ethics” as part of their continuing education provisions. The majority of the remaining states did not address continuing education content requirements in their SOP.

Completion Time and Renewal: Completion time refers to the minimum number of months of practice required before licensure. The majority of the states require at least 24 months of practice. Georgia, New York, and Washington require 36 months, and Connecticut has no stated minimum. Renewal refers to the number of months a license is valid before requiring renewal. The national average for social worker license renewal is 24 months (range: 12-36 months).

Reciprocity and Endorsement: For social work, 26 states (51%) have reciprocity provisions in their SOP language, and 32 states (63%) have endorsement provisions. Of these states, 10 offer both reciprocity and endorsement.

Authorized Services

Social workers are permitted to perform assessments in all states and to diagnose patients in 45 states. California, Georgia, Illinois, Nebraska, Pennsylvania, and Utah do not specify whether or not diagnosis is allowed. Language permitting social workers to engage in telehealth (i.e., providing services through electronic means) was found for 21 states; the remaining 30 states do not include language specifying telehealth rules or regulations within the social worker SOP.

Licensed Professional Counselors

Regulatory Information

All 50 states and D.C. have a state SOP available for LPCs. However, the regulatory bodies issuing licenses for LPCs vary; 11 states have a licensing board that is specifically assigned the LPC profession, while the other 40 states have governing bodies that oversee LPCs in addition to at least one other profession, which often include MFTs and social workers. Forty states and D.C. have title protection for LPCs, meaning that a state license is required to self-advertise as an LPC or perform services allowed by the profession. The remaining 10 states did not address title protection in the SOPs.

Licensure Requirements

Across the 50 states and D.C., there is variability in the title used for individuals permitted to provide behavioral health services under counseling licensure. Most states title their licensed counselors, “Licensed Professional Counselor” (27/51); however, 6 states use the title “Licensed Mental Health Counselor,” 5 states use “Professional Counselor,” three use “Clinical Mental Health Counselor,” 3 use “Licensed Clinical Professional Counselor” or “Licensed Professional Clinical Counselor,” 3 use “Mental Health Counselor,” 2 use “Licensed Professional Counselor of Mental Health,” one uses “Clinical Professional Counselor,” and one uses “Clinical Counselor of Mental Health”. The variability

of these titles across states presents a potential obstacle for the profession by reducing name recognition. Further, adding qualifiers such as “mental” and “health” into the title narrows the definition of authorized services.

Education: All governing bodies require LPCs to have a master’s degree for licensure. Forty-seven states explicitly list the number of hours needed to meet education requirements, with an average of 55 required credit hours for degree completion. Delaware, Georgia, Nebraska, and Washington do not list the number of hours necessary to meet education requirements. LPCs in all 50 states and D.C are required to pass an exam for licensure. Every state accepts examinations from the National Board for Certified Counselors, including the National Counselor Examination for Licensure and Certification and the National Clinical Mental Health Counseling Examination.

Practice, Supervision, and Continuing Education Requirements: There is minimal consistency across states with regard to practice requirements and 3 states (North Dakota, Florida, and Illinois) do not specify a required number of practice hours at all. The mean number of required practice hours for LPCs is 2820 (mode: 3000 hours; range: 1000-4000 hours). The majority (46 states) require in-person or face-to-face clinical activities to be eligible for licensure. Forty-four SOPs include supervision requirements, and the majority of states (24) require 100 hours of supervision (mean: 126; range: 50-400). Alabama, Florida, Hawaii, Illinois, New Jersey, Ohio, and Wisconsin do not specify supervised practice hours in the SOP.

Every state but Michigan lists continuing education hour requirements for licensure renewal. The number of hours required in each renewal cycle varies by state. On average, 32 hours of continuing education are required for licensure renewal (mode: 40 hours; range: 10-55 hours). Thirty-eight states list continuing education requirements in their SOP and roughly half (28 states) require “ethics” as part of their continuing education provisions.

Completion Time and Renewal: The majority of the states (26) require a minimum of 24 months of practice (mean: 25 months; range: 12-48 months). Renewal refers to the number of months a license is valid before requiring renewal. The national average for LPC renewal is 22 months (mode: 24 months; range: 12 to 36 months).

Reciprocity and Endorsement: Twenty-six states have reciprocity provisions in their SOP language, and 24 states have endorsement provisions. Only Pennsylvania offers both reciprocity and endorsement.

Authorized Services

LPCs are authorized to perform assessments, provide crisis intervention, and engage in psychotherapy in all 50 states and D.C. Thirty-two states permit LPCs to perform patient diagnosis, while Indiana, Kansas, Maine, and Texas expressly prohibit LPCs from providing diagnostic services. Language permitting LPCs to engage patients in telehealth exists for 14 states. While more states may allow LPCs to be reimbursed for telehealth services, the ability to do so was not listed in the SOP language.

Marriage and Family Therapists

Regulatory Information

MFTs are professionals who are licensed to provide behavioral health services specialized within the context of marriage, couples, and families. All 50 states and D.C. have a state SOP available for MFTs. Forty-three states have title protection for MFTs, meaning that a state license is required to self-advertise as an MFT or perform services allowed by the profession. SOPs in Iowa, Maine, New Mexico, Oregon, Texas, Utah, Virginia, and West Virginia do not address title protection.

Licensure Requirements

Although education requirements are fairly similar across states, SOPs for MFTs do outline differences in practice, supervision, continuing education, completion time, and renewal.

Education: All licensing boards require MFTs to have a master's degree for licensure. Forty states explicitly list the number of hours needed to meet education requirements, with an average of 47 required credit hours for degree completion (range: 27-60 credit hours). The remaining 11 states do not list the number of hours necessary to meet education requirements in their SOP. MFTs in 50 states and D.C. are required to pass an exam for licensure. Every state accepts the National Marital and Family Therapy Examination.

Practice, Supervision, and Continuing Education Requirements: All states but Alaska and Oklahoma outline practice hour requirements in their SOPs. Most states require 3000 hours of practice for licensure (mean: 2387 hours; range: 1000–4000 hours). Forty-two state SOPs require direct client contact to be eligible for licensure; the remaining state SOPs do not address this requirement. Forty-six SOPs have direct supervision requirements, as well; most states require 200 supervised practice hours (mean: 169; range: 52-360). SOPs in Colorado, Florida, Nebraska, New York, and Pennsylvania do not mention a direct supervision requirement.

Every state but Michigan lists continuing education hour requirements for licensure renewal. The number of required continuing education hours for licensure renewal ranges from 15 to 55 continuing education hours (mean: 32; mode: 40). Thirty-eight states list continuing education requirements in their SOP and over half (33 states) require “ethics” as part of their continuing education provisions.

Completion Time and Renewal: Completion time refers to the minimum number of months which must be spent practicing before licensure. Thirty-six states specified completion time in their SOP; 32 states require at least 24 months of practice (mean: 24 months; range: 12-36 months). The national average for MFT license renewal is 22 months (mode: 24 months; range: 12-36 months).

Reciprocity and Endorsement: Only twenty state SOPs permit license reciprocity for MFTs; 28 state SOPs permit endorsement. California, Kansas, Louisiana, Minnesota, Pennsylvania, and Tennessee offer both reciprocity and endorsement. Kentucky does not address reciprocity or endorsement in its SOP for MFTs.

Authorized Services

MFTs are authorized to provide crisis intervention and psychological services in all 50 states and the District of Columbia. All states allow MFTs to perform patient assessments, except Rhode Island, which does not list this service in their SOP. Thirty-four states allow MFTs to perform patient diagnosis. Arkansas, California, Idaho, Illinois, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, New York, Pennsylvania, Rhode Island, South Carolina, and Virginia do not list diagnosis as a service that MFTs can or cannot provide and Indiana explicitly indicates that MFTs cannot perform the service. Language permitting MFTs to engage patients in telehealth exists for 13 states.

Addiction Counselors

Addiction Counselors are unique in that 25 states have licensed addiction counselors (LACs), whereas the other half (26) did not, and instead made use of certified addiction counselors, often referred to as certified alcohol and drug counselors (CADCs). In addition, 40 states have multiple levels of licensure/certification with varying experience and education requirements. In order to obtain a consistent sample set with only one addiction counselor SOP per state, we followed a simple algorithm to decide which SOP was included:

- 1) *Licensure Before Certification.* SOPs for LACs were prioritized above CADCs due to the assumption that licensure by a state body would better reflect state-level SOP variation in behavioral health credentialing than certification. Example: South Dakota has a certified addiction counselor credential as well as a licensed addiction counselor credential. For this state, we chose to include the LAC credential.
- 2) *Least Education Required.* When multiple levels of certification or licensure were available, we defaulted to the SOP that required the least amount of formal education. This typically meant choosing positions that required only a GED. Thirty-two states allow licensees to substitute an advanced degree for practice hours and/or supervision hours. Example: To become a certified chemical dependency professional in Washington, an applicant must have an associate's degree. However, if they have a bachelor's degree, the 2500 practice hour requirement is reduced to 2000 hours. As a result of this substitution mechanism, a feature unique to the addiction counselor field, the practice hour and supervision hour requirements for addiction counselors are higher than other occupations in our data set.
- 3) *No Trainee/Assistant Positions.* We excluded SOPs for trainee and assistant positions, which tended to be the certification with the lowest education requirement. These were usually positions meant to help addiction counselors provide therapy to clients, or to engage in a professional experience prior to licensure.

Regulatory Information

Licensure/certification for addiction counselors is coupled with oversight of another behavioral health occupation in 37 states and comes from one of three sources: a regulatory board that specifically mentions addiction, drugs, or alcohol in their title; a certification board; or a broader credentialing authority such as multi-professional behavioral health licensing boards or state public health authorities. LACs are more likely to have title protection than certified addiction counselors; twenty-one of the 25 LAC SOPs are title protected in the SOP, while only 5 of the 26 CADC SOPs are title protected.

Licensure Requirements: Licensed Addiction Counselors

Education: All but 4 LAC SOPs (Maine, Montana, Nebraska, and Tennessee) require education above a high school diploma/GED. All states require an examination before licensure, and all states but Nevada and New Jersey specify IC&RC or NAADAC examination requirements.

Practice, Supervision, and Continuing Education Hours: The number of practice hours required for licensure as an addiction counselor is most commonly specified as 2000 hours (mean: 3568 hours; range: 1000-6000 hours). Direct client contact is specified by 5 states as part of the practice hour requirement. All states with a LAC credential require continuing education for re-licensure. Twenty-one states specify requirements for supervised practice hours, which average 210 hours across the SOPs (mode: 300 hours; range: 24-500 hours).

The number of required continuing education hours varies from a low of 15 hours in Tennessee to a high of 60 hours in Kentucky (mean: 36 hours; mode 40 hours). Fourteen state SOPs have an ethics requirement as part of their continuing education. Other specified content requirements include knowledge of laws relevant to addiction counseling (Arizona, New Jersey, and Virginia), as well as cultural competency/diversity (Arizona, Connecticut, and New Jersey). Nine states do not outline specific continuing education content requirements in the SOP.

Completion Time and Renewal: Only 10 states have a minimum completion time requirement, which ranges from 6 months to 36 months (mean: 24 months; mode: 36 months). Renewal periods range from a minimum of 12 months to a maximum of 36 (mean: 22 months; mode: 24 months).

Reciprocity and Endorsement: Fifteen states have reciprocity language that would allow licensed addiction counselors to obtain a credential in another state without requiring extra practice, education, or tests. Five states have endorsement language in the SOP that would allow experience/education gained in other states to count for their experience/education requirements.

Certification Requirements: Certified Alcohol and Drug Counselors

Education: Of the 26 CADC SOPs analyzed, only 8 require a degree greater than a high school diploma. All state SOPs except one require an examination before licensure, most of which require IC&RC or NAADAC examination. Alaska and New York did not specify an examination in the SOP.

Practice, Supervision, and Continuing Education Hours: The number of practice hours required for certification as an addiction counselor is most commonly 6000 hours (mean: 4562 hours; range: 1000-6000 hours). Supervision hours are specified by 25 states and range from 100 to 500 hours (mean: 246 hours; mode: 300 hours). All states with a CADC credential require continuing education for re-certification. The number of required continuing education hours varies from a low of 20 hours to a high of 60 hours (mean: 38 hours; mode: 40 hours). Seventeen state SOPs have an ethics requirement as part of their continuing education; HIV/AIDS is the second most common continuing education content requirement. Seven state SOPs do not require any specific subjects for continuing.

Completion Time and Renewal: Only 4 states have a minimum completion time, ranging from 18 months to 36 months (mean: 29 months; mode: 36 months). Renewal periods for CADC certification range from a minimum of 12 months in Alabama, Florida, and Idaho, to a maximum of 36 months in New York (mean: 23 months; mode: 24 months).

Reciprocity and Endorsement: Twenty-two states have reciprocity language that permits addiction counselors with a credential in one state to obtain a credential in another state without requiring extra practice, education, or tests. D.C. has endorsement language that allows experience/education gained in other states to count toward their experience/education requirements. No states have both reciprocity and endorsement language in their SOP.

Authorized Services: All Addiction Counselors

All addiction counselors, whether certified or licensed, are given the authority to perform assessments, provide counseling, and engage in crisis interventions in all state SOPs. LACs are more likely than CADCs to be given explicit diagnostic authority. Twelve of the 25 LAC SOPs authorize diagnosis, as do 2 of the 26 CADC SOPs. Addiction counselors in Utah and Tennessee are explicitly forbidden from performing diagnosis. All remaining SOPs do not specify diagnosis authority for addiction counselors. LACs are also more likely than CADCs to be given explicit telehealth authority. Seven of the 25 LAC SOPs authorize telehealth (Delaware, Kentucky, Louisiana, Nebraska, Nevada, New Hampshire, and Wyoming). Only Idaho and Illinois grant this authority in CADC SOPs. All remaining addiction counselors have no mention of telehealth in their SOP.

Peer and Paraprofessional Workers

The following occupations included in these analyses: prevention specialists, psychiatric rehabilitation specialists, and psychiatric aides.

Prevention Specialists

Regulatory Information

Forty-four states have an SOP for prevention specialists. Nearly all positions are titled “certified prevention specialist”/“prevention specialist”, with the exception of North Carolina, which uses the title “certified substance abuse prevention consultant”.

Twenty-seven of the regulatory boards for prevention specialists oversee at least one additional behavioral health profession, usually addiction counselors and/or peer recovery specialists. Colorado, Georgia, Kansas, Kentucky, Maine, Maryland, New Hampshire, New Jersey, South Carolina, and Washington appear to have regulatory boards focused solely on prevention professionals. Only Louisiana and Ohio authorizes title protection for prevention specialists in the SOP.

Certification Requirements

Education: Thirteen state SOPs require a degree beyond a high school diploma/GED. Thirty-nine states require the IC&RC written examination; Illinois requires a state examination; and Georgia does not reference an examination requirement in the SOP. Forty states outline education hour requirements which range from 15 to 270 hours (mean: 136 hours; mode: 120 hours). Thirty-nine states reference education content requirements, which primarily focus on alcohol, tobacco, and other drug use, prevention ethics, and HIV/AIDS content.

Practice, Supervision, and Continuing Education Hours: The number of required practice hours for prevention specialist certification for most of the 40 states listing this requirement in the SOP is 2000 hours (mean: 2388 hours; range: 2000-6000 hours). Direct supervision is included in the SOPs for 39 states and ranges from 120 to 300 hours (mean: 138 hours; mode: 120 hours). The majority of states (28) require 40 hours of continuing education as a condition of re-certification (mean: 36 hours; range: 12-60 hours). Twenty-eight state SOPs outline continuing education content requirements, which most frequently include ethics (22 states), and prevention of alcohol and substance abuse (12 states).

Completion Time and Renewal: Required completion time of requirements to obtain certification is not addressed in any SOP for prevention specialists. However, certification renewal periods are outlined for 40 states and are most commonly 24 months (mean: 22 months; range: 12-36 months)

Reciprocity and Endorsement: Reciprocity language is included in 42 state SOPs, though no SOP includes endorsement language.

Authorized Services

The SOPs analyzed in this study do not reference any service authority related to assessment, diagnosis, psychotherapy, crisis intervention, or telehealth for prevention specialists.

Peer Recovery Specialists

Regulatory Information

Nine states do not have SOPs for peer recovery specialists. For the remaining 41 states and D.C., the SOPs in this analysis include peer providers that may have different job titles. Most states use peer-related terminology for job titles such as: peer recovery specialist, peer support specialist, certified peer specialist, and certified recovery peer advocate; other job titles included in this analysis are: certified recovery support specialist (4 states); rehabilitation counselor (2 states); certified recovery coach (1 state); and mental health support specialist (1 state). States have varying types of regulatory bodies overseeing certification for peer recovery specialists. Five SOPs reference a regulatory board specifically for peer behavioral health professionals (Georgia, Montana, New Mexico, North Carolina, and Wisconsin). Of the remaining 37 states, 20 are credentialed by certification boards, while the rest (17) are credentialed by broader licensing bodies – typically state boards for addiction counselors. Four states (Kentucky, Massachusetts, New Hampshire, and New Jersey) have title protection for peer recovery specialists, meaning that state certification is required to self-advertise as a certified peer specialist.

Licensure and Certification Requirements

Education: Most states reference certification as the required credential for peer recovery specialists; however, the two states with rehabilitation counselors, Massachusetts and New Jersey, require licensure. Massachusetts requires 48 education hours and New Jersey requires 45 hours before taking a required exam for licensure. Seventeen state SOPs require IC&RC examination for certification and 10 state SOPs require a different type of examination that is usually state-specific; 13 SOPs for peer recovery specialists do not reference examination requirements. Of the 42 states that have certification training, 34 state SOPs have a required number of education and training credit hours, averaging 49 hours for program completion with a range from 10 (Montana) to 100 hours (Illinois).

Practice, Supervision, and Continuing Education Requirements: Little consistency exists across states with regard to practice requirements. The mean number of required practice hours for peer specialist certification is 1034 and ranges from 250 (Mississippi) to 4500 (Ohio). Each state has varying designations of what activities should be performed while completing practice hours, with less than half (17 states) requiring 6-36 months of work experience that includes face-to-face clinical activities (paid or volunteer work in peer recovery support setting, etc.) to be eligible for certification. Twenty states have direct supervision requirements; most states require 25 hours of supervision (mean: 48; range: 24-300). Notably, Massachusetts requires 300 supervised practice hours, Illinois requires 100 hours, D.C. requires 80 hours, and Tennessee requires 75 hours.

Once licensed or certified, 35 states require continuing education hours for licensure renewal; however, the course content and number of hours vary. For example, the number of required continuing education hours for renewal ranges from 5 (Montana) to 40 (Illinois, Indiana, New Jersey, and New Mexico) (mean: 20; mode: 20). Twenty-five states have specific continuing education designations; of these, 20 states specify “ethics” as part of their continuing education provisions for SOPs.

Completion Time and Renewal: Only three state SOPs reference completion time requirements; Massachusetts and New Jersey establish a minimum of 24 months, while New York requires completion of 1000 practice hours within 60 months. No other states mention any parameters for completion time. Renewal refers to the number of months a license is valid before requiring renewal. The national average for renewal is 20 months (range: 12 - 36 months). Little more than half of the states (22) require renewal at 24 months of practice, while 12 require renewal at 12 months. Only New York requires renewal at 36 months.

Reciprocity and Endorsement: Fifteen state SOPs have reciprocity provisions and only 1 state (Wyoming) has an endorsement provision. No state includes both reciprocity and endorsement in their SOPs.

Authorized Services

Peer recovery specialists are explicitly authorized to provide crisis intervention services in 27 state SOPs. They are permitted to perform assessments in 2 states (New Hampshire and New Jersey) and only New Jersey’s SOP allows peer recovery specialists to assist with psychotherapy services. No SOP specifies whether diagnosis is allowed. Finally, language permitting peer recovery specialists to engage in telehealth (i.e., providing services through electronic means) was not found for any of the states.

Psychiatric Aides

Regulatory Information

For the purpose of this study, “psychiatric aide” is defined as a paraprofessional whose main job duties include assisting a licensed behavioral health professional with assessments and/or therapy. Similar job titles included in this analysis are psychiatric technician, behavioral health technician, and behavioral health aide. Thirty-seven states have some form of psychiatric aide position, but the majority of these positions (30) are only listed as job descriptions under a state’s human resources website. Five states have licensed positions for psychiatric aides, including Alabama, Arkansas, California, Colorado, and Kansas. Florida is unique in having a certification for behavioral health technicians, instead of a license

Only 9 states have a regulatory board for psychiatric aides mentioned in their SOPs. Of these, Arkansas, California, Colorado, and Kansas license their psychiatric aides through the state board of nursing, Alabama and Oklahoma license their psychiatric aides through the state board of psychology, and Alaska and Delaware license their psychiatric

aides through larger regulatory boards; Florida certifies its behavioral health technicians through a certification board. Five states reference title protection in the SOP: Alabama, Arkansas, California, Colorado, and Kansas.

Licensure and Certification Requirements

Education: Eleven of the 36 psychiatric aide SOPs require a degree beyond a high school diploma/GED. Seven state SOPs require an examination before receiving their credential, most of which are state-specific examinations.

Practice, Supervision, and Continuing Education Hours: The number of practice hours required for a psychiatric aide credential is outlined in 9 state SOPs and ranges from 500 hours in Alabama to 4000 hours in Minnesota (mean: 1606 hours; mode: 1000 hours). Direct supervision hours are required in 4 states and range from 10 hours (Delaware) to 85 hours (Alaska) (mean: 42 hours). Only 6 states include continuing education requirements in their psychiatric aide SOPs. The number of hours required ranges from a low of 10 hours in Alabama and Florida to a high of 40 hours in Alaska (mean: 23 hours; mode: 10 hours). Only Alaska includes specific continuing education requirements, namely courses in “ethics & consent”, “confidentiality & privacy”, and “cross cultural communication & understanding and working with diverse populations”.

Completion Time and Renewal: Thirteen state SOPs specify completion time, which is most often stated as 12 months (mean: 16 months; range: 6-36 months). Of the 6 SOPs that outline renewal periods, two have a 12-month requirement and the other 4 have a 24-months requirement.

Reciprocity and Endorsement: Arkansas and California include reciprocity language in their SOP. Alaska, Arkansas, and Colorado include endorsement language in their SOP. No other state SOPs have language referring to reciprocity or endorsement tracks for credentialing.

Authorized Services

All psychiatric aide SOPs, with the exception of those from Minnesota, Montana, Nevada, New Jersey, and New York permit patient assessment. Psychiatric aides from these states do not have assessment explicitly granted or denied in the SOP. No psychiatric aides are given the authority to diagnose patients; instead, they are tasked with assisting patients with treatment already prescribed by a licensed behavioral health provider. Individual provision of psychotherapy is not an authorized service for psychiatric aides, but 22 SOPs permit assistance with therapy or treatment; Louisiana’s SOP expressly prohibits psychiatric aides from providing this service. Because of the broad definition used for “psychiatric aide,” 14 SOPs reference custodial duties. The language often references tasks such as “patient hygiene” or “maintaining a safe, clean environment.” Authority to restrain patients is authorized in some psychiatric aide SOPs, but was not referenced in SOPs for the other occupations included in this study. This authority is extended in seven states: Hawaii, Idaho, Kansas, Louisiana, New Mexico, Rhode Island, and Vermont. Telehealth authority is not referenced in any psychiatric aide SOPs.

CONCLUSIONS AND POLICY CONSIDERATIONS

This project successfully addressed its two aims of cataloging SOPs for behavioral health workers and identifying and comparing SOP variables that can guide policies to improve workforce capacity. Among the key findings of this study:

- SOPs lack standardization across states and professions. There were recognizable inconsistencies across states regarding the extent to which the SOP granted service authorities. In some cases, the SOP did not reference services that workers within the profession almost certainly provide (e.g., psychotherapy was not referenced for psychiatrists in 4 state SOPs). This is likely done to ensure that the SOP isn't overly prescriptive in order to promote flexibility of service provision, but it also limits our ability to assess service capacity throughout the workforce, as it is unclear for some professions whether omission of the service in the SOP implies it is outside the scope of authority or is a service regularly provided but simply isn't mentioned.
- More SOP detail is needed for peers and paraprofessionals (i.e., prevention specialists, peer recovery specialists, and psychiatric aides). Many states have not codified the parameters of service authority or regulatory requirements for these professions. This is a concern because these workers can provide niche behavioral health services and require less training than the core licensed professionals. Expanded SOPs for peer support positions, in particular, are advisable, as peer specialists are expected to become a substantial segment of the future behavioral health workforce. The profession has increasingly standardized its credentialing requirements in recent years, while Medicaid reimbursement for peer services expands to more states and mechanisms for integrating peer workers into additional settings are developed.¹⁹
- Addiction counselors have a unique role in the behavioral health workforce. Half of states appear to characterize these workers in more of a support position using certification and requiring they work under a licensed professional, while the other half of states license addiction counselors as an independent behavioral health provider. In addition, addiction counseling can be a supplemental credential to a provider licensed in another discipline. More research around the levels of licensure/certification and job functions for this important segment of the workforce would be valuable.
- Telehealth authority is noticeably absent from many SOPs. Although Medicaid reimburses for telehealth services in nearly every state, our study only found telehealth authorized in any profession's SOP in a little over half of states. This is potentially problematic, as SOPs serve as a fundamental source of information for behavioral health professionals. Without explicitly mentioning telehealth services in professional SOPs, or explaining requirements for training in, delivering, and billing for this service, providers may be less inclined to engage in telehealth.

Statutory or rule language changes could help promote the use of this service, which has the potential of expanding service coverage to traditionally underserved areas.

- More uniform definitions are needed among SOPs. For example, for social work professionals, the variation in “clinical” services allowed from state to state and variability in the practice and supervision hour requirements for licensure and certification across all states was evident. Further, each state has its own regulatory body for behavioral health workers and they are not necessarily aligned with each other. By making allowed services more uniform across the country, as well as by expanding reciprocity and endorsement protocols, states could encourage the free movement of behavioral health professionals and paraprofessionals across borders. Such changes could potentially help alleviate shortages in underserved areas.
- Although licensing examinations for behavioral health professionals were fairly uniform across the country, the examinations required for paraprofessional licensure or certification varied. The International Credentialing & Reciprocity Consortium (IC&RC) is responsible for much of the testing for paraprofessional workers, but states frequently create their own examinations. Varying standards of paraprofessional credentialing could prevent qualified persons from relocating to states where standards are more rigorous, or where the credential is not officially recognized. By establishing national standards for these positions, as the IC&RC attempts to do, such barriers could potentially be eliminated, thus increasing the mobility of behavioral health paraprofessionals across states.
- Requirements for professional licensure varied across the country, particularly regarding postgraduate supervision hour requirements. However, educational standards (both curriculums and required semester hours) were fairly uniform across professions, likely due to the influence that professional associations had in drafting the state SOPs. MFTs, licensed professional counselors, and psychologists were the most likely professions to have educational requirements defined in their SOPs.

Although changes in SOP authority may strengthen overall behavioral health workforce capacity, several barriers exist that could prohibit such changes. First, disciplines are often resistant to SOP changes, particularly those that expand authority of other disciplines, in order to protect their field’s identity and differentiate themselves in the service market. National professional associations already work with states to craft SOP language; if states initiate changes without cooperation and input from these associations, serious workforce repercussions could result. Second, if states expand authority for certain providers, they would need to ensure that those workers are properly trained. Such training introduces questions of cost and availability of supervision. Furthermore, service providers may be unwilling to provide new services unless they see a commensurate increase in pay. Finally, the field lacks empirical literature detailing how SOP changes lead to high quality and effective care delivery.

Despite these barriers, as we continue to pursue integrated and team-based care models, ensuring that all team members are authorized to work to the full extent of their training and scope of practice in every state could address some of the access to care issues impeding the behavioral healthcare delivery system. Although this study does not clearly define all solutions for addressing SOP concerns that impact workforce capacity, the data collected provide an evidence base to support several steps state policymakers could undertake to make SOPs more uniform and potentially close service gaps. Future research should look at SOP variability across states and professions and determine whether enhanced SOPs are associated with better access to care and health outcomes for those with behavioral health conditions.

ACKNOWLEDGMENT

This work is funded through HRSA Cooperative Agreement U81HP29300: Health Workforce Research Centers Program.

REFERENCES

1. Patient Protection and Affordable Care Act. House.gov. 2010.
<http://housedocs.house.gov/energycommerce/ppacacon.pdf>.
2. Implementation of the Mental Health Parity and Addiction Equity Act. SAMHSA.gov.
<https://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>.
Published January 24, 2017. Accessed April 25, 2017.
3. Thomas KC, Ellis AR, Konrad TR, Holzer CE, Morrissey JP. County-level estimates of mental health professional shortage in the united states. *Psychiatric Services*. 2009; 60(10):1323-1328.
4. Cochran G. Health care reform and the behavioral health workforce. *Journal of Social Work Practice in the Addictions*. 2014; 14(2):127-140.
5. Vernon D, Salsberg E, Erikson C, Kirch D. Planning the future mental health workforce: with progress on coverage, what role will psychiatrists play? *Academic Psychiatry*. 2009; 33(3):187-192.
6. Spetz J, Parente ST, Town RJ, Bazarko D. Scope-of-practice laws for nurse practitioners limit cost savings that can be achieved in retail clinics. *Health Affairs*. 2013;32(11); 1977-1984.
7. Dower C, Moore J, Langelier M. It is time to restructure health professions scope-of-practice regulations to remove barriers to care. *Health Affairs*. 2013; 32(11):1971-1976.
8. Regan PB, Salsberry PJ. The effects of state-level scope-of-practice regulations on the number and growth of nurse practitioners. *Nursing Outlook*. 2013;61(6):392-399.
9. Yee T, Boukus E, Cross D, Samuel D. Primary care workforce shortages: nurse practitioner scope-of-practice laws and payment policies. *National Institute for Health Care Reform Research Brief*. 2013;13:1-7. <http://www.floridanurse.org/ARNPCorner/ARNPDocs/ARNPResearchpaper2013.pdf>.
Accessed April 25, 2017.
10. West C, Hinton JW, Grames H, Adams MA. Marriage and family therapy: examining the impact of licensure on an evolving profession. *Journal of Marital and Family Therapy*. 2013; 39(1):112-126.
11. Mellin EA, Hunt B, Nichols LM. Counselor professional identity: findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development*. 2011;89(2): 140-147.
12. Dyeson TB. Social work licensure: a brief history and description. *Home Health Care Management & Practice*. 2004;1(5):408-411.
13. American Psychological Association. Model act for state licensure of psychologists. *American Psychologist*. 2011; 66(3):214-226.
14. Swagler RM, Harris DA. An economic analysis of licensure and public policy: evidence from the social work case. *The Journal of Consumer Affairs*. 1977;11(1):90.
15. White WD. The introduction of professional regulation and labor market conditions: occupational licensure of registered nurses. *Policy Sciences*. 1987;20(1):27-51.
16. Robiner WN. The mental health professions: workforce supply and demand, issues, and challenges. *Clinical Psychology Review*. 2006;26(5):600-625.
17. Cox DR. Board certification in professional psychology: promoting competency and consumer protection. *The Clinical Neuropsychologist*. 2009;24:493-505.
18. Morgen K, Miller G, Stretch LS. Addiction counseling licensure issues for licensed professional counselors. *The Professional Counselor*. 2012;2(1):58-65.
19. Mental Health America. What is a peer? 2017. <http://www.mentalhealthamerica.net/conditions/what-peer>.

Appendix Table 1. Variable definitions

Regulatory Information Variables	
State ID	This variable helps categorize data by state. Each state is spelled out in lower case, without spaces. For instance, Washington D.C. is coded as "districtofcolumbia"
State SOP	This is a binary variable, meant to signify whether a scope of practice was found for the profession in the specified state. Either a "Yes" or "No" is recorded. For our purposes, scope of practice had to include some specific professional responsibilities. Even if a scope of practice was not found, licensing information (such as experience or educational requirements for licensure) may still exist and have been recorded. In the case of paraprofessionals, we accepted professional "domains" as a scope of practice.
Year Initial	This is the year when legislation was passed in the state to allow for professional licensure. This information was difficult to ascertain, and very often the stand-in was to record the earliest date on the statute/code. Some states, instead of amending statutes and codes, re-write these sections or their entire constitution every so many years.
Year Renewed	This is the most current year when the legislation for professional licensure was renewed or amended. When there was a difference between the latest renewal year of the statutes or the administrative codes, we used whichever year was more recent. This determination rarely occurred, and overall the variable was less ambiguous than the Initial Year as it required no stand-ins.
Issuer	This variable helps to determine whether licensing is done by a state board for a single profession (i.e. "Colorado state board of psychologist examiners"), a state board for multiple professions (i.e. "Arkansas board of examiners in counseling"), or a broader regulatory body (i.e. "Connecticut department of public health"). All entries are spelled out in lower case with spaces. Whenever possible, we extracted the name for the licensing board from statutory definitions, often under the term "board."
Profession Code Definition/ Clinical Scope	These variables separate the description of the profession (definition) from the profession's scope of practice (clinical scope.) This language was usually contained under statutory definitions, but could sometimes be its own entry later in the statutes or in the administrative codes. The definition of the profession is usually broad language describing the nature of the services the professional is licensed to provide, while the clinical scope is a specific list of authorized services (like psychotherapy, diagnosis, etc.) Both variables are recorded as strings verbatim from the statutory/rule language.
Title Protect/Title Protect Desc	Title protection maintains the integrity of the profession by only allowing licensed/certified individuals to advertise themselves as a professional and/or punishing unlicensed/uncertified professionals for advertising to perform services they have not been credentialed to perform. "Title Protect" is a binary variable which is coded either as "Yes" or "No". "Title Protect Desc" is a string variable with the specific language about the title protection from the statutory/rule language.
Statute/Rule URL	These fields were meant for citing our sources for future research. The Statute URL should contain a hyperlink for the statute or state law language for the profession, and the Rule URL should contain the administrative code or rule language for the profession. Whenever possible, static links are to be provided. In the event that the link does not appear static, and is just a document upload subject to change when the document is updated, a URL is provided for the nearest static page that links to the appropriate content. In the event that statutes and rules are combined into a single document, the Statute URL

	variable will be a static URL that links to the document, and the Rule URL will be a direct link to the document. For professions that did not have statute language, but rather had manuals or application materials as hosted by a recognized state certification board/agency, the link to such materials under the Rule URL was included and Statute URL left blank.
Licensure and Certification Variables	
License Name	This variable is the full name of the license provided to the applicant, spelled out in lower case with spaces. In the event that the position is for a certified professional instead, this variable will reflect that as well (“certified addiction counselor” versus “licensed addiction counselor”). Particularly relevant for addiction counselors, there are often tiers of professional certification/licensure. Rather than documenting all possible levels for every state we used the following algorithm: 1) Licensure takes priority over certification: Licensure is overseen by the state and might be more likely to reflect state-dependent differences in behavioral health outcomes. As such, if there was an option for a certified addiction counselor and a licensed addiction counselor offered by the same state, we always chose the licensed counselor as the entry for the grid. 2) Minimal educational achievement: Our goal was to find the absolute <u>minimum</u> requirements for each profession. It made sense, then, to choose tracks that required less educational achievement. Some paraprofessionals (addiction counselors, prevention specialists, etc.) have different tracks depending on educational achievement. In these instances, we always chose the track with the <u>least</u> education required (Usually a GED or high school equivalent, which is reflected as “No” on the “degree_type” variable.) These no-degree options often came with greater necessary supervised and unsupervised work hour requirements as a balance. 3) When given the choice between an associate counselor or a counselor, we always chose to avoid associate statuses because they often could not practice independently – which seemed relevant to health outcomes, given there’d be no direct supervision or oversight of these professionals, making their preparation all the more important.
Degree Type	This binary variable refers to any educational degree beyond a high school diploma. If no such degree is required, a “No” is recorded. If an associate’s, bachelor’s, master’s, PhD, or other advanced degree is required, a “Yes” is recorded. See “License Name” for an explanation of why some paraprofessional or counseling entries did not require an advanced degree.
Education Hours/Description	The first variable is an integer meant to collect either the number of semester credit hours required in an educational program prior to licensure, or the number of training hours required before certification/licensure. Typically speaking, if the value in this variable is less than or equal to 60, then the variable is tracking semester hours of education. The second variable is a string variable meant to capture the core areas of education/training and the requisite time needed in each. In some cases, codes and statutes do not specify a minimum number of total education/training hours, but still require specified training hours in various subfields. In these instances, “edu_hours” has been left blank, even if there are minimum-standards required specified in “edu_hours_desc”. This seemed more accurate than summing the number of hours in “edu_hours_desc” and

	using that as the “edu_hours” value. For example, a paraprofessional title might require 6 hours of ethics training, 20 hours of alcohol, tobacco, and drug education, and 15 hours of counseling training – but not offer a total number of hours needed to fulfill the education requirement. Rather than marking “edu_hours” as 41, “edu_hours” was left blank, and the above values were included in “edu_hours_desc”.
Exam	This is a binary variable (“Yes” or “No”) that reflected whether or not an examination was required prior to licensure.
Exam Type	An addendum to the prior variable, this variable held the name of the examination required for licensure. The information was saved as a string in lower case with spaces.
Practice Hours / Number	The first variable is a binary variable referring to whether practice hours were required for licensure (“Yes”) or not (“No.”) The second variable is an integer variable referring to the <u>post-degree</u> practice hours required prior to obtaining a license. Occasionally, states will require a residency or other post-graduate training that extends for a certain period of time (like a 1-year residency for physicians after they obtain their medical degree) but no explicit minimum-hour requirement. In these instances, the “prac_hours” or “super_hours” variables were coded “No” and their corresponding “prac_hours_num” and “super_hours_num” are blank. However, in this case, “prac_hours_desc” and “super_hours_desc” was coded “Yes” and the time-component was added to the fields “prac_hours_desc” or “super_hours_desc”. This process fits the actual scope of practice documents better than the alternative of assuming 2000 hours for a year’s worth of experience.
Practice Hours Designation / Description	The first variable is a binary variable referring to whether the practice hours required in the previous variables had to be performed in a certain way (“Yes”) or not (“No”). Possibilities include some practice needing to be performed in a community service capacity, or in specific practice domains. The second variable is a string variable that listed the specific designations as to how the practice hours were to be performed.
Supervision Hours / Number:	The first variable was a binary variable referring to whether supervised work experience was required for licensure (“Yes”) or not (“No.”) The second variable was an integer variable referring to the <u>post-degree</u> supervised practice hours required prior to obtaining a license. If practice requirements in the statutes/rules did not explicitly state that supervision was required, the requirements were assumed to fall under Practice Hours instead of Supervision Hours.
Supervision Hours Designation / Description	The first variable is a binary variable referring to whether the practice hours required in the previous variables had to be performed in a certain way (“Yes”) or not (“No”). Possibilities include some practice needing to be performed in a community service capacity, or in specific practice domains. The second variable is a string variable that listed the specific designations as to how the practice hours were to be performed.
Completion Time	This is an integer variable meant to capture the <u>minimum</u> time required of practicing post-degree, in months, prior to licensure. Any time a state reported a minimum completion time in years, the value was converted into months. Often states only had a maximum time that professionals seeking licensure could not surpass if their education, practice, and supervision hours were to count for degree. In those cases, a time was not recorded.
Background Check	This is a binary variable that addresses whether a background check was explicitly required (“Yes”) or not (“No”). “Background check” could mean a criminal background check and/or requiring references from professionals.

Reciprocity A and B	Reciprocity A is a binary variable meant to capture whether or not a pathway for licensure by reciprocity was spelled out in the scope of practice (“Yes”) or not (“No”). Often, the word “reciprocity” was not used in the SOP, so contextually similar mechanisms by which a person with a license from another state is allowed to obtain a license based on the merits of their professional experience, with minimal to no other requirements, were also accepted. Reciprocity B is a string variable that captures the full language of how licensure by reciprocity functions in the state. There are often provisions in statute language for licensure by reciprocity. Almost invariably, the statute reads, “the board may confer a license of reciprocity on a professional licensed in another state, without examination, provided the requirements of that state have met the minimum standards of the requirements in this state.” However, the word “may” is not contractually obligating; licensing boards can choose to ignore this path to licensure at their discretion. Unless protocol for reciprocity is also spelled out in administrative codes and assured for out-of-state professionals, Reciprocity A was coded as “NA”.
Endorsement A and B	Endorsement A is a binary variable meant to capture whether or not a pathway for licensure by endorsement was detailed in the scope of practice (“Yes”) or not (“No”). Often, the word “endorsement” was not used in the SOP, so contextually similar mechanisms by which a person with substantial experience, but no previous license, is allowed to obtain a license based on the merits of their professional experience, with minimal to no other requirements, were considered. Endorsement B is a string variable that captures the full language of how licensure by endorsement functions in the state. Similar to the algorithm for Reciprocity, if a pathway for licensure by endorsement is not in both the state’s statutes and administrative codes, then Endorsement A was coded as “NA”.
Renewal	This is an integer variable meant to capture how long a license is valid, in months, before it must be renewed. If the scope of practice language determined this time in years, the time was converted to months before being put into the grid.
Continuing Education/Hours	The first variable is binary and meant to capture whether continuing education is a requirement for license renewal (“Yes”) or not (“No”). If it was not specifically mentioned, it was coded as “NA”. The second variable is an integer variable meant to capture the number of continuing education hours required for renewal.
Continuing Education Designation/Description	The first variable is binary and meant to capture whether the required continuing education hours have specific conditions that must be for license renewal (“Yes”) or not (“No”). If it was not specifically mentioned, “NA” was recorded. The second variable is a string variable meant to capture the specific areas required to be covered in continuing education, as well as the specific hours for each of those areas.
Authorized Services Variables: All service variables were binary variables recorded as either “Yes” or “No.” If the service was not explicitly mentioned in the SOP, “NA” was recorded to signify the term was missing.	
Assessment and Diagnosis	We defined “assessment” to mean having the knowledge and skills to generally identify symptoms and suggest a treatment. “Diagnosis,” on the other hand, was more explicitly medical and meant being able to use established diagnostic criterion to properly identify a disorder. To explain the difference, imagine someone falling and then going to an emergency room. The nurse on staff could “assess” the patient, recognize they’ve been injured, and properly splint

	the affected area. A trauma physician on staff could later “diagnose” the exact nature of the injury and suggest a more targeted treatment. For our purposes, if an SOP allowed a practitioner to diagnose, we assumed the practitioner was also allowed to assess, since diagnosis is applying specialized criteria on top of an assessment. We did not assume the reverse.
Psychotherapy	Psychotherapy, when used in the context of professional counseling, is a specific sub-practice of counseling. Often this word does not appear explicitly in the scopes of practice. Instead, we considered words such as “therapy,” “counseling,” or other phrases denoting a variation of therapeutic talk-therapy to be considered as “psychotherapy.”
Crisis Intervention	Crisis intervention is a specialized sub-practice that addresses severe psychological distress, such as a patient with suicidal impulses, or destructive behavior, such as a patient with a drug addiction.
Telehealth	Any provisions for providing care at a distance (via telephone, videoconference, email correspondence, etc.) were considered as allowing “telehealth” even if the term was not used explicitly. Occasionally, telehealth had its own statute or administrative code which was applied retroactively to certain licensed healthcare providers.

Appendix Table 2. Occupations regulated by a composite board by state

State	Psychiatrist	Psychologist	PMH-APRN	Licensed Professional Counselor	MFT	Social Worker	Addiction Counselor	Prevention Specialist	Peer Recovery Specialist	Psychiatric Aide
Alabama		X							N/A	X
Alaska								N/A	N/A	
Arizona				X	X	X	X	*	*	N/A
Arkansas			*	X	X				N/A	*
California			#	X	X	X	*	*	*	#
Colorado			X						N/A	X
Connecticut	X	X	X	X	X	X	X	*	*	
Delaware				X	X		X	*	*	
D.C.				X			X			N/A
Florida				X	X	X	*	*	*	*
Georgia				X	X	X				N/A
Hawaii				X	X	X	*	*		
Idaho				X	X		*	*	*	
Illinois	X	X	X	X	X	X	*	*	*	
Indiana				X	X	X	*	*	*	N/A
Iowa				X	X		*	*	*	
Kansas		*	X	*	*	*	*			X
Kentucky							X		X	N/A
Louisiana				X	X		*	*	N/A	
Maine				X	X					
Maryland				X	X		X			N/A
Massachusetts				X	X				X	N/A
Michigan							X	X	X	N/A
Minnesota							X	X	X	
Mississippi					X	X	*	*		
Missouri							X	X	X	
Montana				X	X	X	X	N/A		
Nebraska	X	X	X	X	X	X	X	N/A		N/A
Nevada				X	X			N/A	N/A	
New Hampshire				X	X	X	*		*	N/A
New Jersey				X					X	
New Mexico				X	X		*	*		

State	Psychiatrist	Psychologist	PMH-APRN	Licensed Professional Counselor	MFT	Social Worker	Addiction Counselor	Prevention Specialist	Peer Recovery Specialist	Psychiatric Aide
New York	X	X	X	X	X	X	*	*		
North Carolina							X	X		
North Dakota								N/A	N/A	
Ohio				X	X	X	*	*		
Oklahoma		X		*	*					X
Oregon				X	X		*	*	*	
Pennsylvania				X	X	X	*	*	*	
Rhode Island	X	X	X	X	X	X	*	*	*	
South Carolina				X	X					
South Dakota				X	X		*	*	N/A	
Tennessee				X	X					
Texas							X	X	X	N/A
Utah	X	X	X	X	X	X	X	N/A		
Vermont				X	X	*	*	N/A	N/A	
Virginia				X	X		X	*	*	N/A
Washington				X	X	X				
West Virginia				X	X		*	*	*	N/A
Wisconsin		*		X	X	X	*	*		N/A
Wyoming				X	X	X	X	N/A		

PMH-APRN, Advanced Practice Psychiatric Nurse; MFT, Marriage and Family Therapist

X= Professions are regulated by a composite board

*= Professions are regulated by a composite board (which doesn't include those designated with X)

#= Professions are regulated by a composite board (which doesn't include those designated with X or *) N/A=Scope of practice was unavailable

Appendix Table 3. State scopes of practice authorizing license/certification reciprocity and/or endorsement

State	Psychiatrist	Psychologist	PMH-APRN	Licensed Professional Counselor	MFT	Social Worker	Addiction Counselor	Prevention Specialist	Peer Recovery Specialist	Psychiatric Aide
Alabama	R E	R	E	R	E	R		R	*	
Alaska			E	E	E	E		*	*	E
Arizona	E		E	R	R	R E	R	R	R	*
Arkansas	E	E	E	E	E	R		R	*	R E
California	R	R E		E	R E	E		R	R	R
Colorado	E	E	E	E	E	E		R	*	E
Connecticut	E	E	E	E	E	E	E	R	R	*
Delaware	E	R	R E	R	R	R	R	R	R	
D.C.	E	E	R E	E	E	R E	E	R		*
Florida	E	E	E	E	E	E	R	R		
Georgia		E	E	E	E		R			*
Hawaii			E	R	R	R E	R	R		
Idaho	E	E	R E	E	E	E	R	R	R	
Illinois	E	E	E	E	E	E		R	R	
Indiana	E	R E	E	E	E		R	R	R	*
Iowa	R E	R E	R E	E	E	E	R	R	R	
Kansas	E	R		R	R E	R	R	R		
Kentucky	R E	R E	E	R		R		R		*
Louisiana	R	R	E	E	R E	R E	R	R	*	
Maine	R E		R	R	R	R		R		
Maryland			R E			E		R	R	*
Massachusetts		R E	R	R	R	R	R E	R		*
Michigan	E	E	E	E	E	E	R	R		*
Minnesota	R E	E	R E		R E	E	R	R		
Mississippi	R E	E	R E		E	R E	R	R		
Missouri	R E	R E	R E			R	R E	R	R	
Montana		R	R E	R	R	E		*	R	
Nebraska	R	R	R E	R	R	R	R	*		*
Nevada						E	R	*	*	
New Hampshire		R				E		R		*
New Jersey	E	E	E	E	R	E		R		
New Mexico	E	R	E	R	R	R	R	R		

State	Psychiatrist	Psychologist	PMH-APRN	Licensed Professional Counselor	MFT	Social Worker	Addiction Counselor	Prevention Specialist	Peer Recovery Specialist	Psychiatric Aide
New York	E			E	E	E	R	R		
North Carolina			E	R		E	R	R		
North Dakota	R E		R E	E	E	R E	R	*	*	
Ohio	E		E	E	E	R E	R	R		
Oklahoma	E	R	E	R E	E	R E	R	R		
Oregon	E	E		R	R	R E	R	R	R	
Pennsylvania	E		E	R E	R E	R E	R	R		
Rhode Island	E	E	R E	E	E	E	R	R	R	
South Carolina			R E	E	E	E	R	R		
South Dakota	R	R		R	R	R	R E	R	*	
Tennessee	E	R	R E	R	R E	R	R	R		
Texas		R E	R			R	R	R	R	*
Utah	E	E	R			E	R	*		
Vermont	R	E		E	E	E	R E	*	*	
Virginia		E	R E	E	E	E		R	R	*
Washington			E			R		R		
West Virginia	E	R	E	R	R		R	R	R	*
Wisconsin		E		R	R	R	R	R		*
Wyoming			E	R	R	R	R	*	E	

PMH-APRN, Advanced Practice Psychiatric Nurse; MFT, Marriage and Family Therapist

*=Scope of practice was not accessible

R=Scope of practice authorizes reciprocity of license/certification

E=Scope of practice authorizes endorsement of license/certification

Appendix Table 4. Licensure and certification data by state

State	Psychiatrist					Psychologist						PMH-APRN			
	Educ (Hrs)	Practice (Yrs)	Comp (Months)	Cont Ed (Hs)	Renewal (Months)	Educ (Hs)	Practice (Hrs)	Super (Hs)	Comp (Months)	Cont Ed (Hs)	Renewal (Months)	Educ (Hrs)	Practice (Hrs)	Cont Ed (Hrs)	Renewal (Months)
Alabama		1	12	25	12	60				20	12			24	24
Alaska		1	12	25	24		1500	100	10	20	12		500	24	24
Arizona		1	12	40	24		1500	150	12	40	24		500	90	48
Arkansas		2	36	20	12	80	2000	50	12	20	12		500	20	24
California		1	12	50	24		3000	300		36	24	30	1000	30	24
Colorado		1	12		24		1500	75	12	40	24		750		24
Connecticut		2	24	50	24		1800	135	24	10	12		2000	50	24
Delaware		3	36	40	24		1500	150	12	40	24			10	24
D.C.		3	36	50	24		4000	400	24	30	24			15	24
Florida		2	24	30	24	60	2000	100		40	24			24	24
Georgia		1	12	40	24	50	1500	50	11	40	24		500		24
Hawaii		2	24	50	24		1900		12	18	24			30	24
Idaho		1	12	40	24		2000	100	24	20	12			30	24
Illinois		1	12	150	36		1750	50	12	24	24			50	24
Indiana		1	12		24		1800	100		40	24			30	24
Iowa		1	12	40	24		1500	45	10	40	24			36	36
Kansas		1	12	100	12	90	3600	150	24	50	24	45	1000	30	24
Kentucky		3	36	20	12	45	1800	200		39	36			14	12
Louisiana		1	12	20	12		2000			40	12		500	30	12
Maine		3	36	100	24		1500	100	12	40	24		1500	75	24
Maryland		1	12	50	24		3250	162		40	24				24
Massachusetts		2	24	100	24		1600	100	10	20	24			15	24
Michigan		2	24	150	36		2000	96	24	30	24			25	24
Minnesota		1	12	75	36		1800	150	12	40	24		2080	24	24
Mississippi		1	12	40	24		2000			20	12		720	40	24
Missouri	60	1	12	25	12		1500	50	12	40	24		800		
Montana		1	12		24	60	1600	50	12	40	12			24	24
Nebraska		1	12	50	24		1500	200	12	24	24			20	24
Nevada		3	36	40	24	60	1750	100	10	30	24		1000	45	24
New Hampshire		2	24	100	24		3000	50	24	40	24		400	60	24
New Jersey		3	36	100	24	40	1750	200	12		24	39		30	24

State	Psychiatrist					Psychologist						PMH-APRN			
	Educ (Hrs)	Practice (Yrs)	Comp (Months)	Cont Ed (Hs)	Renewal (Months)	Educ (Hs)	Practice (Hrs)	Super (Hs)	Comp (Months)	Cont Ed (Hs)	Renewal (Months)	Educ (Hrs)	Practice (Hrs)	Cont Ed (Hrs)	Renewal (Months)
New Mexico		2	24	75	36		1500	46	12	40	24		400	50	24
New York	60	2	24		24	30	1750	100	24		24				24
North Carolina		1	12	20	12	60	4500	150	36	18	24	400	400	50	12
North Dakota		1		60	36		1500	100		20	12			12	24
Ohio	60	2	24	100	24	60			12	23	24			24	24
Oklahoma	60	1	12	20	12	90	2000	75	12	20	12			39	24
Oregon		1	12	60	24	30	1500		12	40	24		384	45	24
Pennsylvania		2	24	25	24		1750		12	30	24			30	24
Rhode Island		2	24	40	24	72	1500	50	12	24	24			10	24
South Carolina		1		150	36			50	12	24	24			30	24
South Dakota		2	24		12			24	12	6	12				24
Tennessee		1	12	40	24		1900	50	12	40	24				24
Texas	60	2	24	48	24	90	1750		24	20	12		400	20	24
Utah		2	24	40	24		4000	100	24	48	24		3000		24
Vermont		3	36	30	24	60	2000			60	24		400		24
Virginia		1	12	60	24	45	1500	100	12	14	12				24
Washington		2	24	200	48	40	1500		24	20	12		500	30	24
West Virginia		1	12	50	24	50		250	60		24			24	12
Wisconsin		2	24	30	24	30	2000			40	24	45		8	12
Wyoming		1	12	20	12	40	1500	75	24	15	12			15	24
Total n	5	51	49	46	51	22	46	40	40	48	51	5	22	48	51
Mean	60	1.6	19	58	24	56	2001	115	17	31	21	118	874	31	21
Mode	60	1	12	40	24	60	1500	100	12	40	24	45	500	30	24

PMH-APRN, Advanced Practice Psychiatric Nurse

Educ=education; Super=supervision; Comp=completion time; Cont Ed= continuing education

Note: Supervision requirements do not apply to psychiatrists or PMH-APRNs. Completion time does not apply to PMH-APRNs. Only Indiana specified completions time for PMH-APRNs (24 months). Blank cells indicate the requirement was not specified in the scope of practice.

State	Social Worker					Licensed Professional Counselor						Marriage and Family Therapist					
	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)	Educ (Hrs)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)	Educ (Hours)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)
Alabama		96	24	30	24	48	3000			40	24	30	1000	200	24	40	24
Alaska	3000	100	24	45	24	60	3000	100	24	40	24			200	24	45	24
Arizona	3200	100	24	30	24	60	3200	100	24	30	24		3200	100	24	30	24
Arkansas	4000	104	24	48	24	60	3000	175		24	24	60	3000	175	36	24	24
California	3200	104	24	36	24	60	3000	150		36	24	60	3000	52	24	36	24
Colorado	3360	96	24	40	24	60	2000	200	24	40	24		2000		24	40	24
Connecticut	3000	100		15	12	60	3000	100	12	15	12	45	1000	100	12	15	12
Delaware	3200	100	24	45	24		1600	100		40	24	45	3200	100	24	40	24
D.C.	3000	100	24	40	24	60	3500	200	24	40	24	60	3000	150	24	30	24
Florida	1500	52	24	30	24	60				30	24	36	4000			30	24
Georgia	3000	60	36	35	24		2400	120	48	35	24		2000	100	24	35	24
Hawaii	3000	100	24	45	36	48	3000	100	24	45	36	33	1000	200	24	45	36
Idaho	3000	100	24	20	24	60	1000	50	24	20	12	60	3000	200	24	20	12
Illinois	3000	96	24	30	24	48				30	24	48	3000	200	24	30	24
Indiana	3000	96	24	40	24	48	3000	100	24	20	12	27	1000	100	24	15	12
Iowa	4000	110	24	27	24	60	3000	200	24	40	24	60	3000	200	24	40	24
Kansas	4000		24	40	24	45	4000	267		30	24		4000	150		40	24
Kentucky	3120	200	24	30	36	60	4000	100		10	12		2000	200	24	15	12
Louisiana	5760	96	24	20	24	60	3000	100	24	40	24	60	4000	200	24	40	24
Maine	3200	120	24	25	24	48	2000	67	24	55	24	60	3000	200	24	55	24
Maryland	3000		24	40	24	60	2000	100	36	40	24	60	2000	100	24	40	24
Massachusetts	3500	100	24	30	24	48	3360	130	24	30	24	60	3360	200		30	24
Michigan	4000	96	24	45	36	48	3000	100	24		36		1000	200			24
Minnesota	4000	200	24	40	24	48	2000	100	12	20	12		1000	200	24	30	12
Mississippi	4000	100	24	40	24	60	3500	100	24	24	24		1000	200	24	24	24
Missouri	3000	104	24	30	24	48	3000	100	24	40	24	45	3000	360	24	40	24
Montana	3000	100	24	20	12	60	1500	75		20	12	48	3000	200		20	12
Nebraska	3000		24	32	24		3000			32	24		1500			32	24
Nevada	3000		24	36	24	48	3000	200	24	20	12	48	3000	200	24	20	12
New Hampshire	3000	100	24	40	24	60	3000	100	24	40	24		3000	200	12	40	24
New Jersey	1920		24	40	24	60	3000			40	24	33	3000	100		40	24
New Mexico	3600	90	24	30	24	48	3000	100	24	40	24	45	1000	200		40	24

State	Social Worker					Licensed Professional Counselor						Marriage and Family Therapist					
	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)	Educ (Hrs)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)	Educ (Hours)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)
New York	2000		36	36	36	60	3000	100		36	36	45	1500			36	36
North Carolina	3000	100	24	40	24	60	3000	100		40	24	45	1500	200		20	12
North Dakota	3000	150	24	30	24	48		100	24	30	24	33	1500	200	24	30	24
Ohio	3000	150	24	30	24	42	3000		24	30	24	30	1000	200	24	30	24
Oklahoma	4000	100	24	16	12	60	3000	112	36	20	12	33		150	24	20	12
Oregon	3500	100	24	40	12	60	2400	400	36	40	24	60	2000	150	36	40	24
Pennsylvania	3000	150	24	30	24	60	3000	75	24	30	24	60	3000		24	30	24
Rhode Island	3000	100	24	30	24	60	2000	100	24	40	24	60	2000	100	24	40	24
South Carolina	3000	100	24	40	24	48	1500	150	24	40	24	48	1500	150	24	40	24
South Dakota	3120	96	24	30	24	48	2000	100		20	12	48	1700	200		20	12
Tennessee	3000	100	24	30	24	60	3000	150	24	20	24	33	1000	200		20	24
Texas	3000		24	30	24	48	3000	75	18	24	24	45	3000	100	24	30	24
Utah	4000	100	24	40	24	60	4000	100	24	40	24	30	4000	100	24	40	24
Vermont	3000	100	24	20	24	60	3000	100	24	40	24	48	3000	100	24	20	24
Virginia	3000	50	24	30	12	60	3400	200		20	12	60	3000	200		20	12
Washington	4000	130	36	36	12		3000	100	36	36	24	45	3000	200	24	36	24
West Virginia	3000		24	40	24	60	3000	150		35	24	60	3000	150	24	35	24
Wisconsin	3000	104	24	30	24	42	3000		24	30	24	27	3000	300		30	24
Wyoming	3000	150	24	45	24	60	3000	100		45	24	48	3000	100		45	24
Total n	50	43	50	51	51	47	48	44	34	50	51	40	49	46	36	50	51
Mean	3224	107	25	34	24	55	2420	126	25	32	22	47	2387	169	20	32	22
Mode	3000	100	24	30	24	60	3000	100	24	40	24	60	3000	200	24	40	24

Educ=education; Super=supervision; Comp=completion time; Cont Ed= continuing education

Note: Blank cells indicate the requirement was not specified in the scope of practice. Education hours not specified in any social work scope of practice.

State	Addiction Counselor (licensed)						Addiction Counselor (certified)					
	Educ (Hrs)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)	Educ (Hrs)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)
Alabama							140	2000	150		20	12
Alaska									100		40	24
Arizona		3200	100	24	20	24						
Arkansas	270	6000		36	40	24						
California							315	3000	160		50	24
Colorado		5000	24		40	24						
Connecticut	360	6000	300	36	20	12						
Delaware	30	1600	100		40	24						
D.C.									180		40	24
Florida							350	4000	200		20	12
Georgia							270	6000	144		40	24
Hawaii							270	6000	240		40	24
Idaho							270	6000	300		20	12
Illinois							225	4000	150		40	24
Indiana							180	2000	220		40	24
Iowa							150	3000	500	18	40	24
Kansas	30	4000	200		30	24						
Kentucky	180	2000	300		60	36						
Louisiana	270	2000	300	12	48	24						
Maine		6000	300		36	24						
Maryland	60	2000	100	24	40	24						
Massachusetts	270	6000	300		40	24						
Michigan							270	6000	300		40	24
Minnesota							270	6000	300		40	24
Mississippi							270	6000	300		40	24
Missouri							180	4000	300		40	24
Montana	400	1000	500	6	20	12						
Nebraska	270	6000	300	36	40	24						
Nevada		2000			40	24						
New Hampshire		6000			48	24						
New Jersey	18	4000	270		40	24						
New Mexico							270	6000	300	36	40	24
New York							350	6000	300	36	60	36
North Carolina	180	4000	300	24	30	24						

State	Addiction Counselor (licensed)						Addiction Counselor (certified)					
	Educ (Hrs)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)	Educ (Hrs)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)
North Dakota	32	1400	50	6	40	24						
Ohio	650	2000	220		40	24						
Oklahoma	45	2000			20	12						
Oregon							150	1000			40	24
Pennsylvania							300	4000	300		40	24
Rhode Island							270	6000	300		40	24
South Carolina							270	4000	150		40	24
South Dakota	21	2000	300		40	12						
Tennessee	270	6000	100	36	15	12						
Texas							270	6000	300		40	24
Utah	60	2000	50		40	24						
Vermont							270	6000	300		40	24
Virginia	60	4000	200		20	12						
Washington							60	2500	150		28	24
West Virginia							270	6000	300		40	24
Wisconsin							360	4000	200	24	40	24
Wyoming	21	3000	100		45	24						
Total n	20	25	21	10	25	25	24	24	25	4	26	26
Mean	175	3568	210	24	36	24	250	4563	246	29	38	23
Mode	270	2000	300	36	40	24	270	6000	300	36	40	24

Educ=education; Super=supervision; Comp=completion time; Cont Ed= continuing education

Note: Blank cells indicate the requirement was not specified in the scope of practice.

State	Prevention Specialist					Peer Recovery Specialist						Psychiatric Aide					
	Educ (Hrs)	Practice (Hrs)	Super (Hrs)	Cont Ed (Hrs)	Renewal (Months)	Educ (Hrs)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)	Educ (Hours)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)
Alabama	100	4000		12	12							45	500	50	6	10	12
Alaska												180	1000	85		40	24
Arizona	120	2000	120	20	12	46	500	25									
Arkansas													1000			15	24
California	120	2000	120	20	12	100	500	25			24	576	954		12	30	
Colorado	120	2000	120	40	24					10		400					24
Connecticut	100	2000	120	20	12	50	500	25			12	80					
Delaware	120	2000	120	40	24	54	1000			10	24			10			
D.C.								80		20							
Florida	120	2000	300	20	12	75	1000	24			12	30	1000	24		10	12
Georgia	120	2000		40	24					10	12						
Hawaii	100	2000	120	40	24					12	12						
Idaho	120	2000	120	20	12	46	500	25		16	12						
Illinois	120	2000	120	40	24	100	2000	100		10	24						
Indiana	100	2000	120	40	24	30				40	24						
Iowa	168	2000	120	40	24	46	500	25		40	24						
Kansas	150	3500	120	40	24	15				20		900				30	24
Kentucky	150	2000	120	40	24	60	500	25			12						
Louisiana	100	2000	120	48	24					10							
Maine	120	2000	120	40	24	75											
Maryland	120	2000	120	40	24	46	500	25			24						
Massachusetts		2000	120	40	24	48	3000	300	24	20	24						
Michigan	120	2000	120	40	24	46	500	25		30	24						
Minnesota	120	2000	120	40	24	40				20	24		4000				
Mississippi	150	2000	120	40	24		250			20							
Missouri	120	4000	120	40	24	46	500	25			24				12		
Montana						10				20	12				24		
Nebraska						40				5	12						
Nevada										6					12		
New Hampshire	240	4000	240	40	24						24						
New Jersey	120	4000	120		24	45	3000		24	12	24		2000		12		
New Mexico	120	2000	120	40	24	40				40	24		2000		12		

State	Prevention Specialist					Peer Recovery Specialist						Psychiatric Aide					
	Educ (Hrs)	Practice (Hrs)	Super (Hrs)	Cont Ed (Hrs)	Renewal (Months)	Educ (Hrs)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)	Educ (Hours)	Practice (Hrs)	Super (Hrs)	Comp (Months)	Cont Ed (Hrs)	Renewal (Months)
New York	120	2000	120	60	36	46	1000	25		40	36		2000		12		
North Carolina	270		300	30	24	40				30	24						
North Dakota										20							
Ohio	190	2000	120	40	24	56	4500				24						
Oklahoma	150	2000	120			40				30	12						
Oregon	150	2000	120	40	24	80	500	25		12	24				18		
Pennsylvania	150	4000	150	40	24	54				20	24	75					
Rhode Island	175	2000	120	40	24	46	500	25		30	24				12		
South Carolina						40				10	12						
South Dakota	15	2000	300	20	12					20							
Tennessee	120	2000	120	40	24			75			12						
Texas	120	2000	120	40	24	46	500	25		10	24						
Utah										20							
Vermont																	
Virginia	120	6000	120	40	24	46	500	25			24						
Washington	150	2000	120	40	24	40				20							
West Virginia	180	2000	150	40	24	46	500	25			24						
Wisconsin	240	2000	120	40	24					20	24						
Wyoming						32				20	12						
Total n	39	39	38	38	39	34	22	20	2	35	35	8	9	4	13	6	6
Mean	136	2398	139	37	22	49	1034	48	24	20	20	286	1606	42	16	23	20
Mode	120	2000	120	40	24	46	500	25	24	20	24	n/a	1000	n/a	12	10	24

Educ=education; Super=supervision; Comp=completion time; Cont Ed= continuing education

Note: Blank cells indicate the requirement was not specified in the scope of practice.

Appendix Table 5. Services explicitly authorized by state scopes of practice

State	Psychiatrist	Psychologist	PMH-APRN	Licensed Professional Counselor	MFT	Social Worker	Addiction Counselor	Peer Recovery Specialist	Psychiatric Aide
Alabama	A D P C I	A D P C I	A D P	A D P C I	A D P C I	A D P C I	A P C I	*	A P
Alaska	A D P C I	A P C I	A	A D P C I	A D P C I	A D P T	A P C I	*	A P C I
Arizona	A D P C I T	A D P C I T	A D P C I	A D P C I T	A D P C I T	A D P T	A D P C I	C I	*
Arkansas	A D P T	A D P C I	D P	A P C I T	A P C I T	A D P T	A P C I	*	A P
California	A D P T	A D P C I	A D P C I	A P C I	A P C I	A P C I	A P C I		A P
Colorado	A D P C I T	A D P C I T	D P C I	A D P C I	A D P C I	A D P C I T	A D P C I	*	A P C I
Connecticut	A D P C I T	A D P C I T	A D P C I	A D P C I	A D P C I	A D P	A P C I	C I	A
Delaware	A D P C I T	A D P C I T	A D P C I	A D P C I T	A D P C I T	A D P C I T	A P C I	C I	A P C I
D.C.	A D P C I	A P C I	A D P	A D P C I	A D P C I T	A D P	A D P C I	C I	*
Florida	A D P C I	A D P C I	A D P	A D P C I	A D P C I	A D P C I	A P C I	C I	A C I
Georgia	A D P C I T	A D P C I	A D P	A D P C I T	A D P C I T	A P C I T	A P C I	C I	*
Hawaii	A D P C I T	A D P C I	A D P	A D P C I	A D P C I	A D P	A P C I	C I	A C I
Idaho	A D P C I T	A D P C I T	D P C I	A P C I T	A P C I T	A D P	A P C I T	C I	A P C I
Illinois		A P C I	A D P C I	A D P C I T	A P C I T	A P	A P C I T	C I	A C I
Indiana	A D P C I	A D P C I	A D P	A P C I	A P C I	A D P	A P C I	C I	*
Iowa	A D P C I T	A D P C I T	D P C I	A P C I T	A P C I T	A D P T	A P C I	C I	A P C I
Kansas	A D P C I	A D P C I	A D P	A D P C I	A D P C I	A D P C I	A D P C I	C I	A P C I
Kentucky	A D P C I T	A D P C I T	A D P C I	A P C I T	A P C I T	A D P C I T	A P C I T	C I	*
Louisiana	A D P C I T	A D P C I T	A D P C I	A D P C I T	A D P C I	A D P	A P C I T	*	A C I
Maine	A D P C I T	A D P C I T	A D P	A P C I	A D P C I	A D P	A P C I	C I	A P C I
Maryland	A D P C I	A D P C I T	A D P	A D P C I	A D P C I	A D P	A D P C I	C I	*
Massachusetts	A D P C I T	A D P C I T	A D P	A D P C I	A P C I	A D P T	A P C I	C I	*
Michigan	A D P C I	A D P C I	D P	A P C I	A P C I	A D P C I	A P C I	C I	*
Minnesota	A D P C I T	A D P C I	A D P	A P C I	A P C I	A D P C I T	A P C I	C I	
Mississippi	A D P C I T	A D P C I T	A D P C I	A D P C I	A D P C I	A D P C I	A P C I	C I	A
Missouri		A D P C I	A D P C I	A P C I	A D P C I	A D P	A P C I	C I	A P C I
Montana	A D P C I T	A D P C I	A D P	A D P C I	A D P C I	A D P	A P C I	C I	
Nebraska	A D P C I T	A D P C I T	A D P C I	A P C I T	A P C I T	A P	A D P C I T	C I	*
Nevada	A D P C I T	A D P C I T	A D P C I	A D P C I T	A D P C I T	A D P T	A D P C I T	*	P C I
New Hampshire	A D P C I T	A D P C I T	A D P C I	A D P C I	A D P C I	A D P	A D P C I T	A C I	*
New Jersey	A D P C I T	A D P C I T	A D P	A P C I	A P C I	A D P	A D P C I	A P C I	P C I
New Mexico	A D P C I T	A D P C I	A D P	A D P C I	A D P C I	A D P C I T	A P C I	C I	A P C I
New York	A D P C I	A D P C I T	A D P	A P C I	A P C I	A D P C I	A P C I	C I	P C I

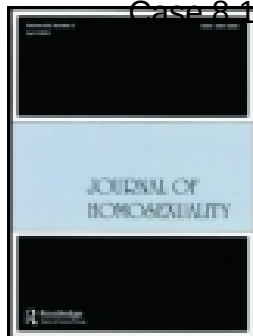
State	Psychiatrist	Psychologist	PMH-APRN	Licensed Professional Counselor	MFT	Social Worker	Addiction Counselor	Peer Recovery Specialist	Psychiatric Aide
North Carolina	A D P C I T	A D P C I	A D P	A D P C I	A D P C I	A D P	A P C I		A P C I
North Dakota	A D P C I	A D P C I	A D P	A P C I	A D P C I	A D P T	A P C I	*	A C I
Ohio		A D P C I T	D P C I	A D P C I T	A D P C I	A D P C I T	A D P C I		A C I
Oklahoma	A D P C I T	A D P C I	A D P	A D P C I	A D P C I	A D P C I T	A D P C I		A P
Oregon	A D P C I T	A D P C I	A D P	A D P C I T	A D P C I T	A D P	A P C I		A P
Pennsylvania	A D P C I T	A P C I	A D P	A P C I	A P C I	A T	A P C I		A
Rhode Island	A D P C I	A D P C I	A D P	A D P C I	P C I	A D P	A P C I		A P C I
South Carolina	A D P C I T	A D P C I	D P	A P C I	A P C I	A D P T	A P C I		A
South Dakota		A D P C I	A D P	A D P C I	A D P C I	A D P	A P C I	*	A P C I
Tennessee	A D P C I T	A D P C I T	D P C I	A D P C I	A D P C I	A D P	A P C I		A P C I
Texas	A D P C I T	A D P C I	A D P	A P C I	A D P C I	A D P T	A P C I		*
Utah	A D P C I	A D P C I	A D P	A P C I	A D P C I	A P T	A P C I		A C I
Vermont	A D P C I	A D P C I T	A D P	A D P C I	A D P C I	A D P	A P C I	*	A C I
Virginia	A D P C I	A D P C I	D	A D P C I	A P C I	A D P T	A D P C I		*
Washington	A D P C I	A D P C I	A D P	A D P C I	A D P C I	A D P	A D P C I		A
West Virginia	A D P C I T	A P C I		A D P C I	A D P C I	A D P	A P C I		*
Wisconsin	A D P C I	A D P C I	A D P	A P C I	A D P C I	A D P	A P C I		*
Wyoming	A D P C I T	A D P C I	D P	A D P C I T	A D P C I T	A D P T	A D P C I T	C I	A P

PMH-APRN, Advanced Practice Psychiatric Nurse; MFT, Marriage and Family Therapist

A=Assessment; D=Diagnosis; P=Psychotherapy; CI=Crisis Intervention; T=Telehealth

*=Scope of practice was not accessible

Notes: Authorized services were not specified in any state scope of practice for prevention specialists. For psychiatric aides and peer recovery specialists, “psychotherapy” does not refer to individual provision of this service, but indicates that the SOP permits assistance with therapy or treatment. Seven states prohibit diagnosis (CO: APRNs; TN and UT: addiction counselors; IN: MFTs and LPCs; KS: LPCs; ME: LPCs; TX: LPCs). Additionally, LA prohibits psychiatric aides from engaging in psychotherapy.



Journal of Homosexuality

ISSN: 0091-8369 (Print) 1540-3602 (Online) Journal homepage: <http://www.tandfonline.com/loi/wjhm20>

Parent-Initiated Sexual Orientation Change Efforts With LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment

Caitlin Ryan, Russell B. Toomey, Rafael M. Diaz & Stephen T. Russell

To cite this article: Caitlin Ryan, Russell B. Toomey, Rafael M. Diaz & Stephen T. Russell (2018): Parent-Initiated Sexual Orientation Change Efforts With LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment, Journal of Homosexuality, DOI: 10.1080/00918369.2018.1538407

To link to this article: <https://doi.org/10.1080/00918369.2018.1538407>



Published online: 07 Nov 2018.



Submit your article to this journal [↗](#)



Article views: 344



View Crossmark data [↗](#)



Parent-Initiated Sexual Orientation Change Efforts With LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment

Caitlin Ryan, PhD^a, Russell B. Toomey, PhD^b, Rafael M. Diaz, PhD^a, and Stephen T. Russell, PhD^c

^aFamily Acceptance Project, San Francisco State University, San Francisco, California, USA; ^bFamily Studies and Human Development, The University of Arizona, Tucson, Arizona, USA; ^cDepartment of Human Development and Family Sciences, University of Texas at Austin, Austin, Texas, USA

ABSTRACT

Studies of adults who experienced sexual orientation change efforts (SOCE) have documented a range of health risks. To date, there is little research on SOCE among adolescents and no known studies of parents' role related to SOCE with adolescents. In a cross-sectional study of 245 LGBT White and Latino young adults (ages 21–25), we measured parent-initiated SOCE during adolescence and its relationship to mental health and adjustment in young adulthood. Measures include being sent to therapists and religious leaders for conversion interventions as well as parental/caregiver efforts to change their child's sexual orientation during adolescence. Attempts by parents/caregivers and being sent to therapists and religious leaders for conversion interventions were associated with depression, suicidal thoughts, suicidal attempts, less educational attainment, and less weekly income. Associations between SOCE, health, and adjustment were much stronger and more frequent for those reporting both attempts by parents and being sent to therapists and religious leaders, underscoring the need for parental education and guidance.

KEYWORDS

Sexual orientation; LGBT youth; reparative therapy; conversion therapy; sexual orientation change efforts; suicidality; depression

The American Psychiatric Association removed homosexuality from its diagnostic manual as a mental disorder more than four decades ago, yet efforts to change sexual orientation, often referred to as “conversion” or “reparative” therapy, continue to be practiced by some mental health providers, clergy, and religious leaders (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Substance Abuse, Mental Health Services Administration, 2015). Although research on adult populations has documented harmful effects of sexual orientation change efforts (SOCE), no studies have examined SOCE among adolescents (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Yet

CONTACT Caitlin Ryan  fap@sfsu.edu  Family Acceptance Project, Marian Wright Edelman Institute, San Francisco State University, 1600 Holloway Ave, HSS 258, San Francisco, CA 94132, USA.

© 2018 Taylor & Francis Group, LLC

because some people believe that homosexuality can be changed or “cured,” some parents engage in efforts to change their child’s sexual orientation, and some may seek professional therapies for a child’s same-sex sexual orientation. In this study we consider the health and adjustment of a sample of lesbian, gay, bisexual, and transgender (LGBT)¹ young adults in association with retrospective reports of efforts by their parents to change their sexual orientation during adolescence.

Existing research and field consensus

SOCE continues to be practiced despite a lack of credible evidence of effectiveness, reported harm from a range of studies on SOCE with adults (see APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; SAMHSA, 2015), and increased adoption of practice guidance from major professional associations that caution against SOCE.² In one controversial study, 200 individuals who reported some change from homosexual to heterosexual following therapy were examined (Spitzer, 2003). The majority reported some minimal change from a homosexual to a heterosexual orientation; complete sexual orientation change was rare. The study received a great deal of attention and criticism for methodological limitations that included sample recruitment bias and problems in measurement and statistical reporting (see Drescher & Zucker, 2006 for a comprehensive review of the critiques of this study; the author later retracted the study). A review of 28 empirically based studies that have examined the use of these therapies strongly criticized the body of literature for multiple significant methodological flaws (see Serovich et al., 2008).

By the 1990s a wide range of major professional associations in the United States adopted position statements that supported affirmative care for lesbian, gay, and bisexual (LGB) clients and patients, and in the same time period several of them published statements that opposed efforts to change an individual’s sexual orientation (e.g., American Academy of Pediatrics, 1993; American Psychiatric Association, 1994; American Psychological Association, 1998; National Association of Social Workers, 1992). Despite these professional statements, some providers have continued to engage in SOCE with adults and adolescents, and the American Psychological Association (APA) convened a task force in 2007 to conduct a systematic review of peer-reviewed studies related to SOCE. The task force report concluded that published studies making claims that sexual orientation had been changed were methodologically unsound (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Moreover, the report noted that SOCE were unlikely to be successful and involved risk of harm. Specifically, studies of SOCE with adults (e.g., Shidlo & Schroeder, 2002) have reported a range of negative outcomes, including depression, anxiety, self-hatred, low self-esteem, isolation, and

suicidality (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Adolescents, parents, and SOCE

At the time of the APA report, no studies were identified that focused on sexual orientation change efforts among adolescents (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009); nevertheless, several organizations continued to market the effectiveness of sexual orientation change efforts for youth (see Ryan & Rivers, 2003). As the Group for the Advancement of Psychiatry—a policy organization that provides guidance for the psychiatric profession—has noted, “Despite ... changes in scientific thinking in the last two decades, social and religious conservatives have advanced their own illness/behavior model of homosexuality [which] maintains that homosexuality is not inborn and that variations of long disproven theories of homosexuality’s etiology can serve as a basis for offering conversion therapies” (Drescher et al., 2016, p. 8).

Understanding adolescent experiences is especially important, particularly since SOCE with minors raises distinct ethical concerns (Hicks, 1999; Substance Abuse and Mental Health Services Administration, 2015). These include determining what constitutes appropriate consent, the potential for pressure from parents and other authority figures, the minor’s dependence on adults for emotional and financial support, and the lack of information regarding the impact of SOCE on their future health and wellbeing.

Concerned parents who believe that being lesbian, gay, or bisexual (LGB) is wrong and that an individual’s sexual orientation can be changed may engage in rejecting behaviors, such as trying to change their child’s sexual orientation; excluding them from family events and activities to discourage, deny, or minimize their identity; or using religion to prevent or change their sexual orientation (e.g., Ryan, Huebner, Diaz, & Sanchez, 2009). These parental behaviors are typically motivated by concern and represent efforts to try to help their child “fit in,” to be accepted by others, to conform with religious values and beliefs, and to meet parental expectations (Morrow & Beckstead, 2004; Ryan et al., 2009; Ryan & Rees, 2012; SAMHSA, 2014). Moreover, such efforts are based on a belief that homosexuality is a mental illness or developmental disorder that needs to be corrected or cured. Yet SOCE are at odds with mainstream understandings of human development and professional standards of care, which hold that LGB identities are normative and that social stigma and minority stress contribute to negative health outcomes and self-hate (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Substance Abuse and Mental Health Services Administration, 2015).

There is growing concern that SOCE has continued to be practiced despite serious ethical conflicts and potentially harmful effects (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). An analysis by the Williams Institute estimated that nearly 700,000 U.S. LGBT adults have received SOCE conversion therapy interventions, including 350,000 LGBT adults who received SOCE interventions as adolescents (Mallory, Brown & Conron, 2018). This concern led legal advocates in the United States to introduce legislation to prevent SOCE among licensed practitioners, an approach that has been adopted in 10 U.S. states and a growing number of jurisdictions and that has sought to inform families, the public, practitioners and religious leaders of the impact of such practices (Drescher, 2013; Movement Advancement Project, 2018). Although these laws appear to have raised awareness and informed public perceptions and responses (Ames, 2015), they do not prevent SOCE in families or by unlicensed practitioners, clergy, and others.

The U.S. Substance Abuse and Mental Health Services Administration asked the APA to convene a scientific advisory panel of researchers and practitioners who were experts in the field to review existing research, professional policies, and clinical guidelines to develop consensus recommendations related to the ethical and scientific foundations of conversion therapy with minors (Substance Abuse and Mental Health Services Administration, 2015). Concurrently, the Obama administration called for an end to conversion therapy of minors, citing, in particular, the importance of family support for LGBT young people (Jarrett, 2015). Most recently, in March 2018 the European parliament passed a resolution condemning the practice and urging member nations to ban SOCE.

The current study

Historically, SOCE research has focused on adults. Decades ago, Gonsiorek theorized that the experience of SOCE during adolescence can “contribute to negative self-esteem and mental health problems” (Gonsiorek, 1988, p. 116), yet there are no known studies of the link between such interventions and the health and wellbeing of lesbian, gay, bisexual, and transgender (LGBT) young people, particularly SOCE efforts carried out both by parents and caregivers, as well as by practitioners and religious leaders.

To our knowledge, we present the first study to examine young adults’ retrospective reports of parent-initiated efforts to change their sexual orientation during adolescence, and the associations between these experiences and young adult mental health and adjustment. The two goals of this study include: (1) to identify demographic and family characteristics that are associated with parent-initiated attempts to change a child’s sexual

orientation during adolescence, and (2) to examine associations among these parent-initiated attempts in adolescence with a range of indicators of young adult health and adjustment.

Method

The sample included 245 participants who self-identified as LGBT. Participants were recruited from local bars, clubs, and community agencies that serve this population in a 100-mile radius of the research center. Screening procedures were used to select participants into the study based on the following criteria: age (21–25); ethnicity (White, Latino, or Latino mixed); self-identification as LGBT during adolescence; being open about LGBT status to at least one parent or guardian during adolescence; and having lived with at least one parent or guardian during adolescence at least part-time. The survey was administered in both English and Spanish, and it was available in either computer-assisted or paper-and-pencil format. The study protocol was approved by the university's institutional review board.

Sample

Of the 245 participants, 46.5% were male, 44.9% were female, and 8.6% were transgender. The majority of participants identified as gay (42.5%), 27.8% as lesbian, 13.1% as bisexual, and 16.7% as other (e.g., queer, dyke, homosexual). Approximately one half of the sample identified as Latino (51.4%), and the other 48.6% identified as White, non-Latino. In addition, 18.78% of the respondents were immigrants to the United States. The age of the participants ranged from 21 to 25 years ($M = 22.8$, $SD = 1.4$). Family of origin socioeconomic status was assessed retrospectively (1 = *both parents in unskilled positions or unemployed* to 16 = *both parents in professional positions*; $M = 6.75$, $SD = 4.77$).

Measures

Parent-initiated efforts to change youths' sexual orientation

Participants responded to two items that assessed past parental and caregiver-initiated efforts to change the youths' sexual orientation. The first item asked: "Between ages 13 and 19, how often did any of your parents/caregivers try to change your sexual orientation (i.e., to make you straight)?" (0 = never [49.64%]; 1 = ever [53.06%]). A second item asked: "Between ages 13 and 19, how often did any of your parents/caregivers take you to a therapist or religious leader to cure, treat, or change your sexual orientation?" (0 = never [65.71%]; 1 = ever [34.29%]). We created a single measure with

three categories that identifies the severity of parent-initiated attempts to change youths' sexual orientation. The three categories include: (1) no attempt to change sexual orientation ($n = 109$; 41.63%), (2) parent and caregiver-initiated attempt to change sexual orientation without external conversion efforts ($n = 52$; 21.22%), and (3) parent and caregiver-initiated attempt to change sexual orientation with external conversion efforts ($n = 78$; 31.84%). Six participants who reported conversion efforts but not parental attempts to change sexual orientation were dropped from the current study, for a total analytic sample of 239 participants.

Young adult health and adjustment

Indicators of mental health and adjustment assessed included suicidal ideation, lifetime suicidal attempts, depression, self-esteem, and life satisfaction. Suicidal ideation was assessed by one item: "During the past six months, did you have any thoughts of ending your life?" (0 = no, 3 = many times). Lifetime suicidal attempts were assessed by one item: "Have you ever, at any point in your life, attempted taking your own life?" (0 = no, 1 = yes). Depression was measured by the 20-item CES-D (Radloff, 1977, 1991). Two dichotomized cut-off scores were also used: a clinical cut-off score (≥ 16) and a prescription intervention cut-off score (≥ 22). Self-esteem was measured by Rosenberg's 6-item self-esteem scale (Rosenberg, 1979). Life satisfaction was measured by an 8-item scale (e.g., "At the present time, how satisfied are you with your living situation?"). Social support was measured by the 12-item Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988).

Behavioral health risk indicators included substance use and abuse and engagement in risky sexual activities. Binge drinking (or heavy alcohol use) was assessed by two items that measured the frequency of drinking and the number of drinks per occasion (0 = less than 1–2 times per week and less than 3 drinks per occasion; 1 = 1–2 times per week or more and more than 3 drinks per occasion). Substance abuse problems were assessed by four items (e.g., "In the past five years, have you had problems with the law because of your alcohol or drug use?") and were dichotomized to represent ever having problems versus never having problems. Risky sexual behavior was assessed in six ways: unprotected sex during the last 6 months (0 = no, 1 = yes), unprotected sex with a casual or HIV positive partner during the last 6 months (0 = no, 1 = yes), unprotected sex during last sexual encounter (0 = no, 1 = yes), unprotected casual sex during last sexual encounter (0 = no, 1 = yes), ever been diagnosed with a sexually transmitted disease (0 = never, 1 = ever), and one item that assessed HIV risk ("In the last six months, were you ever at risk for being infected with or transmitting HIV?"; 0 = no, 1 = yes).

Finally, two indicators of young adult socioeconomic status were assessed: current monthly income and educational attainment. Current weekly income as assessed by one item: "What is your personal weekly income (after taxes,

unemployment, social security, etc.)?” (1 = less than \$100, 7 = more than \$2000). Educational attainment was assessed by one item: “What is the highest level of education you have completed?” (1 = *less than elementary school*, 7 = *postgraduate*).

Demographic and family characteristics

Adolescent gender nonconformity and family religiosity were included as possible characteristics that may predict whether or not parents/caregivers attempted to change the participant’s sexual orientation during adolescence. Adolescent gender nonconformity was measured by one item: “On a scale from 1–9, where 1 is extremely feminine and 9 is extremely masculine, how would you describe yourself when you were a teenager (age 13–19)?” This item was reverse coded for males such that a higher score is representative of more nonconformity to gender norms ($M = 4.40$, $SD = 1.87$). Family religiosity was measured by one item: “How religious or spiritual was your family while you were growing up?” (0 = *not at all*, 3 = *extremely*; $M = 1.35$, $SD = 0.91$).

Plan of analysis

First, demographic and family characteristics were included in a multinomial logistic regression to predict the likelihood of a participant experiencing parent-initiated attempts to change their sexual orientation during adolescence without external conversion intervention efforts (= 1) and parental attempts to change sexual orientation with external conversion efforts (= 2) compared to no attempts (= 0). Second, to understand the associations among parent-initiated attempts to change the participant’s sexual orientation during adolescence with young adult health and wellbeing, we used logistic regressions for dichotomous outcomes and multiple linear regression for continuous outcomes, including known covariates for the outcomes of interest (Ryan et al., 2009). To minimize exclusion of participants due to missing data and to maximize statistical power, we used PRELIS, a component of LISREL, to impute missing data (total <5%; Graham, Cumsille, & Elek-Fisk, 2003) using all numeric variables in an expectation maximization algorithm for imputation. All continuous variables were checked for assumptions of normality; the depression measure was significantly skewed, but after a square-root transformation the items met assumptions of normality. Finally, we conducted linear trend analyses for study outcomes across the three groups of participants based on no attempts, parent-initiated attempts, and parent-initiated attempts with external conversion efforts.

Results

Similar background characteristics predicted both types of parent-initiated SOCE (see Table 1). Notably, there were no differences in reports of SOCE

Table 1. Demographic and family characteristics predicting parent/caregiver-initiated sexual orientation change efforts.

	Parent-initiated SOCE	Parent-initiated SOCE with external conversion efforts
Female (Ref = male)	1.62 (0.76–3.46)	0.94 (0.46–1.92)
Transgender (Ref = male)	2.30 (0.40–13.14)	1.93 (0.44–8.47)
Bisexual (Ref = gay/lesbian)	0.80 (0.30–2.17)	0.40 (0.13–1.23)
Queer (Ref = gay/lesbian)	0.49 (0.14–1.74)	1.24 (0.46–3.34)
White, non-Latino (Ref = Latino)	0.86 (0.39–1.90)	1.51 (0.70–3.23)
Immigrant (Ref = U.S. native)	1.98 (0.67–5.90)	6.47 (2.43–17.23)***
Family of origin SES	0.85 (0.78–0.93)***	0.88 (0.81–0.95)***
Adolescent gender nonconformity	1.18 (0.96–1.45)	1.27 (1.05–1.54)*
Family religiosity	1.72 (1.13–2.61)*	1.88 (1.28–2.76)**

N = 239. Ref = reference group. Adjusted odds ratios and 95% confidence intervals from a multinomial logistic regression are shown. The reference category for the model was “neither change efforts nor conversion efforts.” ****p* < .001. ***p* < .01. **p* < .05.

based on gender, sexual identity (bisexual or queer), or ethnicity. However, adolescents who grew up in religious families were more likely to experience SOCE (with and without external conversion efforts). Higher family of origin socioeconomic status was also associated with fewer parent-initiated SOCE (with and without conversion efforts). Additionally, participants who were not born in the United States and who reported more gender nonconformity during adolescence were more likely to experience parent-initiated attempts to change with external conversion efforts.

Table 2 displays the results of logistic and linear regressions predicting young adult health and adjustment based on reports of parent-initiated SOCE during adolescence (both with and without external conversion efforts). Both levels of parent-initiated attempts to change participant’s sexual orientation during adolescence were associated with more negative mental health problems for young adults. Specifically, those who experienced SOCE were more likely to have suicidal thoughts (although only for those who reported SOCE with external conversion efforts) and to report suicidal attempts and higher levels of depression. Participants who experienced SOCE had lower life satisfaction and less social support in young adulthood. Parental-initiated SOCE in adolescence were not associated with self-esteem, substance use or abuse, or risky sexual behavior. Finally, parent-initiated SOCE during adolescence were associated with lower young adult socio-economic status: less educational attainment and less weekly income (although only for those who experienced attempts to change with external conversion efforts).

Differences across the three groups defined by parent-initiated SOCE are presented in Table 3. Trend analyses confirmed that parental attempts to change adolescents’ sexual orientation are significantly associated with negative health outcomes in young adulthood, and that those problems are worse

Table 2. Parent/caregiver-initiated sexual orientation change efforts predicting young adult outcomes.

	Parent-initiated SOCE	Parent-initiated SOCE with external conversion efforts
Mental Health		
Suicidal ideation (continuous)	0.13	0.27***
Suicidal attempt (1 = ever)	3.08 (1.39–6.83)**	5.07 (2.38–10.79)***
Depression – Clinical cut-off score (≥ 16)	2.20 (1.02–4.73)*	3.92 (1.92–8.00)***
Depression – Prescription intervention cut-off score (≥ 22)	1.94 (0.82–4.57)	3.63 (1.67–7.87)**
Depression (continuous)	0.15*	0.30***
Self-esteem (continuous)	–0.13	–0.13
Life satisfaction (continuous)	–0.19**	–0.34***
Social support (continuous)	–0.26***	–0.45***
Substance Use/Abuse		
Binge drinking (1 = yes)	0.90 (0.42–1.93)	1.01 (0.50–2.03)
Substance abuse problems (1 = yes)	0.87 (0.42–1.82)	1.70 (0.84–3.44)
Sexual Risk Behavior		
Unprotected sex during last 6 months (1 = yes)	1.61 (0.70–3.72)	2.05 (0.91–4.59)
Unprotected sex with casual or HIV + partner last 6 months (1 = yes)	0.91 (0.36–2.30)	2.09 (0.91–4.78)
Unprotected sex at last intercourse (1 = yes)	0.90 (0.43–1.87)	1.23 (0.62–2.45)
Unprotected casual sex at last intercourse (1 = yes)	1.01 (0.41–2.49)	1.11 (0.48–2.58)
STD diagnosis (1 = ever)	0.79 (0.33–1.91)	1.36 (0.62–2.99)
HIV risk in last 6 months (1 = yes)	0.74 (0.31–1.74)	1.06 (0.50–2.26)
Current Socioeconomic Status		
Educational attainment (continuous)	–0.15*	–0.32***
Current weekly income (continuous)	–0.12	–0.27***

N = 239. Adjusted odds ratios and 95% confidence intervals are shown for dichotomous outcomes and standardized beta coefficients are shown for continuous outcomes. All analyses controlled for gender, sexual orientation, ethnicity, immigrant status, family of origin socioeconomic status, adolescent gender nonconformity, and family of origin religiosity. ****p* < .001. ***p* < .01. **p* < .05.

for young adults who experienced SOCE that included external conversion efforts during adolescence. This pattern of results emerged as statistically significant for 12 of the 18 outcomes tested, including significant findings for all outcomes related to mental health and socioeconomic status.

Discussion

Results from this study clearly document that parent/caregiver efforts to change an adolescent’s sexual orientation are associated with multiple indicators of poor health and adjustment in young adulthood. The negative associations were markedly stronger for participants who experienced both parental attempts to change their sexual orientation, coupled with efforts to send the adolescent to a therapist or religious leader to change their sexual orientation (strategies often called “conversion” or “reparative” therapy). In this sample of LGBT young adults, more than half reported some form of

Table 3. Trend effects related to parent/caregiver-initiated sexual orientation change efforts predicting young adult health outcomes.

	No SOCE (<i>n</i> = 109)	Parent- Initiated SOCE (<i>n</i> = 52)	Parent-Initiated SOCE with External Conversion Efforts (<i>n</i> = 78)	Group difference (χ^2 ; <i>F</i>)
Mental Health				
Suicidal ideation (continuous)	.17	.38	.57	***
Suicidal attempt (1 = ever)	22.0 %	48.1 %	62.8 %	***
Depression – Clinical cut-off score (≥ 16)	26.6 %	46.2 %	65.4 %	***
Depression – Prescription intervention cut-off score (≥ 22)	15.6 %	32.7 %	52.3 %	***
Depression (continuous)	9.21	12.99	16.10	***
Self-esteem (continuous)	2.88	2.74	2.72	**
Life satisfaction (continuous)	3.05	2.78	2.61	***
Social support (continuous)	4.18	3.66	3.31	***
Substance Use/Abuse				
Binge drinking (1 = yes)	42.2 %	36.5 %	41.3 %	NS
Substance abuse problems (1 = yes)	49.5 %	50.0 %	66.7 %	*
Sexual Risk Behavior				
Unprotected sex during last 6 months (1 = yes)	28.4 %	36.5 %	42.3 %	*
Unprotected sex with casual or HIV + partner last 6 months (1 = yes)	22.0 %	21.2 %	38.5 %	*
Unprotected sex at last intercourse (1 = yes)	49.5 %	53.9 %	59.0 %	NS
Unprotected casual sex at last intercourse (1 = yes)	15.6 %	23.1 %	25.6 %	NS
STD diagnosis (1 = ever)	24.8 %	21.2 %	30.8 %	NS
HIV risk in last 6 months (1 = yes)	28.4 %	25.0 %	37.2 %	NS
Current Socioeconomic Status				
Educational attainment (continuous)	5.19	4.65	4.26	***
Current weekly income (continuous)	2.73	2.31	2.03	***

Six participants who reported conversion efforts but not parent attempts are excluded. Percentages are shown for dichotomous outcomes with chi-square significance levels, and average scores are shown for continues outcomes with ANOVA *F* significance levels.

****p* < .001. ***p* < .01. **p* < .05.

attempt by their parents and caregivers to change their sexual orientation during adolescence. With the exception of high-risk sexual behavior and substance abuse, attempts to change sexual orientation during adolescence were associated with elevated young adult depressive symptoms and suicidal behavior, and with lower levels of young adult life satisfaction, social support, and socioeconomic status. Thus SOCE is associated with multiple domains of functioning that affect self-care, wellbeing, and adjustment.

The results of this study point to a number of factors that impact practice and provision of appropriate care. Family religiosity was strongly linked to

parental attempts to change sexual orientation. In a related study, families that were highly religious were least likely to accept their LGBT children (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Religiously conservative families often have misinformation about sexual orientation and gender identity and need accurate information to help support their LGBT children in the context of their values and beliefs (for guidance see Ryan & Rees, 2012; Substance Abuse Mental Health & Services Administration, 2014). Moreover, parents and caregivers often conflate sexual orientation with gender expression. Discomfort with gender nonconformity may be at the root of much of parents' and caregivers' motivations for SOCE: in the current study, gender nonconforming youth were more likely to experience attempts to change their sexual orientation through conversion therapy with therapists and religious leaders. Further, our results show that immigrant parents are more likely to try to change their children's sexual orientation by sending them for clinical or religious intervention.

Related research has found that SOCE typically happens in the context of other family rejecting behaviors that contribute to health risks in young adulthood (Ryan et al., 2009). Parents, caregivers and others who provide support for LGBT children and adolescents need to understand that family rejection encompasses a wide range of behaviors, and education is critical for families, providers, and religious leaders on the relationship between family rejection and acceptance with health and wellbeing for LGBT young people (Ryan, 2009; Ryan & Chen-Hayes, 2013; Ryan et al., 2010; Substance Abuse and Mental Health Services Administration, 2015; Substance Abuse Mental Health & Services Administration, 2014).

Studies on responses of parents and caregivers with LGBT children indicate that parents' reactions are motivated by a number of concerns, which include helping their child "fit in" to their family and cultural world, responding to religious and cultural values, keeping their families together, and trying to protect their LGBT child from harm (Maslowe & Yarhouse, 2015; Ryan, 2009; Substance Abuse Mental Health & Services Administration, 2014). In other words, parents are typically motivated by doing what they think is best for their child. Nonetheless, our study did not directly examine the motives of the parents of study participants. However, these findings reinforce the critical need for culturally appropriate family education and guidance on sexual orientation and gender identity and expression, the harmful effects of family rejecting behaviors, including SOCE, and the need for supporting their LGBT children, even in the context of parental and familial discomfort and religious conflict.

There are several limitations of this study. First, study inclusion criteria called for current identification as LGBT; it is likely that this inclusion criterion excludes persons who are dissatisfied with their LGBT identity, or persons who had identified as LGBT during adolescence but not at the time

of the study. Thus we acknowledge that we did not include young people whose sexual orientation may be more fluid (e.g., sexual orientation in adolescence not consistent with sexual orientation in young adulthood). Second, although the study included a measure of family religiosity, there is no measure of specific religious affiliation, a factor that might be a further predictor of the role of parents in SOCE of their children. Third, the design is retrospective, and thus causal claims cannot be made. We cannot rule out the possibility that those who were most maladjusted as young adults retrospectively attribute parental behaviors during adolescence as attempts at changing their sexual orientation; we also cannot rule out the possibility that well-adjusted LGBT young adults may be less likely to recall experiences related SOCE. However, we note that the face validity of the specific measures is compelling: the alternatives are less plausible than the explanation that sexual orientation change attempts would likely undermine health and wellbeing.

Most attention to SOCE has focused on the ethics of professional practice and recent efforts to end such practice through legislation. This study highlights the crucial role parents play in SOCE—either directly themselves or through sending their children to therapists or religious leaders. Results point to the need for multicultural and faith-based family education resources and approaches to help parents and caregivers learn how to support their LGBT children in the context of their family, cultural, and religious values (see, for example, Kleiman & Ryan, 2013; Ryan, 2009; Ryan & Rees, 2012). In addition to supporting families and educating religious leaders and congregations, legislative and professional regulatory efforts to end SOCE therapies are important for raising awareness about and preventing a contraindicated practice that contributes to health risks, and for changing negative attitudes and bias regarding LGBT people.

Taken together, these findings provide a needed empirical framework for understanding the scope of SOCE in and outside of the home and the costs of sexual orientation change efforts directly from those individuals who are most affected—LGBT young people themselves. Historically, research and strategies to prevent SOCE have focused on mental health practitioners and much less on religious leaders, with limited awareness of the role of families in pressuring LGBT young people to change core identities. As indicated by this study, more attention is needed on family-based efforts to change a child's sexual orientation and gender expression. Because LGBT youth cannot escape family rejecting behaviors (see, for example, Ryan, 2009; Ryan & Rees, 2012), approaches to prevent and ameliorate efforts to change a child's sexual orientation and gender identity must include the broader social context that includes the home and social, cultural, and religious influences on families and caregivers to change or suppress a child's sexual orientation and gender expression.

Notes

1. The sampling frame for the study included youth who identified as LGBT during adolescence. Of note, all transgender youth in this sample also identified as lesbian/gay, bisexual, homosexual, or queer.
2. Policy statements cautioning against SOCE have been issued across disciplines ranging from counseling (American Counseling Association, 2013) to medicine (Society for Adolescent Health and Medicine, 2013), nursing (International Society of Psychiatric-Mental Health Nurses, 2008), psychiatry (American Psychiatric Association, 2000; World Psychiatric Association, 2016), psychology (American Psychological Association, 2009), and social work (National Association of Social Workers, 2015).

Disclosure statement

No potential conflict of interest was reported by the authors.

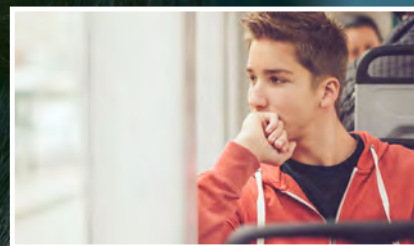
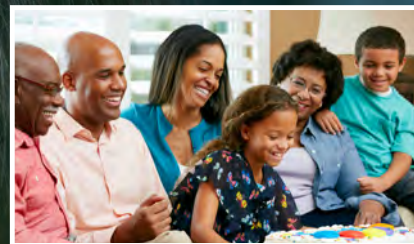
References

- American Academy of Pediatrics. (1993). Homosexuality and adolescence. *Pediatrics*, 92, 631.
- American Counseling Association. (2013). *Ethical issues related to conversion or reparative therapy*. Retrieved from <https://www.counseling.org/news/updates/2013/01/16/ethical-issues-related-to-conversion-or-reparative-therapy>
- American Psychiatric Association. (1994). Gay and lesbian issues. In *Fact Sheet*. Washington, DC: Author.
- American Psychiatric Association. (2000). Position statement on therapies focused attempts to change sexual orientation (reparative or conversion therapies). *American Journal of Psychiatry*, 157, 1719–1721.
- American Psychological Association. (1998). Resolution on appropriate therapeutic responses to sexual orientation. *American Psychologist*, 53, 934–935.
- American Psychological Association. (2009). *Resolution on appropriate therapeutic response to sexual orientation distress and change efforts*. Retrieved from <http://www.apa.org/about/policy/sexual-orientation.aspx>
- Ames, S. (2015, May 26). How we'll end 'conversion therapy' in four years flat. *Advocate*.
- APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the task force on appropriate therapeutic responses to sexual orientation*. Washington, DC: American Psychological Association.
- Drescher, J. (2013, April 16). Gay therapy is not just sticks and stones. *Star Ledger*.
- Drescher, J., Schwartz, A., Casoy, F., McIntosh, C. A., Hurley, B., Ashley, K., ... Tompkins, D. A. (2016). The growing regulation of conversion therapy. *Journal of Medical Regulation*, 102(2), 7–12.
- Drescher, J., & Zucker, K. J. (Eds.). (2006). *Ex-gay research: Analyzing the Spitzer study and its relation to science, religion, politics, and culture*. Binghamton, NY: Haworth Press.
- Gonsiorek, J. C. (1988). Mental health issues of gay and lesbian adolescents. *Journal of Adolescent Health Care*, 9, 114–122. doi:10.1016/0197-0070(88)90057-5
- Graham, J. W., Cumsille, P. E., & Elek-Fisk, E. (2003). Methods for handling missing data. In J. Shrinka & W. Velicer (Eds.), *Handbook of psychology: Vol. 2, Research methods in psychology* (pp. 87–114). New York, NY: Wiley.
- Hicks, K. A. (1999). "Reparative" therapy: Whether parental attempts to change a child's sexual orientation can legally constitute child abuse. *American University Law Review*, 29, 505–547.

- International Society of Psychiatric-Mental Health Nurses. (2008). *Position statement on reparative therapy*. Retrieved from <http://www.ispn-psych.org/assets/docs/ps-reparativetherapy.pdf>
- Jarrett, V. (2015). *Petition response: On conversion therapy*. Retrieved from <https://obamawhitehouse.archives.gov/blog/2015/04/08/petition-response-conversion-therapy>
- Kleiman, V. (Director), & Ryan, C. (Executive Producer). (2013). *Families are Forever* [video]. Family Acceptance Project, Marian Wright Edelman Institute, San Francisco State University. (Best Practices Registry for Suicide Prevention).
- Mallory, C., Brown, T. N. T., & Conron, K. J. (2018). *Conversion therapy and LGBT youth*. Los Angeles, CA: UCLA School of Law: The Williams Institute. Retrieved from <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-LGBT-Youth-Jan-2018.pdf>
- Maslowe, K. E., & Yarhouse, M. A. (2015). Christian parental reactions when a child comes out. *American Journal of Family Therapy*, 43, 1–12. doi:10.1080/01926187.2015.1051901
- Morrow, S. L., & Beckstead, A. L. (2004). Conversion therapies for same-sex attracted clients in religious conflict: Context, predisposing factors, experiences, and implications for therapy. *The Counseling Psychologist*, 32, 641–650. doi:10.1177/0011000004268877
- Movement Advancement Project. (2018). *Conversion therapy laws*. Retrieved from http://www.lgbtmap.org/equality-maps/conversion_therapy
- National Association of Social Workers, National Committee on Lesbian and Gay Issues. (1992). *Position statement regarding “reparative” or “conversion” therapies for lesbians and gay men*. Washington, DC: Author.
- National Association of Social Workers, National Committee on Lesbian, Gay, Bisexual, and Transgender Issues. (2015). *Position statement: Sexual orientation change efforts (SOCE) and conversion therapy with lesbians, gay men, bisexuals, and transgender persons*. Retrieved from <https://www.socialworkers.org/LinkClick.aspx?fileticket=IQYALknHU6s%3D&portalid=0>
- Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385–401. doi:10.1177/014662167700100306
- Radloff, L. S. (1991). The use of the Center for Epidemiological Studies Depression Scale in adolescents and young adults. *Journal of Youth and Adolescence*, 20, 149–166. doi:10.1007/BF01537606
- Rosenberg, M. (1979). *Conceiving the Self*. New York, NY: Basic Books, Inc.
- Ryan, C. (2009). *Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children*. San Francisco, CA: Family Acceptance Project, Marian Wright Edelman Institute, San Francisco State University. (English, Spanish & Chinese).
- Ryan, C., & Chen-Hayes, S. (2013). Educating and empowering families of LGBTQ K-12 students. In E. S. Fisher & K. Komosa-Hawkins (Eds.), *Creating school environments to support lesbian, gay, bisexual, transgender, and questioning students and families: A handbook for school professionals* (pp. 209–229). New York, NY: Routledge.
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123, 346–352. doi:10.1542/peds.2007-3524
- Ryan, C., & Rees, R. (2012). *Supportive families, healthy children: Helping Latter-day Saint families with lesbian, gay, bisexual & transgender children*. San Francisco, CA: Family Acceptance Project, Marian Wright Edelman Institute, San Francisco State University.
- Ryan, C., & Rivers, I. (2003). Lesbian, gay & bisexual youth: Victimization in international perspective. *Culture, Health & Sexuality*, 5(2), 103–119. doi:10.1080/1369105011000012883
- Ryan, C., Russell, S. T., Huebner, D. M., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), 205–213. doi:10.1111/j.1744-6171.2010.00246.x

- Serovich, J. M., Craft, S. M., Tovielli, P., Gangamma, R., McDowell, T., & Gafsky, E. L. (2008). A systematic review of the research base on sexual reorientation therapies. *Journal of Marital and Family Therapy*, 34, 227–238. doi:10.1111/j.1752-0606.2008.00065.x
- Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research and Practice*, 33, 249–259. doi:10.1037/0735-7028.33.3.249
- Society for Adolescent Health and Medicine. (2013). Recommendations for promoting the health and well-being of lesbian, gay, bisexual, and transgender adolescents: A position paper of the society for adolescent health and medicine. *Journal of Adolescent Health*, 52, 506–510. doi:10.1016/j.jadohealth.2013.01.015
- Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior*, 32, 403–417.
- Substance Abuse and Mental Health Services Administration. (2015). *Ending conversion therapy: Supporting and affirming LGBTQ youth* (HHS Publication No. (SMA) 15-4928). Rockville, MD: Author.
- Substance Abuse Mental Health & Services Administration. (2014). *A practitioner's resource guide: Helping families to support their LGBT children*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- World Psychiatric Association. (2016). *World Psychiatry Association position statement on gender identity and same-sex orientation, attraction, and behaviours*. Retrieved from http://www.wpanet.org/detail.php?section_id=7&content_id=1807
- Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment*, 52, 30–41. doi:10.1207/s15327752jpa5201_2

Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth



October 2015



PAGE INTENTIONALLY LEFT BLANK

Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth

October 2015

PAGE INTENTIONALLY LEFT BLANK

Acknowledgements

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Abt Associates under contract number HHSS283200700008I/HHSS28342001T with SAMHSA, U.S. Department of Health and Human Services (HHS). David Lamont Wilson served as the Government Project Officer. Elliot Kennedy served as the Task Lead.

Disclaimer

The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS. Listings of any non-Federal resources are not all-inclusive and inclusion of a listing does not constitute endorsement by SAMHSA or HHS.

Public Domain Notice

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

Electronic Access and Printed Copies

This publication may be downloaded or ordered at <http://store.samhsa.gov>. Or call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Recommended Citation

Substance Abuse and Mental Health Services Administration, Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. HHS Publication No. (SMA) 15-4928. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Originating Office

Division of Systems Development, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services.



Contents

Executive Summary	1
Introduction	7
Professional Consensus Process	9
Statements of Professional Consensus	11
Research Overview	15
Approaches to Ending the Use of Conversion Therapy	37
Guidance for Families, Providers, and Educators	41
Summary and Conclusion	51
References	52
Appendix A: Glossary of Terms	64
Appendix B: Acknowledgments	64
Endnotes	66



Executive Summary

Lesbian, gay, bisexual, and transgender youth, and those who are *questioning* their sexual orientation or gender identity (*LGBTQ* youth) experience significant health and behavioral health disparities. Negative social attitudes and discrimination related to an individual's LGBTQ identity can contribute to these disparities, and may result in institutional, interpersonal, and individual stressors that affect mental health and well-being. (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Meyer, 2003). This stress, as well as limited opportunities for support, are encountered by *sexual and gender minority*¹ youth in their families, communities, and school settings. Additionally, some transgender youth experience gender dysphoria – psychological distress due to the incongruence between one's body and gender identity (Coleman et al., 2012).

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority communities. One key factor to preventing these adverse outcomes is positive family (including guardians and caregivers) and community engagement and appropriate interventions by medical and behavioral health care providers. Supporting optimal development of children and adolescents with regard to sexual orientation, gender identity, and gender expression is vital to ensuring their health and well-being.

The purpose of this report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*, is to provide mental health professionals and families with accurate information about effective and ineffective therapeutic practices related to children's and adolescent's sexual orientation and gender identity. Specifically, this report addresses the issue of conversion therapy for minors. The conclusions in this report are based on professional consensus statements arrived at by experts in the field. Specifically, conversion therapy—efforts to change an individual's sexual orientation, gender identity, or gender expression²—is a practice that is not supported by credible evidence and

has been disavowed by behavioral health experts and associations. Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm.

Key Findings

This report and its recommendations are based on consensus statements developed by experts in the field after a careful review of existing research, professional health association reports and summaries, and expert clinical guidance. The consensus statements highlight areas of the ethical and scientific foundations most relevant to the practice of conversion therapy with minors. A full list of the consensus statements is found in the body of this report; key statements that form the underpinnings of the guidance in this report are provided here.

- Same-gender³sexual orientation (including identity, behavior, and attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
- There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
- Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment. (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

Understanding Sexual Orientation and Gender Identity in Children and Youth

Behavioral health providers, parents, schools, and communities can best provide support to children, adolescents, and their families when they have access to the most current information about sexual orientation, gender identity, and gender expression in youth. The following overview presents the best current evidence regarding understandings of child and adolescent sexual orientation, gender identity, and gender expression.

Sexuality occurs across a continuum; same-gender attraction and relationships are normal variations of human sexuality (Diamond, 2015; Vrangalova & Savin-Williams, 2012). Similarly, a gender identity that is incongruent with assigned sex at birth, as well as a gender expression that diverges from stereotypical cultural norms for a particular gender, are normal variations of human gender (American Psychological Association, 2015a; Knudson, De Cuypere, & Bockting, 2010). Being a sexual or gender minority, or identifying as LGBTQ, is not pathological (American Psychological Association, 2015a; APA Task Force on Gender Identity and Gender Variance, 2009; Coleman et al., 2012).

There is not a single developmental trajectory for either sexual minority or gender minority youth. Compared to the 20th century, in the 21st century, youth started realizing and disclosing a minority sexual orientation and/or identifying as lesbian, gay, or bisexual at younger ages than in previous generations (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, Bimbi, Nanín, & Parsons, 2006; R. C. Savin-Williams, 2001). Though aspects of sexuality are displayed beginning in infancy, little is known about sexual orientation among pre-pubertal children (Adelson & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI), 2012). Children are rarely if ever distressed about their current or future sexual orientation; more commonly, parents and guardians are distressed about a child's perceived current or future sexual orientation and seek the

assistance of behavioral health providers (American Psychological Association, 2009). Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual orientation identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. In comparison with their heterosexual counterparts, sexual minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Corliss et al., 2010; Friedman et al., 2011; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann et al., 2011; Marshal et al., 2011; Russell, 2003). Supportive families, peers, and school and community environments are associated with improved psychosocial outcomes for sexual minority youth (Bouris et al., 2010; Kosciw, Greytak, Palmer, & Boesen, 2014; Lease, Horne, & Noffsinger-Frazier, 2005).

Gender development begins in infancy and continues progressively throughout childhood. Gender diversity or signs of gender dysphoria may emerge as early as a child's preschool years, or as late as adolescence (Cohen-Kettenis, 2005). For many gender minority children, gender dysphoria will not persist, and they will develop a *cisgender* identity in adolescence or adulthood; a majority of these children will identify as lesbian, gay, or bisexual in adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). Whether or not these individuals continue to have a diverse gender expression is unknown. For other gender minority children, gender dysphoria will persist and usually worsen with the physical changes of adolescence; these youth generally identify as transgender (or another gender identity that differs from their assigned sex at birth) in adolescence and adulthood

(Byne et al., 2012; Coleman, et al., 2012). For still another group, gender dysphoria emerges in post-puberty without any childhood history of gender dysphoria gender diversity (Edwards-Leeper & Spack, 2012). Gender dysphoria that worsens with the onset of puberty is unlikely to remit later in adolescence or adulthood, especially among youth with a childhood onset, and long-term identification as transgender is likely (American Psychological Association, 2015a; American Psychological Association, 2008; Byne, et al., 2012).

While most adolescents with gender dysphoria score within normal ranges on psychological tests (Cohen-Kettenis & van Goozen, 1997; de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Smith, van Goozen, & Cohen-Kettenis, 2001), some gender minority children and adolescents have elevated risk of depression, anxiety, and behavioral issues. These psychosocial issues are likely related to if not caused by negative social attitudes or rejection (Vance, Ehrensaft, & Rosenthal, 2014). As with sexual minority adolescents, other issues of clinical relevance for gender minority adolescents include increased risk of experiencing victimization and violence, suicidal ideation and attempts, and homelessness (Coleman, et al., 2012; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Institute of Medicine, 2011; Mustanski, Garofalo, & Emerson, 2010; Simons, Leibowitz, & Hidalgo, 2014). Improved psychosocial outcomes are seen among youth when social supports are put in place to recognize and affirm gender minority youth's gender identities (Vance, et al., 2014).

Therapeutic Efforts with Sexual and Gender Minority Youth⁴

Given the professional consensus that conversion therapy efforts are inappropriate, the following behavioral health approaches are consistent with the expert consensus statements and current research, and are recommended by professional associations (American Psychological Association, 2015a; APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Byne, et al., 2012). When providing services to children, adolescents, and families, appropriate therapeutic approaches

include: providing accurate information on the development of sexual orientation and gender identity and expression; increasing family and school support; and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Approaches should be client-centered and developmentally-appropriate with the goal of treatment being the best possible level of psychological functioning, rather than any specific gender identity, gender expression, or sexual orientation. Appropriate therapeutic approaches with sexual and gender minority youth should include a comprehensive evaluation and focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support. It is important to identify the sources of any distress experienced by sexual and gender minority youth and their families, and work to reduce this distress. Working with parents and guardians is important as parental behaviors and attitudes have a significant effect on the mental health and well-being of sexual and gender minority children and adolescents. School and community interventions may also be necessary and appropriate.

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation and developmentally-appropriate informed consent of youth and their families, including a weighing of potential risks and benefits are vital when considering medical intervention with gender minority youth.

Eliminating the practice of conversion therapy with sexual and gender minority minors is an important step, but it will not alleviate the myriad of stressors they experience as a result of interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities.

LGBTQ youth still need additional support to promote positive development in the face of such stressors. Supportive family, community, school, and health care environments have been shown to have great positive impacts on both the short- and long-term health and well-being of LGBTQ youth. Families and others working with LGBTQ children and adolescents can benefit from guidance and resources to increase support for sexual and gender minority minors and to help facilitate the best possible outcomes for these youth.

Ending the Use of Conversion Therapy for Minors

Given that conversion therapy is not an appropriate therapeutic intervention; efforts should be taken to end the practice of conversion therapy. Efforts to end the practice have included policy efforts to reduce the negative attitudes and discrimination directed at LGBTQ individuals and families; affirmative public information about LGBTQ individuals, particularly directed at families and youth; resolutions and guidelines by professional associations to inform providers that conversion efforts are inappropriate and to provide guidance on appropriate interventions; and, state and federal legislation and legal action to end the practice of conversion therapy. Future efforts may include improved provider training, federal regulatory action, advancement of legislation at the state and federal level, and additional activities by the Administration, which issued a public statement supporting efforts to ban the use of conversion therapy for minors in the spring of 2015.

PAGE INTENTIONALLY LEFT BLANK



Introduction

This report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*, provides an overview of the current state of scientific understanding of the development of sexual orientation and gender identity in children and adolescents as well as the professional consensus on clinical best practices with these populations. Specifically, this report addresses the issue of conversion therapy for minors. Conversion therapy—efforts to change an individual’s sexual orientation, gender identity, or gender expression⁵—is a practice that is not supported by credible evidence, and has been disavowed by behavioral health experts and associations. Importantly, this report also provides a nuanced overview of appropriate supportive interventions to assist families in exploring the sometimes difficult issues associated with sexual orientation, gender identity, and gender expression.

This work is the result of a collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Psychological Association (APA), which convened a panel of behavioral health professionals (e.g., psychologists, researchers and clinicians from psychology, social work, and psychiatry) with expertise in the fields of gender development, gender identity, and sexual orientation in children and adolescents in July 2015. That convening, which is discussed in greater depth below, aimed to establish consensus with respect to conversion therapy for minors, based on the best available research and scholarly material available, as well as the clinical experience of experts in the field. The resultant statements of professional consensus are printed in their entirety in the following section.

In addition, this report highlights [areas of opportunity for future research](#), and provides an overview of [mechanisms to eliminate the use of harmful therapies](#). In an effort to provide useful tools for families, practitioners, and educators, the report also provides resources on several topics, including: [Family and Community Acceptance](#),

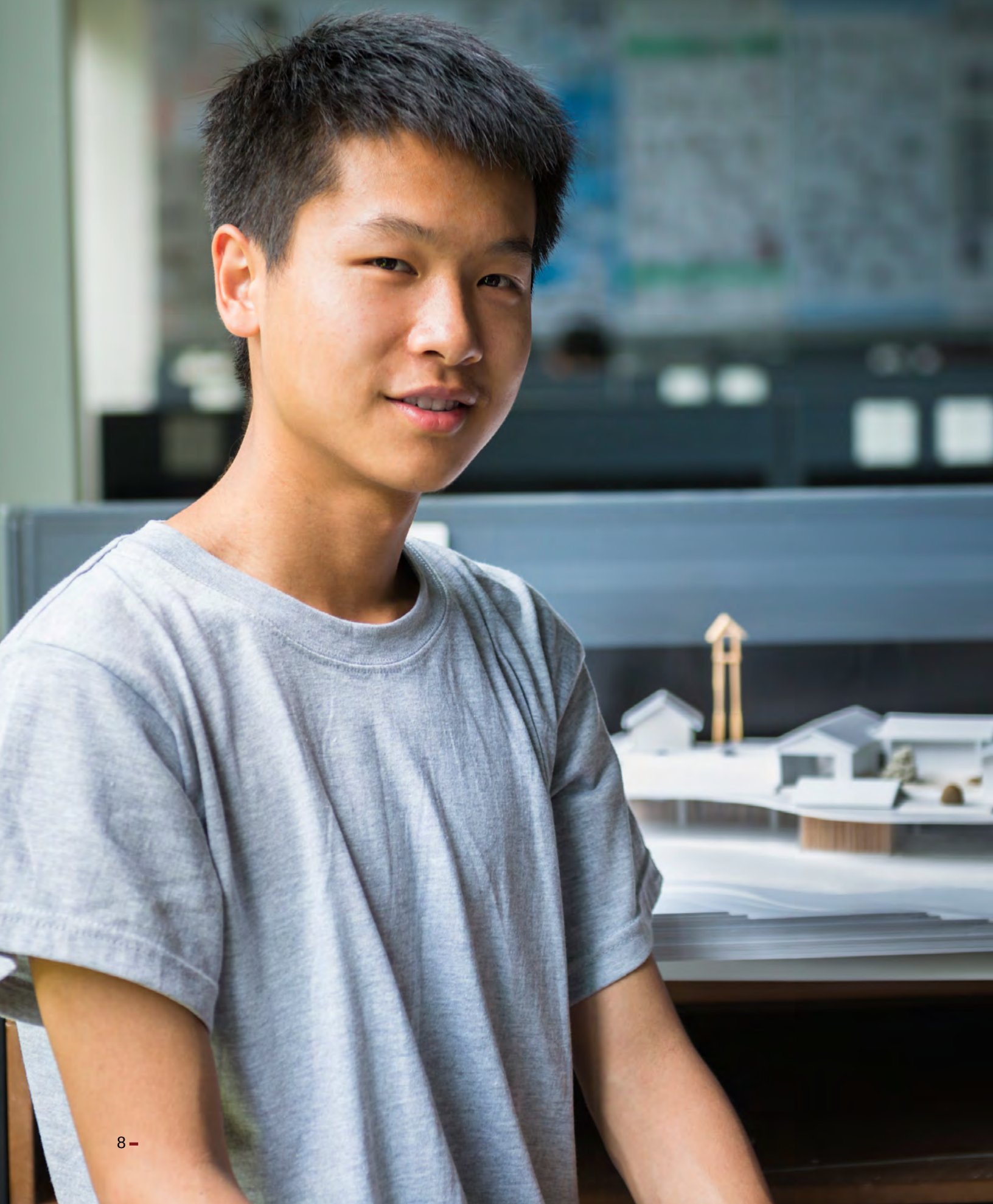
“Being gay is not a disorder. Being transgender is not a malady that requires a cure.”

—Vice Admiral Vivek H. Murthy,
19th U.S. Surgeon General

[School-Based Issues](#), [Pediatric Considerations](#), and [Affirmative Exploratory Therap](#). In addressing these four topics, SAMHSA aims to enable families, providers, educators, and community members to take actions that will reduce the health risks and disparities facing this vulnerable population.

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority communities. In addressing the issues included in this report that have a significant impact on the lives and well-being of sexual and gender minority youth, SAMHSA aims to enable families, providers, and educators to take actions that will reduce the health risks and disparities facing this vulnerable population.

SAMHSA’s mission is to improve the behavioral health of the nation. As such, SAMHSA endeavors to improve public health and eliminate health disparities facing all vulnerable communities, including sexual and gender minority populations.⁶As will be addressed in detail below, conversion therapy perpetuates outdated gender roles and negative stereotypes that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm. This report is one of many steps SAMHSA is taking to improve the health and well-being of sexual and gender minority children and youth.



Professional Consensus Process

In early April 2015, representatives from SAMHSA and APA agreed to collaborate to address the concerns of professional associations, policy makers, and the public regarding efforts to change gender identity and sexual orientation in children and adolescents (also referred to as conversion therapy). Through the support of the Federal Agencies Project, APA hosted an expert consensus convening on this topic in July 2015, which significantly informed this report. The research overview and clinical expertise highlighted throughout serve as the foundation from which the consensus statements were developed. Both the process of achieving consensus and the results of the meeting are published below.

APA initially developed a list of the areas of expertise to be used in identifying potential experts to participate in the consensus panel based on existing professional guidelines and resolutions related to sexual orientation, gender identity, and gender expression, as well as published research. APA solicited nominations from specialists in the field with expertise in gender, sexuality and sexual orientation, child and adolescent development and mental health, and the psychology of religion. Additionally, APA solicited nominations from professional associations representing the major mental health and health professions. Using the input received from these sources, APA extended invitations to a short list of highly recommended group of experts. This initial expert pool nominated additional experts based on their assessment of the expertise needed to achieve the goals of the meeting. The final panel of 13 experts consisted of ten psychologists, two social workers, and one psychiatrist. These individuals included researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel also included experts with a background in family therapy, ethics, and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B.

Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and Mark Yarhouse, PsyD. APA activities were coordinated by Clinton W. Anderson, PhD and Judith Glassgold, PsyD.

Based on published literature on consensus methods, APA developed an iterative process that culminated in a two-day meeting in Washington, DC on July 7 and 8, 2015. During the meeting, panelist-led discussions considered the relevant research, professional guidelines and clinical knowledge-base for each of the topics. The panel developed consensus statements on sexual orientation change efforts as well as gender identity change efforts in children and adolescents for each of the relevant developmental stages: pre-pubertal children, peri-pubertal adolescents, and pubertal and post-pubertal adolescents.

Panelists agreed that unanimous consensus was a strong priority, but that if unanimity could not be reached, 80 percent support would constitute consensus. The panelists also agreed that minority opinions should be reflected in the record if any dissenting expert wished to issue such an opinion. Unanimous consensus was reached in nearly all instances. No dissenting opinions were formally registered. The statements of professional consensus are printed in *Section 3* of this report.

Observers from interested federal agencies, health and human services professional organizations, foundations, and LGBTQ human rights organizations also attended the meeting. These observers were offered an opportunity to submit written questions, which the panel addressed throughout the course of the meeting.



“PFR “created something that was groundbreaking. It was the best piece of work ever created by the federal government.”

Sue Thau

Statements of Professional Consensus

The following are the statements of professional consensus regarding sexual orientation and gender identity and expression that were developed during the July 2015 APA consensus convening. After initially developing separate statements regarding issues relating to the development of sexual orientation and gender identity and gender expression, the panel developed a set of three key summary statements. The panel also developed a statement regarding the guiding human rights and scientific principles that provide a foundation for behavioral health professionals' work in this area.

Guiding Principles

Behavioral health professionals respect human dignity and rights. The foundational ethical principle of “self-determination” requires that children and adolescents be supported in their right to explore, define, and articulate their own identity. The principles of “justice” and “beneficence and nonmaleficence” require that all children and adolescents have access to behavioral health treatments that will promote their health and welfare. Children and adolescents have the right to participate in decisions that affect their treatment and future. Behavioral health professionals respect human diversity and strive to incorporate multicultural awareness into their work.

These guiding principles are based upon the codes of ethics for the professional fields of Psychology, Psychiatry, and Social Work (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

Professional Consensus on Conversion Therapy with Minors

1. Same-gender⁷sexual orientation (including identity, behavior, and/or attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
2. There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
3. Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatments. Directing the child to be conforming to any gender expression or sexual orientation, or directing the parents to place pressure for specific gender expressions, gender identities, and sexual orientations are inappropriate and reinforce harmful gender and sexual orientation stereotypes.

Professional Consensus on Sexual Orientation in Youth

1. Same-gender sexual identity, behavior, and attraction are not mental disorders. Same-gender sexual attractions are part of the normal spectrum of sexual orientation. Sexual orientation change in children and adolescents should not be a goal of mental health and behavioral interventions.
2. Sexual minority children and adolescents are especially vulnerable populations with unique developmental tasks who lack protections from involuntary or coercive treatment, and whose parents and guardians need accurate information to make informed decisions about behavioral health treatment.
3. There is a lack of published research on efforts to change sexual orientation among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter sexual orientation. Given the research on the secondary outcomes of such efforts, the potential for risk of harm suggests the need for other models of behavioral health treatment.
4. Behavioral health professionals provide accurate information on sexual orientation, gender identity, and expression; increase family and school support; and, reduce rejection of sexual minority youth. Behavioral health practitioners identify sources of distress and work to reduce distress experienced by children and adolescents. Behavioral health professionals provide efforts to encourage identity exploration and integration, adaptive coping, and family acceptance to improve psychological well-being.

Professional Consensus on Gender Identity and Gender Expression in Youth

Consensus on the Overall Phenomena of Gender Identity and Gender Expression

1. Variations in gender identity and expression are normal aspects of human diversity and do not constitute a mental disorder. Binary definitions of gender may not reflect emerging gender identities.
2. Pre-pubertal children and peri-pubertal adolescents who present with diverse gender expressions or gender dysphoria may or may not develop a transgender identity in adolescence or adulthood. In pubertal and post-pubertal adolescents, diverse gender expressions and transgender identity usually continue into adulthood.

Consensus on Efforts to Change Gender Identity

3. There is a lack of published research on efforts to change gender identity among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.
4. It is clinically inappropriate for behavioral health professionals to have a prescriptive goal related to gender identity, gender expression, or sexual orientation for the ultimate developmental outcome of a child's or adolescent's gender identity or gender expression.
5. Mental health and behavioral interventions aimed at achieving a fixed outcome, such as gender conformity, including those aimed at changing gender identity or gender expression, are coercive, can be harmful, and should not be part of treatment. Directing the child or adolescent to conform to any particular gender expression or identity, or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes.

Consensus on Appropriate Therapeutic Intervention for Youth with Gender-Related Concerns

6. Children and adolescents experiencing gender-related concerns are an especially vulnerable population with unique developmental tasks. Parents and guardians need accurate scientific information to make informed decisions about appropriate mental health and behavioral interventions, including whether or not to initiate a social gender transition or, in the case of peri-pubertal, pubertal, and post-pubertal adolescents, medical intervention. Treatment discussions should respect the child's and adolescent's developing autonomy, recognizing that adolescents are still transitioning into adult decision-making capacities.
7. Approaches that focus on developmentally-appropriate identity exploration, integration, the reduction of distress, adaptive coping, and family acceptance to improve psychological well-being are recommended for children and adolescents of all ages experiencing gender-related concerns.

Pre-Pubertal Children

8. Gender expression and gender identity are interrelated and difficult to differentiate in pre-pubertal children, and are aspects of identity that develop throughout childhood. Therefore, a detailed psychological assessment should be offered to children and families to better understand the present status of a child's gender identity and gender expression, as well as any associated distress.

Peri-Pubertal Adolescents

9. For peri-pubertal adolescents, the purpose of pubertal suppression is to provide time to support identity exploration, to alleviate or avoid potential distress associated with physical maturation and secondary sex characteristics⁸, and to improve future healthy adjustment. If pubertal suppression is being considered, it is strongly recommended that parents or guardians and medical providers obtain an assessment by a licensed behavioral health provider to understand the present status of a peri-pubertal adolescent's gender identity or gender expression and associated distress, as well as to provide developmentally-appropriate information to the peri-pubertal adolescent, parents or guardians, and other health care professionals involved in the peri-pubertal adolescent's care. The purpose of the assessment is to advise and inform treatment decisions regarding pubertal suppression after sharing details of the potential risks, benefits, and implications of pubertal suppression, including the effects of pubertal suppression on behavioral health disorders, cognitive and emotional development, and future physical and sexual health.

Pubertal and Post-Pubertal Adolescents

10. Decision-making regarding one's developing gender identity is a highly individualized process and takes many forms. For pubertal and post-pubertal adolescents, if physical gender transition (such as hormone therapy or gender affirming surgeries) is being considered, it is strongly recommended that adolescents, parents, and providers obtain an assessment by a licensed behavioral health provider to understand the present status of an adolescent's gender identity and gender expression and associated distress, as well as to provide developmentally-appropriate information to adolescents, parents or guardians, and other health care professionals involved in the pubertal or post-pubertal adolescent's care. If physical transition is indicated, the potential risks, benefits, and implications of the transition-related procedures being considered – including the effects on behavioral health disorders, cognitive and emotional development, and potentially irreversible effects on physical health, fertility, and sexual health – are presented to the adolescent and parents or guardians.

Withholding timely physical gender transition interventions for pubertal and post-pubertal adolescents, when such interventions are clinically indicated, prolongs gender dysphoria and exacerbates emotional distress.

Research Overview

Sexual Orientation

Sexual orientation is a multidimensional construct that consists of sexual identity, sexual and romantic attraction, and sexual behavior. Great shifts in the understanding of sexual orientation have occurred over the past century (Herek, 2010). Though a minority sexual orientation was once considered abnormal or a medical problem, scientists now understand that sexuality occurs on a continuum and variations in sexual orientation are part of the normal range of human sexuality (American Psychological Association, 2009; Diamond, 2015; Vrangalova & Savin-Williams, 2012). In 1973, homosexuality was removed as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders with a declaration of support for the civil rights of lesbian, gay, and bisexual people from the American Psychiatric Association. Many health organizations followed suit in passing resolutions that affirmed their support for the civil rights of lesbian, gay, and bisexual people, including the American Psychological Association, the National Association for Social Workers, the American Counseling Association, the American Medical Association, the American Psychoanalytic Association, and the American Academy of Pediatrics. In 1992, the World Health Organization removed homosexuality from the International Classification of Diseases (Nakajima, 2003; World Health Organization, 1992)⁹.

Gender

Gender is a ubiquitous and multi-faceted social category. When discussing the concept of gender, scientists distinguish between biological sex, gender identity, and gender expression. Biological sex refers to one's physical sex characteristics (Hughes, Houk, Ahmed, & Lee, 2006). Infants' biological sex is labeled at birth, almost always based solely on external genital appearance; this is referred to as one's assigned sex at birth¹⁰. Gender identity refers to a person's deeply felt, inherent sense of being a girl, woman or female; a boy, a man or

male; a blend of male or female; or an alternative gender (Bethea, 2013; Institute of Medicine, 2011). Gender expression refers to the ways a person communicates their gender within a given culture, including clothing, communication patterns, and interests; a person's gender expression may or may not be consistent with socially prescribed gender roles or assigned sex at birth, and may or may not reflect his or her gender identity (American Psychological Association, 2008).

Similar to sexual orientation, significant changes have occurred over time in the scientific understanding of gender. Though one's biological sex, gender identity, and gender expression are distinct constructs, society expects that they will align, and for most individuals this is true – that is, most individuals who are assigned female at birth identify as girls or women and adopt a feminine gender expression, while most individuals who are assigned male at birth identify as boys or men and adopt a masculine gender expression¹¹(American Psychological Association, 2015a). However, for some individuals, these constructs do not align. The term transgender refers to individuals whose gender identity is not consistent with their sex assigned at birth. The term gender diverse (or gender nonconforming) refers to individuals whose gender expression does not conform to the stereotypical norms in their culture for their assigned sex at birth. Research in recent decades has also challenged the perception of gender as a binary construct with mutually exclusive categories of male or female, boy or girl, man or woman (American Psychological Association, 2015a; Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). It has also often been assumed that one's gender identity – that is, the deeply felt, inherent sense of one's gender – always aligns with sex assigned at birth (American Psychological Association, 2015a). Scientists now recognize that a wide spectrum of gender identities and gender expressions exist (and have always existed), including people who identify as either man or woman, neither man nor woman,

a blend of man and woman, or a unique gender identity (Harrison, Grant, & Herman, 2012; Kuper, Nussbaum, & Mustanski, 2012).

Furthermore, scientists and clinicians now understand that identifying with a gender that does not align with sex assigned at birth, as well as a gender expression that varies from that which is stereotypical for one's gender or sex assigned at birth, is not inherently pathological (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuypere, & Bockting, 2010) and does not always require clinical attention (Steensma, Kreukels, et al., 2013). However, people may experience distress associated with discordance between their gender identity and their body or sex assigned at birth (i.e., gender dysphoria) as well as distress associated with negative social attitudes and discrimination (Coleman, et al., 2012). This paradigmatic shift in the understanding of diverse gender identities and expressions was reflected in the replacement of Gender Identity Disorder with Gender Dysphoria in the 2013 edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013a). The diagnosis of Gender Dysphoria, which is marked in children and adolescents by clinically significant distress encountered by the discordance between biological sex and gender identity that disrupts school or social functioning, depathologizes diverse gender identities and expressions, instead focusing on the potential psychosocial challenges associated with gender diversity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014).

Sexual Orientation and Gender in Childhood

Sexual Orientation in Childhood

Sexual orientation, as usually conceptualized, begins at or near adolescence with the development of sexual feelings (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). While children display aspects of sexuality from infancy, and almost universally develop sexual feelings by adolescence or earlier, the limited

research focused on children's sexuality generally does not assess sexual orientation (Adelson & AACAP CQI, 2012). Therefore, little is known about sexual orientation in pre-pubertal children, and no direct research on sexual orientation in pre-pubertal children has been conducted. Studies that have retrospectively asked lesbian, gay, and bisexual adults about their childhood experiences have reported that LGB adults often describe having had same-gender emotional and sexual feelings and attractions from childhood or early adolescence; many recall a sense of being different even earlier in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Gender Identity and Gender Expression in Childhood

Gender-related development begins in infancy and continues progressively throughout childhood. Research has focused on three key concepts: gender constancy, gender consistency, and gender identity. On average, children develop gender constancy – stability across time in identification of their gender – between ages 3 to 4 (Kohlberg, 1966) and gender consistency – recognition that gender remains the same across situations – between ages 4 to 7 (Siegal & Robinson, 1987). The development of gender identity appears to be the result of a complex interplay between biological, environmental, and psychological factors (Steensma, Kreukels, et al., 2013). For most people, gender identity develops in alignment with one's sex assigned at birth. However, for some individuals, gender identity may not align with one's assigned sex at birth, and the period during which gender identity is clarified and solidified is unclear (Diamond & Butterworth, 2008; Steensma, Kreukels, et al., 2013). There is no single trajectory of gender identity development for gender minority children.

It is important to note that research on gender identity issues among children is largely clinical in nature and focuses on the treatment and intervention of Gender Dysphoria and, previously, Gender Identity Disorder¹² (APA Task Force on Gender Identity and Gender Variance, 2009). Though there

have been no epidemiological studies to determine the prevalence of gender diverse and transgender children or adolescents, there has been a notable increase in the number of gender minority youth presenting to specialty gender clinics in the past decade (Vance, et al., 2014). Recent evidence indicates that as a culture becomes more supportive of gender diversity, more children are affirming a transgender identity or diverse gender expressions (Vance, et al., 2014).

Some gender non-conforming children experience significant distress, currently termed *gender dysphoria*. Signs of gender dysphoria may emerge as early as the preschool years; children as young as two years may indicate that they want to be another gender, express dislike for the gender associated with their sex assigned at birth, express anatomic dysphoria, and state that they want to be another gender as soon as they can express language (Cohen-Kettenis, 2005). For most gender minority children, gender dysphoria does not persist through adolescence. Existing research suggests that between 12 percent and 50 percent of children attending a specialty clinic for gender dysphoria may persist in their identification with a gender different than sex assigned at birth into late adolescence and young adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). These studies were based on clinical samples of youth and many of the researchers categorized youth no longer attending the clinics (whose gender identity may be unknown) as no longer gender dysphoric, and so this research likely underestimates the percentage of youth who persist with a cross-gender or transgender identity (American Psychological Association, 2015a).

The fact that a large proportion of gender minority children do eventually develop a gender identity consistent with their sex assigned at birth has been viewed as evidence of the malleability of gender identity (Zucker, 2004; Zucker & Bradley, 1995). However, this conclusion has been challenged in recent years by some scholars. These researchers and clinicians have pointed out that the diagnostic

criteria for Gender Dysphoria (and, previously, Gender Identity Disorder) in Childhood includes indicators that might denote gender dysphoria or gender identity, but might also simply be markers of diverse gender expression (for example, children's play preferences; Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013). These scholars have suggested that the inclusion in study samples of many children with diverse gender expressions who may not have gender dysphoria could explain the large proportion of gender minority children who eventually do not meet the diagnostic criteria in adolescence (Hidalgo et al., 2013; Wallien & Cohen-Kettenis, 2008).

One of gender's greatest complexities is that some people never identify with the sex they were assigned at birth, some people consistently identify with the sex they were assigned at birth, and still others vary over time. Gender minority children follow two trajectories¹³: On the first, children will experience gender dysphoria through adolescence and adulthood (unless dysphoria is mitigated through social or medical transition) and will identify as transgender or as a gender different from that assigned at birth. On the other trajectory, gender minority children will develop to be cisgender individuals, i.e., they will eventually identify with a gender consistent with their sex assigned at birth (Simons, et al., 2014). Gender minority children who eventually develop a cisgender identity are more likely to identify as lesbian, gay, or bisexual in adolescence and young adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). It is unknown whether gender minority children who develop a cisgender identity continue to express their gender in ways that do not conform to stereotypical gender norms, as this has not been studied. No prospective data exist on factors that might predict for any particular child which trajectory they will follow. There is, however, recent retrospective evidence identifying factors that are more common among children who eventually identify as transgender: early cognitive ("I am a girl") rather than affective ("I feel like a girl") assertion of gender; consistent and firm gender-

fluid or gender-crossing expressions and identity; and distress about the incongruence between their physical sex characteristics and affirmed gender (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013; Vance, et al., 2014).

Clinical Issues in Childhood

Researchers have not systematically investigated whether children experience distress related to their sexual orientation. No published research suggests that children are distressed about their sexual orientation. When pre-pubertal children are referred to behavioral health professionals for concerns related to sexual orientation, such referrals are often precipitated by a parent or guardian's concern or distress about a child's behavior – generally, a failure to conform to stereotypical gender role behaviors – and possible future sexual orientation (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Research has shown that gender diverse children who develop a cisgender identity do have a higher likelihood of identifying as a sexual minority in adulthood, and that some (but not all) sexual minority adults recall gender nonconforming behaviors in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). It is unknown whether cisgender lesbian, gay, and bisexual adults who were treated by behavioral health providers as youth experienced distress related to their gender nonconformity (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Gender minority children are not a monolithic group: some gender diverse children are distressed; while others are not distressed, but may be referred for mental health care because of parental concerns related to their gender or perceived future sexual orientation. Among those who are distressed, the source of distress varies. Some gender diverse children are distressed by their primary sex characteristics or by the anticipation of future sex characteristics, while others are not (Coleman, et al., 2012; Vance, et al., 2014). In addition to anatomical dysphoria, children's feelings of gender

typicality, gender contentedness, and pressure to conform to stereotypical gender norms also appear related to children's psychosocial adjustment. Researchers have reported on the relationships between these various components of gender identity and indicators of children's psychosocial adjustment, such as self-esteem, internalizing and externalizing problems, and social competence with peers (Carver, Yunger, & Perry, 2003; Egan & Perry, 2001; Yunger, Carver, & Perry, 2004).

Gender minority children, on average, have poorer relationships with parents (Adelson & AACAP CQI, 2012; Alanko et al., 2009) and peers (Smith & Leaper, 2006; Zucker, 2005), experience high rates of mistreatment from peers (D'Augelli, Grossman, & Starks, 2006), and are at increased risk of physical and sexual abuse in childhood, as compared to their gender conforming peers (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Clinical samples of gender minority children with gender dysphoria have increased rates of internalizing disorders, such as depression and anxiety (de Vries, et al., 2011; Spack et al., 2012) and behavioral problems (Simons, et al., 2014; Zucker, 2004), as compared to the general population of children. Behavioral issues among those with gender dysphoria increase with age; poor peer relations explain most of the variance in behavioral problems among children with gender dysphoria (Zucker, 2004). Negative social attitudes or rejection are likely related if not the direct causes of these psychological difficulties (Vance, et al., 2014). Additionally, autism spectrum disorders appear to occur more commonly among clinical samples of children with gender dysphoria than among children in the general population, though the reason for this increased co-occurrence, and whether this increased co-occurrence also occurs outside of clinic populations, is not fully understood (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012).

Sexual Orientation and Gender in Adolescence

Sexual Orientation in Adolescence

Significant physical, cognitive, and social development occurs during adolescence. Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. Various factors affect the trajectory of development related to sexual orientation, and there is not a single or simple trajectory experienced by all individuals (Diamond, 2006, 2008; Diamond & Savin-Williams, 2000; Dube & Savin-Williams, 1999; Horowitz & Newcomb, 2001). In a large prospective cohort study of adolescents living throughout the U.S., 12 percent of males and 22 percent of females at one point indicated a minority sexual orientation identity (i.e., mostly heterosexual, bisexual, mostly homosexual, or completely homosexual; Ott, Corliss, Wypij, Rosario, & Austin, 2010)¹⁴. Compared to earlier cohorts, today's sexual minority adolescents are developing an awareness of their sexual orientation and disclosing their sexual orientation to others earlier than previous generations, frequently disclosing their sexual orientation or "coming out" as lesbian, gay, or bisexual in middle or high school (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, et al., 2006; R. C. Savin-Williams, 2001; R.C. Savin-Williams, 2005). This earlier disclosure means that adolescents are now often coming out while still dependent on their families and communities for emotional and instrumental support.

Gender Identity in Adolescence

Gender minority adolescents include both youth who realized a transgender identity or gender diverse presentation in childhood (i.e., early-onset individuals) and youth for whom gender dysphoria first emerges in adolescence (i.e., later-onset individuals). Adolescence is a crucial period for the consolidation of gender identity and persistence of gender dysphoria in early-onset individuals and for the initiation of gender dysphoria in later-onset individuals (Steensma, McGuire, et al., 2013). Youth for whom gender dysphoria first emerges in adolescence may have no history of a gender diverse expression or gender identity questioning in childhood (Edwards-Leeper & Spack, 2012; Wallien & Cohen-Kettenis, 2008). The onset of typical physical changes associated with puberty is often associated with worsening of anatomical dysphoria and distress in adolescents with gender dysphoria (Byne, et al., 2012; Coleman, et al., 2012). Increasing numbers of adolescents have already starting living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003) and many (but not all) adolescents with gender dysphoria express a strong desire for hormone therapy and gender affirming surgeries (Coleman, et al., 2012).

When gender dysphoria persists through childhood and intensifies into adolescence, the likelihood of long-term persistence of gender dysphoria and identification as transgender in adulthood increases. Two different follow up studies reported that 50-67 percent of adolescents attending a specialty clinic for gender dysphoria went on to have gender affirming surgeries, suggesting high rates of persistence (Cohen-Kettenis & van Goozen, 1997; Smith, van Goozen, & Cohen-Kettenis, 2001). Since not all individuals with gender dysphoria have gender affirming surgeries, the percentage of adolescents in these study samples who continued to experience gender dysphoria is likely higher than 50-67 percent; in fact, the Smith et al. (2001) study suggested that a considerable number of the patients who did not have gender affirming surgeries still experienced gender dysphoria four years later.

Clinical Issues in Adolescence

Although many sexual and gender minority youth successfully navigate the challenges of adolescence, others experience a variety of mental health and psychosocial concerns. In comparison with their heterosexual and cisgender counterparts, sexual and gender minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Coleman, et al., 2012; Corliss, et al., 2010; Friedman, et al., 2011; Garofalo, et al., 2006; Goldbach, et al., 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann, et al., 2011; Liu & Mustanski, 2012; Marshal, et al., 2011; Mustanski, et al., 2010; S. T. Russell, 2003; Simons, et al., 2014). Sexual and gender minority youth who lack supportive environments are especially vulnerable to these negative outcomes (for example, research from Kosciw, et al., (2014), Ryan, Huebner, Diaz, & Sanchez, (2009), and Travers, et al. (2012)).

Pubertal development can be especially distressing for transgender adolescents and can set off a cascade of mental health problems during adolescence (Byne, et al., 2012; Coleman, et al., 2012). Mental health challenges are more common among adolescents with gender dysphoria than among children with gender dysphoria (Byne et al., 2012), which may be due to peer ostracism that increases with age (APA Task Force on Gender Identity and Gender Variance, 2009). Additionally, as with children, the prevalence of autism spectrum disorders appears to be higher among clinical samples of adolescents with gender dysphoria than among the general population of adolescents (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012). Adolescents with autism spectrum disorders (ASD) would benefit from careful assessment distinguishing between symptomatology related to gender dysphoria and symptoms related to ASD. de Vries, et al. (2010) reported a rate of autism spectrum disorders 10 times higher among children and adolescents referred to their gender clinic

in Amsterdam, Netherlands as compared to the general population. This research only examined cases of severe autism and not milder versions such as Asperger's disorder, which Edwards-Leeper and Spack (2012) reported being more commonly seen among patients in the GeMS clinic in Boston, especially among those with a late-onset of gender dysphoria. The question of whether gender dysphoria is simply a symptom of autism spectrum disorder among youth with ASD has been raised by behavioral health providers; Edwards-Leeper and Spack (2012) suggest that it is also worth questioning validity of the autism diagnosis among transgender youth, particularly those with Asperger's disorder, as it is possible that social awkwardness and lack of peer relationships are the result of feeling isolated and rejected due to gender identity and expression (Edwards-Leeper & Spack, 2012). More research is needed into appropriate treatment for sexual and gender minority children and adolescents with developmental disabilities as well; behavioral health providers should not presume that young people with developmental disabilities cannot also be sexual and gender minorities.

Influences on Health and Well-Being

The increased risks faced by sexual or gender minority youth are not a function of their identity. Rather, these risks stem from the stresses of prejudice, discrimination, rejection, harassment, and violence (Bockting et al., 2013; Harper & Schneider, 2003; Hendricks & Testa, 2012; Meyer, 1995). The presence of sexual orientation- and gender-related stressors – and opportunities for support – encompasses multiple social systems, including family, school, and religious networks (U. Bronfenbrenner, 1979; U. Bronfenbrenner, 2005; Harper, 2007); Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2013)¹⁵. Therefore, when a distressed sexual and gender minority adolescent is evaluated by a behavioral health provider, it is imperative to assess the broader family and community systems in which the child lives, in addition to individual issues. Assessing

not only the adolescent's level of distress, but also identifying the source(s) of distress and support are vital components of a comprehensive assessment.

Family

Family response to an adolescent's sexual orientation, gender identity, or gender expression has a significant impact on the adolescent's wellbeing. Parents can serve as both a source of stress and a source of support for sexual and gender minority youth (Bouris, et al., 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Travers et al., 2012). Negative parental responses to sexual orientation or gender are associated with young people's psychological distress; however, parent-child relationships characterized by closeness and support, however, are an important correlate of mental well-being. Research by Doty, Willoughby, Lindahl and Malik (2010) has emphasized the benefits of sexuality-specific family and peer support to sexual minority adolescents' well-being.

Sexual and gender minority adolescents are at increased risk for experiencing violence and victimization, including psychological, physical, and sexual abuse from those within their families compared to adolescents from the general population (Friedman, et al., 2011; Roberts, et al., 2012). Past parental verbal and physical abuse has been associated with suicide attempts in transgender adolescents (Grossman & D'Augelli, 2007). These adolescents may also be ejected from their homes or run away, contributing to the overrepresentation of sexual and gender minority adolescents among the nation's homeless youth; 20-40 percent of all homeless youth identify as lesbian, gay, bisexual, or transgender (Durso & Gates, 2012; Ray & National Gay and Lesbian Task Force, 2006). Some data suggest that, compared to cisgender youth who conform to stereotypical gender norms, transgender and other adolescents whose gender expressions do not conform to stereotypical norms have a higher risk of abuse from family members (Roberts, et al., 2012; Roberts, Rosario, Slopen, Calzo, & Austin, 2013).

Furthermore, the level of family acceptance or rejection an adolescent experiences appears to have effects that extend into young adulthood. Data from the Family Acceptance Project have shown that sexual and gender minority young adults who experienced high levels of family rejection during adolescence fared significantly worse than those who experience low levels of family rejection in terms of depression, substance abuse, sexual risk behaviors, and suicide attempts (Ryan, Huebner, Diaz, & Sanchez, 2009); conversely, high levels of family acceptance in adolescence predicted greater self-esteem, social support, and general health status, and protected against depression, substance abuse, and suicidal ideation and behaviors in young adulthood as compared to those with low levels of family acceptance in adolescence (Ryan, et al., 2010).

Religion & Spirituality

When considering family and community influences, an adolescent's religious background is also an important factor. Religious beliefs and background are far-reaching influences that encompass multiple arenas of one's life, including: personal and family religious identity, beliefs and coping; family attitudes, beliefs and relationships; and community character and support. Religious views of homosexuality in the United States vary widely (Moon, 2014), and religion can have a large influence on sexual minority adolescents' mental health and wellbeing (cf. Ream & Savin-Williams, 2005; Page, Lindahl, & Malik, 2013). Though research on who seeks conversion therapy to change sexual orientation is lacking, it appears that such requests occur primarily among religious communities that view minority sexual orientations as undesirable or morally wrong (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Though religiosity is often associated with better psychosocial adjustment among young people in general, sexual minority youth may feel rejected by their religion or experience conflict between their sexual orientation and religious identities (Cotton, Zebracki, Rosenthal, Tsevat, & Drotar,

2006). However, various ways in which adolescents and young adults reconcile this conflict have been identified (Meanley, Pingel, & Bauermiester, 2015; Ream & Savin-Williams, 2005). Sexual minority youth growing up in more conservatively religious families are, on average, exposed to more messages that portray minority sexual orientations as undesirable or morally wrong (Schope & Eliason, 2000), which are associated with shame, guilt, and internalized homophobia (Ream & Savin-Williams, 2005). Sexual minority adolescents with religious parents may be less likely to disclose their sexual orientation to others (Schope, 2002; Stewart, Heck, & Cochran, 2015). Some research has indicated that involvement with religious or spiritual belief systems that cast rejecting or disapproving messages about sexual minorities is associated with greater psychosocial challenges, including increased internalized homophobia (Meanley, Pingel, & Bauermeister, 2015; Page, Lindahl, & Malik, 2013).

Religiosity or spirituality can be a deeply affirming and supportive aspect of identity, including for sexual minorities from faith communities. Research with adults indicates that affirming religious environments – that is, those that are inclusive and supportive of sexual minorities – may be associated with improved psychological wellbeing and reduced internalized homophobia (e.g., research from Lease, et al. (2005) and Yakushko (2005). Research from Hatzenbuehler, Pachankis, and Wolff (2012) supports the benefit of affirming religious environments for youth as well; the researchers reported that lesbian, gay, and bisexual high school students who lived in Oregon counties with a supportive religious climate (i.e., counties where the majority of religious individuals adhered to a religious denomination supportive of minority sexual orientations) had significantly fewer alcohol abuse symptoms and fewer sexual risk behaviors than those living in counties with a less supportive religious climate.

It is important not to reify categories within faiths such as “traditional”, “liberal”, “affirming” and “non-affirming”; religion and spirituality are complex, nuanced aspects of human diversity.

Parents from faith backgrounds have reactions that are similar in essential ways to all parents (e.g., sense of loss, desire for information, coming to terms with difference between hopes and reality; Maslowe and Yarhouse, 2015). Research indicates that families who identify superordinate goals such as unconditional love, mercy, forgiveness, and respect for all human beings can remain connected to their children in positive ways (Ryan et al, 2009; Maslowe & Yarhouse, 2015).

Given the great potential impact of religion on the lives of sexual and gender minority youth, little research has been done in this area with sexual minority adolescents and almost none has been completed with gender minority adolescents; further, almost no research has focused on sexual minority youth or adults in the United States from non-Christian religious backgrounds (cf. Harari, Glenwick, & Cecero, 2014; Siraj, 2012). It is unknown whether similar relationships between various aspects of religion and well-being would be seen among gender minority youth and among sexual and gender minority youth from non-Christian religious backgrounds.

School

Sexual and gender minority adolescents may also experience a myriad of sexual orientation and gender-related stressors in the school environment, where they spend a large portion of their time. The climates of U.S. middle and high schools are generally unsupportive and unsafe for many sexual and gender minority youth, who experience high levels of verbal and physical harassment and assault, sexual harassment, social exclusion and isolation, and other interpersonal problems with peers (Kosciw, Greytak, & Diaz, 2009). In the most recent National School Climate Survey, the Gay, Lesbian & Straight Education Network (GLSEN) found that 55.5 percent of surveyed sexual and gender minority students felt unsafe at school because of their sexual orientation and 37.8 percent felt unsafe because of their gender expression (Kosciw, et al., 2014). Most students reported hearing homophobic remarks and negative remarks about their gender expression at school

from fellow students and teachers or other school staff; a third of students reported hearing negative remarks specifically about transgender people. Of the students surveyed, 74.1 percent of surveyed students were verbally harassed, 36.2 percent were physically harassed, 16.5 percent were physically assaulted, and 49.0 percent were cyberbullied in the past year because of their sexual orientation. On average, sexual minority students of color and students who did not conform to stereotypical gender roles experienced higher frequencies of victimization. Over half of the students surveyed experienced policies that were discriminatory based on sexual orientation, gender identity, or gender expression at school. Transgender students were particularly targeted by some discriminatory policies: 42.2 percent of transgender students had been prevented from using their preferred name; 59.2 percent were required to use a bathroom or locker room of their legal sex; and 31.6 percent were not allowed to wear clothes consistent with their gender identity.

This mistreatment has a significant effect on sexual and gender minority adolescents' mental health and wellbeing. Those who experience victimization due to sexual orientation or gender expression are more likely to report depressive symptoms, suicidality, and low self-esteem (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Kosciw, et al., 2014). Experiences of victimization and discrimination are linked to negative academic outcomes, including missing school, lower grades, and not planning to pursue post-secondary education (Kosciw, et al., 2014). Further, these effects may last into young adulthood (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Victimization from peers and school staff, combined with discriminatory policies, likely contributes to the over-representation of sexual and gender minorities in the juvenile justice system: though sexual and gender minority youth comprise only five to seven percent of the nation's youth, it is estimated that 13 to 15 percent of youth in the juvenile justice system are sexual and gender minority youth (Majd, Marksamer, & Reyes, 2009).

School and peer networks can also be a place where

sexual and gender minority youth find support. The presence of friends to whom youth can be out about their sexual orientation or gender identity has been linked to mental health and wellbeing (Doty & Brian, 2010; Elizur & Ziv, 2001). Sexual and gender minority friends may be of particular importance, as they are more likely than heterosexual and cisgender friends to provide support for sexuality-related stress, which is associated with lower levels of both emotional distress and sexuality distress (Doty, et al., 2010; Snapp, Watson, Russell, Diaz, & Ryan, 2015). Additionally, both the presence of and participation in a Gay-Straight-Alliance (GSA) – a student-led, school-based club aiming to provide a safe place for LGBTQ students – has beneficial outcomes for sexual and gender minority students (for example, research from Goodenow, Szalacha, and Westheimer (2006), Kosciw, Greytak, Diaz, and Bartkiewicz (2010), Toomey, Ryan, Diaz, and Russell (2011), and Walls, Kane, and Wisneski (2010)).

Identity Development

Sexual and gender minority adolescents may experience identity conflict when reconciling a sexual minority identity that may conflict with the expectations of their family, peers, and community. Difficulty with the identity development process, such as difficulty accepting one's sexual orientation and dissonance between one's self-image and societal beliefs about sexual minorities, can increase internalized homophobia (Page et al., 2013). Sexual orientation conflict has been linked to negative psychosocial outcomes in adolescents and young adults (Willoughby, Doty, & Malik, 2010). Furthermore, a negative self-image as a sexual minority contributes to the relationship between sexuality-specific stressors, including family rejection and victimization, to poorer mental health outcomes (Page, et al., 2013; Willoughby, et al., 2010).

Though less research has been done with gender minority adolescents overall, and especially on topics related to identity, internalized transphobia is expected to have a deleterious effect on mental health (Hendricks & Testa, 2012). Therefore,

important areas of focus for behavioral health professionals who work with sexual and gender minority adolescents include internalized homophobia, transphobia, and clients' minority identity.

Intersecting Identities

Finally, sexual and gender minority adolescents are not a single, homogenous population; individuals may hold multiple minority identities. Race, ethnicity, sex assigned at birth, social class, religion, disability, and immigration status may each confer their own unique minority identities, stressors, and strengths that interact with those related to sexual orientation and gender identity and expression. Sexual and gender minority youth have multiple, interlocking identities defined by relative sociocultural power and privilege that shape individual and collective identities and experiences (Crenshaw, 1991; Parent, DeBlaere, & Moradi, 2013; Shields, 2008; Yarhouse & Tan, 2005). Though a full review is beyond the scope of this report, research has begun to identify some of the ways that sexual and gender minority adolescents' experiences vary by race/ethnicity (Corby, Hodges, & Perry, 2007; Grov, et al., 2006; Kosciw, et al., 2014; Ryan, et al., 2009; Ryan, et al., 2010), immigration status (Daley, Solomon, Newman, & Mishna, 2008; Ryan, et al., 2009; Ryan, et al., 2010), gender (Bontempo & D'Augelli, 2002; Ryan, et al., 2009), gender expression (Hidalgo, Kuhns, Kwon, Mustanski, & Garofalo, 2015; Roberts, et al., 2012; Roberts, et al., 2013; Toomey, Ryan, Diaz, Card, & Russell, 2010), and socioeconomic status (Kosciw, et al., 2009; Ryan, et al., 2009; Ryan, et al., 2010). Behavioral health professionals working with sexual and gender minority youth should be aware of and responsive to the intersecting identities held by young people when considering the effects of minority stress on mental health and wellbeing. Given the gaps in our understanding, more research on the experiences of adolescents who hold multiple marginalized identities is needed in order to understand both the unique strengths and sources resilience, as well as the stressors youth and their families may experience.

Therapeutic Efforts with Sexual and Gender Minority Youth

Introduction¹⁶

Despite dramatic social changes in the recognition of same-gender relationships and families and transgender identities, sexual and gender minority children and adolescents and their families face misinformation, negative social attitudes and discrimination that can pose challenges for child development and family acceptance. Behavioral health providers may receive referrals for treatment that include requests to change a child or adolescent's actual, perceived, or future sexual orientation or same-gender sexual behaviors, gender identity, or gender expression. Requests for conversion therapy most often come from a parent or guardian, or more rarely, a child or adolescent.

In providing services to children, adolescents, and families experiencing distress related to sexual orientation or gender, behavioral health providers should consider the following as the scientific basis of treatment¹⁷:

- Same-gender sexual identity, behavior, and attraction do not constitute a mental disorder;
- Transgender identities and diverse gender expressions do not constitute a mental disorder;
- Same-gender sexual attractions are part of the normal spectrum of sexual orientation and occur in the context of a variety of sexual orientations and gender identities;
- Variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender may not reflect emerging gender identities;
- Gay men, lesbians, bisexual and transgender individuals can lead satisfying lives as well as form stable, committed relationships and families.

Conversion Therapy

Lesbian, gay, and bisexual orientations are normal variations of human sexuality and are not mental health disorders; therefore, treatment seeking to

change an individual's sexual orientation is not indicated. Thus, behavioral health efforts that attempt to change an individual's sexual orientation are inappropriate. In 2009, the APA Taskforce on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts conducted a thorough review of peer-reviewed literature published on conversion therapy. The APA Taskforce concluded that no methodologically-sound research on adults undergoing conversion therapy has demonstrated its effectiveness in changing sexual orientation. There have been no studies on the effects of conversion therapy on children, though adults' retrospective accounts of their experiences of conversion therapy during childhood or adolescence suggests that many were harmed (American Psychological Association, 2009). No new studies have been published that would change the conclusions reached in the APA Taskforce's 2009 review.

Given the lack of evidence of efficacy and the potential risk of serious harm, every major medical, psychiatric, psychological, and professional mental health organization, including the American Psychological Association, the American Psychiatric Association, the National Association for Social Work, the Pan American Health Organization, and the American Academy of Child and Adolescent Psychiatry, has taken measures to end conversion therapy efforts to change sexual orientation. To the extent that children and adolescents experience distress related to their sexual orientation, treatment efforts should focus on identifying and ameliorating the sources of distress.

The discussion surrounding conversion therapy with gender minority youth is complicated by the fact that though diverse gender expressions and transgender identities are now understood to be part of the normal spectrum of human gender (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuypere, & Bockting, 2010), there remains a related psychiatric diagnosis: Gender Dysphoria (formerly Gender Identity Disorder (American Psychiatric Association, 2013a). Although there is much debate over whether Gender Dysphoria should remain a psychiatric diagnosis (for example, see Bockting

& Ehrbar (2005)), such a discussion is beyond the scope of this report. However, the shift from Gender Identity Disorder to Gender Dysphoria in version five of the Diagnostic and Statistical Manual of Mental Disorders does reflect a shift away from a pathological view of gender diversity towards a focus on the distress experienced as a result of the incongruence between one's physical body and gender identity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014). Thus, the distress remains the target of intervention, rather than gender identity. There is also scientific consensus that for many people, medical intervention in the form of hormone therapy or gender affirming surgeries may be medically necessary to alleviate gender dysphoria (American Medical Association, 2008; American Psychological Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

Historically, conversion therapy efforts to make children's behaviors, dress, and mannerisms more consistent with those stereotypically expected of their assigned sex at birth (i.e., more stereotypically masculine expression for those assigned male at birth and more stereotypically feminine expression for those assigned female at birth) were the primary clinical approach used with children experiencing gender dysphoria (Vance, et al., 2014; Zucker, 2004). Efforts to change children's gender expression have been made with the goal of preventing a transgender identity, as well as with the goal of preventing a future minority sexual orientation. Such efforts were based on the belief that variations in gender identity and expression are pathological and that certain patterns of family relationships cause a transgender identity or minority sexual orientation; research has not supported these theories or interventions (American Psychological Association, 2009). Because there is scientific consensus that gender dysphoria in adolescence is unlikely to remit without medical intervention, even those who support gender identity change efforts with pre-pubertal children generally do not attempt such efforts with adolescents experiencing gender dysphoria

(Adelson & AACAP CQI, 2012; American Psychological Association, 2008). Alternative affirmative and supportive approaches to therapy with transgender and gender diverse children have been developed and are becoming increasingly common (Edwards-Leeper, Leibowitz, & Sangganjanavanich, in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, Tuerk, & Perrin, 2005).

No research has been published in the peer-reviewed literature that demonstrates the efficacy of conversion therapy efforts with gender minority youth, nor any benefits of such interventions to children and their families. Researchers have reported that these interventions are ineffective in decreasing the likelihood of a future same-gender sexual orientation or minority sexual identity (Zucker & Bradley, 1995). In addition to a lack of evidence for the efficacy of conversion therapy with gender minority youth, there are concerns about the ethics of this practice (Byne, et al., 2012; Coleman, et al., 2012) as well as the practice's potential for harm (Minter, 2012; Wallace & Russell, 2013). Although no research demonstrating the harms of conversion therapy with gender minority youth has been published, the potential harms of conversion therapy are suggested by clinicians' observations that the behavioral issues and psychological distress of many children and adolescents with gender dysphoria improves markedly when their gender identities and expressions are affirmed through social and/or medical transition (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Edwards-Leeper & Spack, 2012), as well as by the body of literature demonstrating the negative effects of both rejection and a lack of support on the health and well-being of gender minority youth (e.g., research from Kosciw, et al. (2014), Ryan, et al. (2010), and Travers, et al. (2012)).

In conclusion, given the lack of evidence for the efficacy conversion therapy and the fact that conversion therapy efforts are based on a view of gender diversity that runs counter to scientific consensus, in addition to evidence that rejecting

behaviors and a lack of support have adverse effects on the psychological well-being of gender minority youth – conversion therapy, as well as any therapeutic intervention with an *a priori* goal for a child's or adolescent's gender expression, gender identity, or sexual orientation, is inappropriate. Given the potential for harm associated with conversion therapy efforts, other affirmative behavioral health interventions are recommended for individual or family distress associated with sexual orientation and gender identity.

Appropriate Interventions for Distress in Children, Adolescents, and Families¹⁸

Behavioral health providers are in a unique position to provide accurate information on the development of sexual orientation and gender identity and expression; to increase family and school support; and to reduce family, community and social rejection of sexual and gender minority children and adolescents. The descriptions of interventions below provide general guidance to behavioral health providers working in this area.

Client-Centered Individual Approaches

Behavioral health providers should provide children, adolescents and their families with developmentally-appropriate multiculturally-competent and client-centered interventions that emphasize acceptance, support, assessment, and understanding. A clear treatment goal is to identify sources of distress and work to reduce any distress experienced by children, adolescents and their families.

Appropriate approaches support children and adolescents in identity exploration and development without seeking predetermined outcomes related to sexual orientation, sexual identity, gender identity, or gender expression. Such approaches include an awareness of the interrelatedness of multiple identities in individual development as well an understanding of cultural, ethnic, and religious variation in families. Specific approaches can include (a) providing a developmentally-informed cognitive, emotional, mental health

and social assessment of the child and family; (b) supporting children and adolescents in their developmental processes and age-appropriate milestones and facilitating adaptive coping; (c) providing developmentally-appropriate affirmative information and education on sexual orientation, gender identity, gender expression, sexuality, and the identities and lives of *lesbian, gay, bisexual, transgender* people and those who are *questioning* their sexual orientation or gender identity (LGBTQ) to children and adolescents, parents or guardians and community organizations; and, (d) reducing internalized negative attitudes toward same-gender attractions, gender diversity, and LGBTQ identities in children and youth and in parents or guardians and community institutions (e.g., schools and community social groups).

Behavioral health providers should provide developmentally-sensitive interventions to children and adolescents. Such interventions include a comprehensive evaluation taking into account appropriate developmental emotional and cognitive capacities, developmental milestones, and emerging or existing behavioral health concerns. Specific evaluation procedures for children and adolescents with persistent gender concerns have been described by Leibowitz and Telingator (2012).

Behavioral health providers should not have an *a priori* goal for sexual orientation or gender expression, or identity outcomes. The goal of treatment should be the best level of psychological functioning not a specific orientation or identity. Rather, behavioral health providers should focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support.

Behavioral health providers should strive to incorporate multicultural awareness into their treatment, considering age, ethnicity and race, gender and gender identity, sexual orientation and attraction, ability and disability issues, religion and spirituality, generation, geographic issues and other notable factors. A key aim is to dispel negative stereotypes and to provide accurate information in developmentally-appropriate terms for children and

adolescents. Identity development is multifaceted and may include multiple and intersecting identities, such as ethnic and racial and religious and spiritual identities. Sexual orientation, gender identity and expression are fluid concepts and in flux, requiring the consideration of generational changes and norms. Supporting youth in age-appropriate tasks such as developing positive peer relationships, positive parent and family relations, dating, exploring gender expression, sexuality, multiple identity development and disclosure as appropriate is a critical consideration. Behavioral health providers should take into consideration potential sources of social support and community resources. Client-centered and exploratory approaches specific to gender minority youth have been discussed in numerous publications (Edwards-Leeper, et al., in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, et al., 2005; Yarhouse, 2015c).

Behavioral health providers should describe their treatment plan and interventions to children, adolescents and their families and to ensure the goals of treatment as well as potential benefits and risks are understood. Where appropriate developmentally, behavioral health providers should obtain informed consent with all parties to treatment. If informed consent is not a developmentally appropriate option (as the child cannot cognitively or legally provide consent), behavioral health providers should explain treatment in a developmentally appropriate manner and receive assent for treatment. Interventions that are involuntary, especially those in inpatient or residential settings, are potentially harmful and inappropriate. In addition, interventions that attempt to change sexual orientation, gender identity, gender expression, or any other form of conversion therapy are also inappropriate and may cause harm. Informed consent cannot be provided for an intervention that does not have a benefit to the client.

Family Approaches

Parental attitudes and behaviors play a significant role in children's and adolescents' adjustment and parents' distress often is the cause of a referral for treatment (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Ryan et al., 2009, 2010). Family rejection, hostility, and violence are key predictors of negative health outcomes in LGBTQ children and adolescents (Ryan, et al., 2009; Ryan & Rees, 2012). Reducing parental rejection, hostility, and violence (verbal or physical) contributes to the mental health and safety of the child and adolescent (Ryan, et al., 2009; R. Savin-Williams, 1994; Wilbur, Ryan, & Marksamer, 2006).

Family therapy that provides anticipatory guidance to parents and guardians to increase their support and reduce rejection of children and adolescents is essential. Interventions that increase family and community support and understanding while decreasing LGBTQ-directed rejection are recommended for families. School and community interventions are also recommended to reduce societal-level negative attitudes, behaviors and policies, as well as provide accurate information and social support to children, adolescents, and families.

A key focus of treatment should be addressing parental concerns regarding current or future sexual orientation and gender identity. Behavioral health providers should provide family members with accurate developmentally-appropriate information regarding minority sexual orientations and strive to dispel myths regarding the lives, health, and psychological well-being of sexual and gender minority individuals.

Ryan, et al. (2010) recommended that behavioral health providers assess family reactions to LGBTQ children and adolescents, specifically the presence of family rejection. Further, behavioral health providers should attempt to modify highly rejecting behaviors, providing anticipatory guidance to families that include recommendations for support on the part of the family, and explaining the link

between family rejection and negative health problems in children and adolescents. Behavioral health providers should seek ways to ameliorate parents' distress about their children's sexual orientation and/or gender, such as exploring parental attributions and values regarding minority sexual orientations and gender diversity. Family therapy may be helpful in facilitating dialogues, increasing acceptance and support, reducing rejection, and improving management of conflicts or misinformation that may exacerbate a child or adolescent's distress (Mattison & McWhirter, 1995; Ryan, et al., 2009; Salzburg, 2004, 2007). Such therapy can include family psychoeducation to provide accurate information and teach coping skills and problem-solving strategies for dealing more effectively with the challenges sexual and gender minority youth may face and the concerns the families and caretakers may have (Ben-Ari, 1995; Perrin, 2002; Ryan & Diaz, 2005; Ryan & Futterman, 1998; Ryan, et al., 2009; Salzburg, 2004, 2007; Yarhouse, 1998).

When working with families of young children, behavioral health providers should counsel parents who are concerned that their children may grow up to be lesbian, gay, bisexual, or transgender to tolerate the ambiguity inherent in the limited scientific knowledge of development. A two-prong approach may be helpful: (a) provide information to reduce heterosexism and cisgenderism (that is, attitudes and actions that a heterosexual orientation and gender identity and expression that conform to stereotypical norms are preferable to a same-gender sexual orientation, transgender identity, or diverse gender expression) within the family and increase the family's capacity to provide support; and (b) introduce information about sexual and gender minority issues into family discussions to increase the child's own self-awareness and self-acceptance and to counter negative attitudes directed toward the self that might reduce self-esteem. For example, consider ways in which respect and value of all persons is frequently a shared goal. Even in cases in which family members may disagree about decisions each person may make, there may be opportunity to agree on broader principles and

concepts that can lead to mutual understanding (Yarhouse, 2015b).

Families with strong beliefs who see same-gender attractions or relationships and gender diversity as undesirable and contrary to those beliefs may struggle with a child's emerging minority sexual orientation or gender. Ryan and Rees (2012) and Yarhouse (1998; Yarhouse & Tan, 2005; Maslowe & Yarhouse, 2015) have suggested that family therapy focus encouraging love of their child. This involves focusing on superordinate values such as unconditional love and changing behaviors to reduce rejection. The authors stress that these positive steps can lay a constructive foundation for communication and problem solving and reduce family discord and rejection (Yarhouse & Tan, 2005). Ryan, et al. (2009) and Ryan and Rees (2012) focus on reframing family concerns as a manifestation of care and love and focus on teaching non-rejecting ways to communicate those positive emotions. For example, providers can help the family create an atmosphere of mutual respect that ensures the safety of each person from being hurt or bullied as a natural extension of seeing each person as having intrinsic worth (Yarhouse, 2015b). One of the most important messages that can be communicated to a young person is that their safety is important to the provider and to the family. It is helpful to set an atmosphere of mutual respect for one another in the home and then to see the value of extending that to other settings, such as neighborhood, school, and places of worship. Safety in this context is not just physical safety, but also emotional safety (Yarhouse, 2015b).

Many families may feel they have to choose between competence (in a provider) and deeply held beliefs. It is ideal when a family can work with competent providers who also share their deeply held beliefs and who are affirming of sexual orientation and gender diversity. However, when such providers are not available, it is important for families to work with competent providers who will be sensitive to the family's deeply held beliefs and values while offering competent, appropriate services for sexual and gender minority minors (Yarhouse, 2015b). Thus, behavioral

health providers may wish to increase their own competence in working with certain communities with deeply held beliefs and focus on viewing these beliefs through the imperative of multicultural competence and mutual respect (Bartoli & Gillem, 2008). This includes understanding how to translate between psychology and deeply held beliefs rather than judging those beliefs. Certain language, such as acceptance, might not resonate with communities that have strongly held beliefs, whereas the concept of unconditional love might (Yarhouse, 2015a).

Providing multiculturally-sensitive anticipatory guidance to all parents to address their unique personal concerns can be helpful (Ryan & Futterman, 1998). Behavioral health providers can help the parents plan in an affirmative way for the unique life challenges that they may face as parents of a sexual or gender minority child. Also, parents must deal with their own process of "coming out" and resolve fears of discrimination or negative social reactions if they risk disclosure within their communities, at work, and to other family members (Ryan & Rees, 2012). Further, behavioral health providers can address other stresses, such as managing life celebrations and transitions and coping feelings of loss, and aid parents in advocating for their children in school situations—for example, when they face bullying or harassment. Multiple family groups led by behavioral health providers might be helpful to counter the isolation that many parents experience (Menveille & Tuerk, 2002).

School and Community Interventions

Research has illustrated the potential that school-based and community interventions have for increasing safety and tolerance of sexual and gender minorities, preventing distress and negative mental health consequences, and increasing the psychological well-being and health of sexual minority children and adolescents (American Psychological Association, 2015c; D'Augelli & Patterson, 2001; Goodenow, et al., 2006; Harper, Jamil, & Wilson, 2007; Kosciw & Diaz, 2006; Safren & Heimberg, 1999). For instance, sexual

and gender minority adolescents in schools with support groups for LGBTQ students reported lower rates of suicide attempts and victimization than those without such groups (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011).

These support groups provided accurate affirmative information and social support, and the groups' presence was also related to increased school tolerance and safety for LGB adolescents (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011). School policies that increased staff support and positive school climate have been found to moderate suicidality and to positively affect sexual minority children's and adolescents' school achievement and mental health (Goodenow, et al., 2006).

Additional Appropriate Approaches with Gender Minority Youth

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth.

Social Transition

Social transition refers to adopting a gender expression, name, and pronouns consistent with one's gender identity. Over the past ten years, the age at which individuals socially transition has decreased dramatically, and it has become increasingly common for children to present to specialty gender clinics having already socially transitioned (Cohen-Kettenis & Klink, 2015; Steensma & Cohen-Kettenis, 2011). There is less controversy around social transition with adolescents, for whom gender identity is typically more stable and desistence of gender dysphoria (without social transition or medical intervention) is less common. Gender specialists recommended that

adolescents socially transition at or before the time they begin medically transitioning with hormone therapy, though many adolescents will socially transition earlier (Cohen-Kettenis & Klink, 2015).

There is no research evidence on the benefits vs. risks of social transition among pre-pubertal children, and the impact of social transition on likelihood of persistence or desistence of gender dysphoria has not yet been studied (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). A divergence of expert opinion exists among specialists treating gender minority children (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). Given the lack of data on the risks and benefits of social transition in childhood, the American Academy of Child and Adolescent Psychiatry suggests that concerns related to social transition in school environments should be weighed against the risks of not doing so, including distress, social isolation, depression, or suicide due to lack of social support (Adelson & AACAP CQI, 2012). Edwards-Leeper and Spack (2012) outline several factors that need to be considered in determining when and if a child should socially transition, including the child's needs, the potential impact on the child's siblings, whether it is safe for the child to socially transition in his or her community, and emphasizing to the child and family the possibility that the child's gender identity and gender expression may change as development continues.

Medical Intervention

The appropriateness of medical interventions vary by the age of the child. No medical interventions are currently undertaken or recommended for children with gender dysphoria before the initial onset of puberty. Medical intervention has proven efficacious in improving the well-being of young adolescents with gender dysphoria both during and well after treatment (Cohen-Kettenis & van Goozen, 1997; de Vries, et al., 2011; Smith, et al., 2001), and most adolescents who seek medical intervention usually have extreme forms of gender dysphoria beginning in childhood (Cohen-Kettenis & Klink, 2015). Pubertal suppression and hormone

therapy are medical interventions used to treat gender dysphoria in adolescents.

Medical intervention with gender dysphoric adolescents is a multi-disciplinary endeavor including Behavioral health providers, pediatricians, and often pediatric endocrinologists (Hembree et al., 2009; Leibowitz & Telingator, 2012). A comprehensive assessment, including assessment of the degree of an individual adolescent's gender dysphoria and desire to seek gender reassignment, helps determine the risks and benefits of medical interventions (for featured examples of assessments with children and adolescents, see Leibowitz and Telingator (2012)). Importantly, not all individuals who experience gender incongruence or gender dysphoria necessarily experience a complete cross-gender identity, want hormone therapy as well as gender affirming surgeries, or want to live as the other gender permanently or completely (Coleman et al., 2012).

If a diagnosis of gender dysphoria is assigned and the adolescent desires and is eligible for treatment, readiness for medical treatment must be considered (Cohen-Kettenis & Klink, 2015). Adolescents and their parents or guardians must be informed about possibilities and limitations of pubertal suppression, hormone therapy, and other types of treatment, such as psychological interventions, in order to give full informed consent (Coleman et al., 2012; Vance et al., 2014). Taking into account developmental considerations when working with adolescents is key. Youth should realize that medical intervention or a complement of hormone therapy and gender affirming surgeries are not the only treatment option to solve gender dysphoria, and should realize that gender dysphoria may exist in many forms and intensities (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008). Continued mental health treatment should be offered when an adolescents' gender incongruence requires further exploration and/or when other psychological, psychiatric, or family problems exist. Adolescents receiving medical intervention without these additional concerns may also benefit from continued psychological treatment (Vance et al., 2014); given that pubertal suppression or administration of

hormone therapy occurs over many years during important developmental periods, the need for psychological treatment may change with time as new questions arise (Cohen-Kettenis & Klink, 2015).

Pubertal suppression using gonadotrophin-releasing hormone (GnRH) analogues prevents the development of unwanted secondary sex characteristics in a peri-pubertal adolescent, which are irreversible and highly distressing for some adolescents with gender dysphoria (Leibowitz & Telingator, 2012). Pubertal suppression is fully reversible and serves as an extended diagnostic period, providing additional time for gender exploration as well as cognitive and emotional development that allows adolescents to become psychologically and neurologically mature enough to make decisions regarding their gender and to provide informed consent years later for the partially irreversible treatment interventions (e.g., hormone therapy) without having to experience distressful, irreversible changes of puberty (Hembree et al., 2009; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). Pubertal suppression also has therapeutic effects, often resulting in a large reduction in the distress the physical changes of puberty were producing (de Vries et al., 2011; Edwards-Leeper & Spack, 2012).

Pubertal suppression for young adolescents remains controversial, with concern over whether adolescents are able to make far-reaching decisions and understand the impact of pubertal suppression on their lives and over the lack of robust research on the long-term effects of pubertal suppression on brain and bone development in these populations (Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012). However, results of preliminary research on the long-term effects of pubertal suppression are promising (Delemarre-van de Waal & Cohen-Kettenis, 2006; Cohen-Kettenis, Schagen, et al., 2011; Staphorsius et al., 2015). Abstaining from treatment in adolescence comes with risks as well: adolescents can experience refusal for treatment and the progression of secondary sex characteristic development as extremely psychologically painful, and a refusal

of medical intervention can lead to worse psychological adjustment and risky behaviors (e.g., self-mutilation, self-medication, or suicide; Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012; Vance et al., 2014). Given the current evidence that diagnosis can be made reliably in adolescence, that gender dysphoria that worsens with puberty rarely subsides afterwards, and that – with careful diagnostic procedures – early pubertal suppression leads to good outcomes with young adults, withholding GnRHa is not considered a neutral option (Cohen-Kettenis & Klink, 2015). According to the Endocrine Society Guidelines, pubertal suppression with GnRH analogues is considered a medical standard of care for adolescents in Tanner stage 2 or 3 of puberty, once appropriate mental health assessments and recommendations are in place (Hembree et al., 2009). However, the importance of full informed consent for both adolescents and their parents or guardians is important and must include awareness and consideration of the risks and benefits involved, as well as an emphasis on continued exploration of gender identity.

The initiation of hormone therapy (estrogen and testosterone blocking medication for those assigned male at birth and testosterone for those assigned female at birth) around age 16 promotes the development of secondary sexual characteristics consistent with one's gender identity (Coleman et al., 2012; Hembree et al., 2009). While a minimum age of 16 was previously a requirement, the optimal time for initiation of hormone therapy is now determined by duration of GnRH analogue use (when used) and the adolescent's psychological state (Cohen-Kettenis & Klink, 2015). Unlike GnRH analogues, which are completely reversible, hormone therapy is only partially reversible. Again, once hormone therapy is indicated and an adolescent has been carefully assessed for readiness, care must be taken to get the informed consent of the adolescent and his or her parents or guardians before hormone therapy is initiated, including a full understanding of the potential risks and benefits of hormone therapy and the impact of hormone therapy on future fertility and options

related to fertility (Cohen-Kettenis & Klink, 2015; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). The support of a behavioral health professional during this process can aid an adolescent in adjusting to their changing physical characteristics and the response from people in different aspects of the adolescent's life.

In addition to hormone therapy, some transgender adolescents desire and will eventually pursue gender affirming surgeries. The age of legal consent for surgery is 18, so most surgeries are not performed on adolescents, though behavioral health providers and medical providers working with adolescents may need to obtain and provide knowledge of the surgical processes in order to assist in navigating the emotional issues leading up to gender affirming surgeries; additionally, those assigned female sex at birth may be considered for virilizing mammoplasty beginning at age 16 (Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012).

Future Directions for Research

Areas of opportunity for future research, as well as the validity and quality of extant research are discussed in several sections of this report and were topics of conversation during the APA Consensus Panel Meeting in July, 2015. Methodologically rigorous, longitudinal, and peer reviewed research is vital to improving our understanding of the complexities of sexual orientation and gender identity and expression among children and adolescents. Several potential areas for future research are identified below.

Development of sexual orientation and gender identity

Little is known about the development of sexual orientation and gender identity in childhood and adolescence. Basic research on the developmental pathways of these fundamental issues is necessary. How these identities are embedded in cognitive and emotional development and other developmental processes would aid in the understanding of human development as well as appropriate interventions.

Culturally-specific mitigation of distress relating to sexual orientation, gender identity, and gender expression

More targeted research that acknowledges the intersections of identity, including race, ethnicity, faith, and class, among others, could shed light on positive and appropriate whole-family therapeutic approaches to addressing these issues. Researchers should evaluate these practices and integrate them into behavioral health care. Researchers should also work collaboratively with young people and families from faith communities to better understand the interplay between deeply held religious beliefs and the importance of ensuring the safety and well-being of LGBTQ young people. The work of the Family Acceptance Project, cited throughout this report, speaks to the necessity of an increased focus on approaches specific to various communities including culturally diverse communities and those with deeply held morals and values that include conversations about sexual orientation, gender identity, and gender expression.

Addressing the needs of disconnected LGBTQ youth

LGBTQ youth experiencing homelessness, in juvenile justice facilities, or otherwise in out-of-home care may lack permanent and stable family connections in part because of family distress around issues relating to their LGBTQ identity. These vulnerable populations, as well as low-income and racial and ethnic minority LGBTQ youth, are often neglected in research studies that most often recruit youth who are already connected to clinics or providers. This need for

more representative sampling and better recruitment efforts should be addressed by future researchers interested in sexual orientation and gender identity among youth.

Long-term Outcomes

More research is necessary to explore the developmental trajectory of sexual orientation, gender identity, and gender expression, in addition to the long-term medical and behavioral health outcomes associated with early experiences of family and community distress due to sexual orientation and gender identity and expression. Other recommended areas of opportunity for long-term research topics include:

- A nuanced exploration of the factors that may differentiate children and adolescents who continue to experience gender dysphoria into adolescence and those who do not.
- Long-term outcomes from early social transition and pubertal suppression (including effects on brain development, sexual health function, fertility, etc.).
- Rigorous evaluation of current practices and protocols, including affirmative models, structural interventions, and culturally-specific models, among others.
- Prospective research focusing on younger children, in partnership with pediatric clinics.
- Sources of distress among sexual and gender minority youth, focusing on distinguishing between internal and external factors that may drive gender dysphoria.
- Methods of supporting positive behavioral health for LGBTQ youth, including building resiliency against suicidality, self-harm and risky behaviors, depression, anxiety, substance abuse, and other behavioral health issues.

Integration, Collaboration, and Dissemination

Researchers and clinicians should examine and evaluate the best methods of integrating and disseminating best and promising practices for addressing sexual orientation and gender identity and expression among children and youth, and

how to successfully collaborate with parents and guardians, caregivers and providers, and community leaders. This could include conducting studies with these populations focused on knowledge, attitudes, and beliefs relating to efforts to change sexual orientation, gender identity, or gender expression.

Finally, the behavioral health community can work to support community-based organizations to develop common ground and consensus on these topics and promote the health and well-being of youth. This could also include the development of treatment registries, support for sexual health research across the country, and the inclusion of LGBT-specific questions in national behavioral and mental health surveys.

Based on careful review of the research and the consensus of clinical experts in this field, conversion therapy is not an appropriate therapeutic intervention. Consequently, efforts should be taken to end the practice. The Administration has issued a public statement supporting efforts to ban the use of conversion therapy for minors, [stating in part](#):

“When assessing the validity of conversion therapy, or other practices that seek to change an individual’s gender identity or sexual orientation, it is as imperative to seek guidance from certified medical experts. The overwhelming scientific evidence demonstrates that conversion therapy, especially when it is practiced on young people, is neither medically nor ethically appropriate and can cause substantial harm.

As part of our dedication to protecting America’s youth, this Administration supports efforts to ban the use of conversion therapy for minors.” (Jarrett, 2015)

PAGE INTENTIONALLY LEFT BLANK

A close-up portrait of a young woman with long, dark hair and freckles, looking slightly to the right. She is wearing a white shirt and a necklace with a bird-shaped pendant. Her hand is visible near her hair on the left side of the frame. The background is a blurred field of tall grass under a blue sky.

“PFR “created something that was groundbreaking. It was the best piece of work ever created by the federal government.”

Sue Thau

Approaches to Ending the Use of Conversion Therapy

Several approaches have been employed as mechanisms for eliminating the use of harmful practices, and encouraging positive and appropriate alternatives to discussing issues related to sexual orientation, gender identity, and gender expression with children and adolescents. These efforts will be reviewed in depth in this section:

1. Reducing discrimination and negative social attitudes towards LGBT identities and individuals
 - Adoption of public policies that end discrimination
 - Increasing access to health care
 - Publication of affirmative, culturally competent resources for the public on LGBT individuals and families.
2. Dissemination of information, training and education for behavioral health providers
 - Dissemination of professional association and federal agency documents and resolutions related to ending conversion therapy
 - Guidelines by professional associations on affirmative approaches to LGBTQ children and youth as well as LGBT adults
 - Inclusion of affirmative information and treatment models in professional training curriculum
 - Continuing education on elements of ethical codes and licensing laws relevant to these issues.
3. Legislative, regulatory, and legal efforts
 - State and federal legislation that bans sexual orientation and gender identity change efforts
 - Federal and state regulatory actions and additional Administration activities
 - Legal action

Reducing discrimination and negative social attitudes towards LGBT identities and individuals

Reducing the discrimination and negative social attitudes that many LGBTQ children and adolescents experience can improve health outcomes. As previously discussed, negative social attitudes are stressors that can result in poor mental health. Working with individuals, families, communities, and diverse populations to increase family acceptance and change cultural norms that are unsupportive of sexual and gender minority identities is one way to improve health and well-being overall.

The Administration has taken significant steps to reduce discrimination and negative social attitudes towards and increase support for LGBT communities,¹⁹ including improving access to health care. Among other notable signals of social acceptance and support, the Administration has:

- Ended the “Don’t Ask, Don’t Tell” policy in military service for lesbian, gay, and bisexual people, and taken steps to remove barriers to service for transgender people;
- Supported same-sex marriage and ensured that same-sex couples and their families have full access to federal benefits;
- Prevented employment discrimination by federal contractors;
- Advanced policies that expand access to quality healthcare for millions of Americans, including LGBT Americans; and
- Supported public information campaigns, such as the “It Gets Better” Project, which aims to gives LGBTQ youth hope and build public support.

Broad dissemination of supportive actions such as those outlined above serves to both mitigate negative social attitudes, and to build more

accepting ones. SAMHSA, in addition to partner organizations and professional associations, has developed targeted resources geared towards providers working with sexual and gender minority youth and their families.²⁰

Dissemination of information, training and education for behavioral health providers

The major health associations have issued policy statements critical of conversion therapy including the [World Health Organization](#), the [American Medical Association](#), the [American Academy of Pediatrics](#), the [American Academy of Child and Adolescent Psychiatry](#), the [American Psychological Association](#), [American Counseling Association](#), [American Psychoanalytic Association](#), and the [National Association of Social Workers](#), among others. Other Association publications include professional guidelines on affirmative practices for this population (APA, 2011; APA 2015a).

In addition, some professional associations, including the American Academy of Child and Adolescent Psychiatrists, American Psychiatric Association, and the American Psychological Association, have published reports and professional practice guidelines on appropriate therapeutic efforts for this population. These documents provide important resources for providers on the types of interventions that are appropriate for sexual and gender minority children and youth as well as for LGBT adults.²¹

Professional mental health, medical, and social services organizations can require training that includes appropriate interventions for this population. For example, The American Association of Medical Colleges (AAMC) produced a report on *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD*. As part of this publication, the association indicates that “doctors should be able to demonstrate an investigatory and analytic approach to clinical situations by [...] identifying various harmful practices (e.g., historical practice of using

‘reparative’ therapy to attempt to change sexual orientation; withholding hormone therapy from transgender individuals) that perpetuate the health disparities for [LGBT] patients.”

Professional health and mental health associations also have ethical codes (American Psychiatric Association, 2013; American Psychological Association, 2010; National Association of Social Workers, 2008). These codes include provisions that stress aspirational principles and standards for practice that can be applied to sexual and gender minority youth and LGBT individuals broadly. Many of these codes are integrated into state licensing laws and thus govern standards of professional practice.

Experts have suggested that the use of conversion therapy to change the sexual orientation or gender identity of clients may be inconsistent with the aspirational principles of behavioral health professions. For example, conversion therapy might violate the principle of “*Do No Harm*” through techniques that are deleterious rather than beneficial to mental health. Additionally, conversion therapy may be inconsistent with professional standards that treatment be based on the best scientific knowledge and standards of professional competence, in its use of treatments that cannot be justified by established scientific and clinical knowledge in the field, and which imply that variations in sexual orientation and gender identity are not normative. Experts have also suggested that conversion therapy is inconsistent with principles of non-discrimination and justice that guarantee all clients, including sexual and gender minorities, equal access to the benefits of psychology and to equal quality of services. Finally, by denying the inherent worth of LGBT individuals and engaging in an intervention based on negative social or cultural attitudes, practitioners of conversion therapy could potentially violate principles that dictate respect for people’s dignity.

Legislative, regulatory, and legal efforts

Many individuals, organizations, and several state legislatures have taken steps to regulate and eliminate the practice of conversion therapy. Efforts to end the practice of conversion therapy have included legislative bans and causes of action alleging consumer fraud, among others. Future efforts may include federal regulatory action, advancement of legislation at the state and federal level, and additional activities by the Administration.

As of August 2015, four states and the District of Columbia have passed laws banning the practice of conversion therapy for minors, and 21 other states have introduced similar legislation. All of the bills bar mental health providers from practicing conversion therapy on minors; some also include protections for vulnerable adults, restrictions on the use of state funds, and consumer protection provisions.

There is currently no federal ban on conversion therapy. Several bills and resolutions have been introduced in 2015, including H.R. 2450: Therapeutic Fraud Prevention Act; S.Res. 184: Stop Harming Our Kids Resolution of 2015; HR 3060 Stop Child Abuse in Residential Programs for Teens Act of 2015; and H.Con.Res. 36: Expressing the sense of Congress that conversion therapy, including efforts by mental health practitioners to change an individual's sexual orientation, gender identity, or gender expression, is dangerous and harmful and should be prohibited from being practiced on minors. These efforts discourage or ban conversion therapy or require non-discrimination in the provision of services to sexual and gender minority minors.

Stakeholders have also suggested the following as potential federal actions to end conversion therapy:

- Restrictions on the use of federal or state funding for conversion therapy by federal programs, by recipients of such funding, or through health insurance reimbursements.

- Policies for institutions that house out-of-home youth (such as juvenile justice and foster care programs) that prohibit conversion therapy efforts on minors in care. These entities are often licensed by states or receive federal funding.
- Clarification of existing non-discrimination policies to extend to prohibitions on conversion therapy

In addition to legislative and regulatory action, legal action has been explored as a mechanism for ending the use of conversion therapy. Most notably, a jury found in favor of a claim brought under New Jersey's consumer fraud law, finding that a "conversion therapy" program that offered services purported to change people from gay to straight was fraudulent and unconscionable.²³

In addition, potential claims of discrimination have been raised under the theory that the provision of ineffective and potentially harmful therapy is due solely to an individual's sexual orientation or gender identity.

Notably, the American Bar Association also passed a resolution urging "all federal, state, local, territorial, and tribal governments to enact laws that prohibit state-licensed professionals from using conversion therapy on minors," as well as "to protect minors, particularly minors in their care, from being subjected to conversion therapy by state-licensed professionals."²⁴



Guidance for Families, Providers, and Educators

Being a sexual or gender minority, or identifying as LGBTQ, does not constitute a mental disorder. Sexual or gender minority status, however, is associated with increased risk of psychosocial issues such as psychological distress, mistreatment, and discrimination. Social support, as well as a lack of rejection, in family, community, school, and health care environments has been shown to have great positive impacts on both the short- and long-term health and well-being of LGBTQ youth (see *Research Overview Section 3.2*). Beyond eliminating the practice of conversion therapy with sexual and gender minority minors, LGBTQ youth need additional support to promote resilience and positive development in the spite of the still-pervasive interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities. The following portions of this report provide families and others working with LGBTQ children and adolescents with guidance and additional resources to help facilitate the best possible outcomes for these youth. The information in these sections is based on research findings as well as clinical expertise.

Promoting Family and Community Acceptance and Support

As children and adolescents increasingly experience and integrate LGBTQ and gender diverse identities during childhood and adolescence, it is critical to provide support to reduce risk and promote well-being across social institutions and systems. This includes families, peers, schools, religious institutions, health and social systems and community services.

Over the past decade, the concept of “connectedness” has been seen by researchers and clinicians as an essential aspect in helping to protect against risk and promote wellness for individuals in families and communities. For LGBTQ youth, family, peer and community support have been

shown to be important sources of support, and among these, family support and acceptance during adolescence were found to have the strongest influence on overall adjustment and well-being in young adulthood. Because most young people are nurtured through diverse family, caregiver and kinship systems, LGBTQ and gender diverse children and adolescents need support in the context of their families, cultures and faith communities. Access to accurate information about sexual orientation and gender identity development is critical for families and caregivers who often have limited and inaccurate information about these core aspects of human development. This is particularly important for families and caregivers who believe that LGBTQ identities and gender diversity may be at odds with or disavowed by their religious and cultural values and beliefs.

In 2014, SAMHSA worked with the Family Acceptance Project to publish a resource guide to help practitioners to provide support for families with LGBTQ children. The Family Acceptance Project has developed a family support model and research-based resources to help diverse families, including conservative families, to support their LGBTQ children in the context of their values and beliefs.

Key Points:

- Family reactions to learning that a child is lesbian, gay, bisexual or transgender range from highly rejecting to highly accepting. The largest proportion of families are ambivalent about having an LGBTQ or gender diverse child, and rejecting families become less rejecting over time. Families can learn to support their LGBTQ children – and do so more quickly – when guidance and services are provided in ways that resonate for them, including education presented in the context of cultural and deeply held values.

- All families and caregivers need to receive accurate information about sexual orientation and gender identity and expression in children and adolescents, and they need to understand that how they respond to their LGBTQ children matters. For example, family rejecting behaviors during adolescence – including attempts to change an adolescent’s sexual orientation – have been linked with health risks, including suicidal behavior and risk for HIV, during young adulthood. In addition, family supportive and accepting behaviors during adolescence, which include supporting a child’s gender expression, have been found to help protect against health risks and to help promote well-being for LGBTQ young adults. As family rejecting and supportive behaviors increase, so, too, does the level of health risks and protective role of family acceptance in promoting an LGBTQ child’s overall health and well-being.
- Parents and families with LGBTQ and gender diverse children need to be heard and understood by providers, educators and others who provide services and support for their children and family. This means meeting parents and families where they are, supporting their need to express their feelings, perceptions, hopes and concerns for their LGBTQ child in the context of their cultural and religious perspectives, and being sensitive to how deeply held values shape reactions and responses to having an LGBTQ or gender diverse child.
- Parents and caregivers who are perceived as rejecting their LGBTQ children and who engage in rejecting behaviors (such as trying to change their child’s sexual orientation or gender expression, using deeply held values and morals to prevent or change an adolescent’s identity or preventing them from participating in LGBTQ support groups) are typically motivated by trying to help their LGBTQ child “fit in,” have a good life and be accepted by others. The Family Acceptance Project’s research-informed approach to providing services and care for LGBTQ children and adolescents uses a strengths-based framework that views families and caregivers as potential allies in reducing risk, promoting well-being, and creating healthy futures for their LGBTQ children. The family’s cultural values, including deeply-held morals and values, are viewed as strengths. Research findings related to family accepting and rejecting behaviors are aligned with underlying deeply held morals and cultural values (such as supporting an individual’s dignity and self-worth) to help families understand that it is specific family reactions and communication patterns that contribute to both their LGBTQ child’s risk and their well-being.
- Families that are struggling with having an LGBTQ or gender diverse child don’t have to choose between their LGBTQ child and their culture or their morals and values. Many parents who are struggling believe that responding with positive reactions such as expressing affection once they learn that a child is LGBTQ will condone or encourage a behavior or identity that is at odds with their beliefs. However, expressing affection for an LGBTQ child is a key supportive behavior that helps protect their child against health risks and increases connectedness. In addition, parents that are struggling can respond with other supportive behaviors that help increase parent-child connectedness and have been identified in research to help protect against risk and help promote an LGBTQ child’s well-being - without “accepting” an identity they believe is wrong. This includes behaviors such as talking with their child and listening respectfully to understand their child’s experiences; requiring that other family members treat their child with respect even if they disagree; ensuring their child’s safety by standing up for their child when others hurt, mistreat or discriminate against their LGBTQ or gender diverse child because of who they are. These behaviors also reflect the key values of dignity, mercy, and compassion.

Resources

Family Acceptance Project: <http://familyproject.sfsu.edu/>

Gender Spectrum: www.genderspectrum.org

Institute for the Study of Sexual Identity: www.sexualidentityinstitute.org

PFLAG: www.pflag.org

References

- Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press
- Centers for Disease Control and Prevention. (2009). *Strategic direction for the prevention of suicidal behavior: Promoting individual, family, and community connectedness to prevent suicidal behavior*. Atlanta, GA: Retrieved from www.cdc.gov/ViolencePrevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf.
- Malpas, J. (2011). Between pink and blue: A multi-dimensional family approach to gender nonconforming children and their families. *Family Process*, 50(4), 453–470.
- Ryan, C. (2009). Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children. San Francisco, CA: Family Acceptance Project, Marian Wright Edelman Institute, San Francisco State University.
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346-352. doi: 10.1542/peds.2007-3524
- Ryan, C., Russell, S., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), 205-213. doi: 10.1111/j.1744-6171.2010.00246.x
- Seil, K. S., Desai, M. M., & Smith, M. V. (2014).

Sexual orientation, adult connectedness, substance use, and mental health outcomes among adolescents: Findings from the 2009 New York City Youth Risk Behavior Survey. *American Journal of Public Health*, 104(10), 1950-1956.

Substance Abuse and Mental Health Services Administration. (2014). *A practitioner's resource guide: Helping families to support their LGBT children*. (HHS Publication No. PEP14-LGBTKIDS). Rockville, MD: Substance Abuse and Mental Health Services Administration Retrieved from <http://store.samhsa.gov/product/PEP14-LGBTKIDS>.

Bullying, Harassment, and Other School-Based Issues

Children and adolescents spend the vast majority of their time in schools and other institutional settings. Research has shown that students with positive school experiences achieve healthier outcomes across a range of variables. Conversely, negative experiences in school can have a detrimental impact on educational attainment, in addition to numerous health-related outcomes. LGBTQ young people in schools experience disproportionately high levels of bullying, harassment, and discrimination. This puts them at higher risk of depression, anxiety, suicidal ideation and attempt, substance use, and other mental health problems, in addition to negative educational outcomes. Families, guardians, and school-based professionals can and should take steps to mitigate issues that arise because students are, or are perceived to be, LGBTQ. Safe and supportive school environments are an important factor in ensuring the health and well-being of all students, including LGBTQ students.

Key points:

- Much of the distress that LGBTQ children and adolescents experience is not the result of their gender non-conformity or LGBTQ identity – in other words, it is not *being* LGBTQ that causes the distress, but rather the way they are *treated* for being LGBTQ that does. This can include being bullied, harassed, or otherwise

mistreated, in addition to experiences with structural barriers such as the lack of access to an appropriate restroom for a transgender student. School-based professionals can help minimize mental health issues for LGBTQ students by taking steps to eliminate structural barriers and proactively working to create a positive school climate, which can include measures such as LGBTQ-inclusive curriculum and intervening to stop bullying and harassment.

- School-based mental health professionals may often be one of the few trusted adults with whom young people can be open about who they are and what barriers they are facing as a result. Some LGBTQ young people may not be in a position to discuss their sexual orientation or gender identity with their families, whether because their family has already made it clear that such conversations are not welcome, or because of fears of family rejection if they come out. In addition to providing a safe and welcoming atmosphere, school-based mental health professionals can equip themselves with LGBTQ-related resources, know the warning signs for identity-based mistreatment, and be prepared to serve as one of the primary adults with whom LGBTQ youth can discuss these issues.
- It is important to understand that confidentiality is essential; students should not be outed to their parents or to their peers, and professionals should not assume that the name, pronouns, or manner of dress that a student uses in school is the same at home; often times, school may be the only place where a young person feels comfortable being out or expressing their gender in a certain way. Students should be asked how they would like to be addressed and in which context. Safety and support should be of paramount concern.
- Students should never be asked to change gender non-conforming behavior as a means of resolving issues arising in school. Beyond the potential for increasing psychological distress, such requests occur within the

context of a system that already frequently penalizes LGBTQ youth. This population is disproportionately disciplined in schools, and is over-represented in the juvenile justice system. While five to seven percent of youth are estimated to be LGBTQ, they represent 15 percent of the juvenile justice population, and up to 40 percent of homeless youth. Helping to ensure that LGBTQ youth can be who they are *and* stay in school is a life-changing and potentially life-saving intervention.

- One of the most important steps that families and schools can take is to ensure that schools have inclusive and supportive policies for LGBTQ youth that are implemented effectively. Numerous resources have been developed (several are listed below) that walk through all of the ways in which a school can make system-wide changes that benefit all students, including LGBTQ students. Beyond simply being in the best interest of LGBTQ students and their behavioral health, Title IX of the Education Amendments of 1972 protects transgender and gender nonconforming students from discrimination. Proactive adoption of inclusive policies can prevent costly and time-consuming efforts to remedy issues after damage has already occurred.

Resources:

Centers for Disease Control, Division of Adolescent and School Health (DASH): www.cdc.gov/HealthyYouth/

GLSEN: www.glsen.org

Human Rights Campaign, Welcoming Schools Initiative: www.welcomingschools.org

National Center for Lesbian Rights, Youth Project: www.nclrights.org/our-work/youth

National Association for School Psychologists, Committee on GLBTQ Issues: www.nasponline.org/advocacy/glb.apsx

PFLAG : www.pflag.org

Safe & Supportive Schools Project: <http://www.apa.org/pi/lgbt/programs/safe-supportive/default.aspx>

References

American Psychological Association & National Association of School Psychologists. (2014). Resolution on gender and sexual orientation diversity in children and adolescents in schools. Retrieved from http://www.nasponline.org/about_nasp/resolution/gender_sexual_orientation_diversity.pdf

Fisher, E., & Komosa-Hawkins, K. (Eds.). (2013). *Creating safe and supportive learning environments a guide for working with lesbian, gay, bisexual, transgender, and questioning youth, and families* (1 ed.). London: Routledge.

National Association of School Psychologists. (2014). NASP Position statement: Safe schools for transgender and gender diverse students, from http://www.nasponline.org/about_nasp/positionpapers/Transgender_PositionStatement.pdf

Orr, A., Baum, J., Gill, E., Kahn, E., & Salem, A. (2015, August). Schools in transition: A guide for supporting transgender students in K-12 schools, from <http://www.nclrights.org/wp-content/uploads/2015/08/Schools-in-Transition-2015.pdf>

Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology*, 46(6), 1580-1589. doi: 10.1037/a0020705

U.S. Department of Education. (2014). Questions and answers on Title IX and sexual violence, from <http://www2.ed.gov/about/offices/list/ocr/docs/qa-201404-title-ix.pdf>

U.S. Department of Justice. (2013). Resolution Agreement: Between the Arcadia Unified School District, the U.S. Department of Education, Office for Civil Rights, and the U.S.

“ When I came out to my parents, they found me a conversion therapist who told me transgender people were sick and belonged in mental hospitals. He forced me to throw away all my girl’s clothes as part of my treatment, but, having to dress as a male sent me into complete despair, hopelessness, and depression. Thankfully, one of my friends recognized the warning signs and called social services, which intervened and got me the housing and medical care I needed. It is always darkest before the dawn, but I’m living proof that a smart bystander can save a life. ”

—Amy

Department of Justice, Civil Rights Division, from <http://www.justice.gov/sites/default/files/crt/legacy/2013/07/26/arcadiaagree.pdf>

Pediatric Care Considerations for LGBTQ Children and Adolescents

Pediatricians are often the first health professional that families turn to when they need help addressing issues that have arisen because their child is, or is perceived to be, LGBTQ. Families often develop a longstanding, trusting relationship with their family pediatrician and may feel more comfortable discussing issues with them before reaching out to a behavioral health professional. They may rely also on them for referrals to other appropriate professionals. Consequently, it is important for pediatricians to understand appropriate therapeutic approaches when working with LGBTQ children and their families.

In 2014, the Association of American Medical Colleges (AAMC) published a set of thirty gender, sex anatomy, and sexuality competencies that physicians should be able to demonstrate in their practices (Association of American Medical Colleges, 2014). Additionally, the American Academy of Child and Adolescent Psychiatry published a set of practice parameters pertaining to the care of LGBTQ youth that speaks to the importance of addressing family dynamics when working with families with LGBTQ youth (Adelson & AACAP CQI, 2012). Specifically for eligible transgender adolescents who meet criteria for gender dysphoria (GD), the World Professional Association of Transgender Health Standards of Care, 7th Edition, recommends that family involvement in the consent process is crucial for physical interventions that are prescribed by health professionals who are not behavioral health professionals. The following key principles can be drawn from these resources as they apply to pediatricians and family practice physicians when youth who are, or are perceived to be, LGBTQ present in clinical practice.

Key points:

- *Families need accurate information about LGBTQ identities as being normal variants of the human experience.* Specifically, this is important in helping pediatricians respond

to family and parent questions about the healthiness or normality of their child's or adolescent's behavior or identity is inherently pathological and whether these behaviors or identities can or should be changed. This can be particularly important for transgender and gender nonconforming youth, who may be seeking medical interventions to help mitigate the effects of untreated gender dysphoria, as some parents might hold the belief that their youth's gender identity is inherently pathological. In fact, it is the associated gender identity-sex anatomy discrepancy that characterizes gender dysphoria, and which is the treatable phenomena, not the gender identity itself. This information is readily available (several resources are listed below), and sharing it may be the most important way a pediatrician can support the healthy development of sexual and gender minority youth.

- *Practices should provide office climates that allow all youth to feel comfortable disclosing their gender identity or sexual orientation, whether it differs from societal expectations and cultural norms or not.* Steps to do so can include a number of things, ranging from changing intake forms to include both gender identity and sex assigned at birth, routinely asking about pronoun preferences when with youth alone, training frontline staff to use youths' preferred name and pronoun (and when it is safe and appropriate to do so), to forming partnerships with local LGBTQ organizations and building relationships with LGBTQ community providers to whom they can refer youth and families to when appropriate.
- *Family dynamics are particularly important to address as they pertain to attitudes and beliefs about gender identity and sexual orientation.* Research has shown that LGBTQ youth who come from highly rejecting families are nearly nine times more likely to engage in suicidal behavior when compared to their LGBTQ youth counterparts who come from accepting families (Ryan, et al., 2009). Pediatricians should be aware of the various types of

reactions from family members towards their child or adolescent which can range from subtle forms of rejection (e.g., calling their child's identity a "phase") to more overt forms of rejection (e.g., kicking their youth out of the home or physical abuse). Pediatricians should encourage whole-family resolutions of issues with which they are confronted, including referral to mental health professionals who can work with young people as well as for individual family members who may be struggling with the idea that their child or adolescent is or may be LGBTQ. Partnering with parents or family members who are struggling with their youths' gender identity or sexual orientation may sometimes be necessary in order to gain family members' trust, increasing adherence and reducing resistance to the pediatrician's future recommendations.

- *Pediatricians should be careful not to reinforce gender stereotypes when working with LGBTQ and gender nonconforming youth and their families.* This can require recognizing your own implicit biases and working to change ingrained patterns, such as giving certain stereotypically masculine toys to boys and others to girls, or asking adolescents specifically whether they have a boyfriend or a girlfriend instead of determining the information in a manner that does not presuppose the gender of their romantic or sexual interest or attraction.
- *Pediatricians should be aware of the situations when it is necessary to enlist an interdisciplinary team of providers to address the health of some LGBTQ youth.* While some issues may be resolved through the simple provision of information, it may be necessary to establish an interdisciplinary team that includes qualified behavioral health professionals and ongoing collaboration. For all LGBTQ youth, recognizing and detecting signs of emotional distress and psychiatric co-occurring diagnoses (such as depression, anxiety, substance abuse), requires astute screening (particularly in the case of suicide), detection of psychiatric conditions, and prompt referral to a behavioral

health provider. As is addressed in depth in the *Affirmative Care* section, for adolescents with gender dysphoria, it is important to coordinate the care with a qualified behavioral health provider and endocrinologist in determining eligibility and readiness for physical interventions such as pubertal suppression or cross-gender hormone therapy. In some situations, coordination of care with the behavioral health provider and surgeon may be necessary as well when considering surgical interventions for eligible adolescents with gender dysphoria as described in the WPATH standards of care (Coleman et al., 2012).

Resources:

- American Academy of Pediatrics. (2013). Policy Statement: Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*, 132(1), 198 -203 doi: 10.1542/peds.2013-1282
- Makadon, H., Mayer K., Potter J., & Goldhammer, H. (Eds.). (2015). *The Fenway Guide to lesbian, bisexual, and transgender health* (2 ed.). Philadelphia, PA: American College of Physicians.

References:

- Adelson, S. L., & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 51(9), 957-974. doi: 10.1016/j.jaac.2012.07.004
- Association of American Medical Colleges. (2014). Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD., from <https://www.aamc.org/download/414172/data/lgbt.pdf>

“ Having my family reject me because I’m trans broke my heart into more pieces than I could have imagined. Even more painful was the feeling they no longer loved or valued me. Having my Grandmother take me in restored my belief in love. To have her arms to fall into meant that I no longer was alone, that death did not seem like the only road to stability, comfort, and joy. That perhaps I should build a future because I again had someone to help me do so and enjoy it with me. ”

—Malachi

- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7 ed., Vol. 13, pp. 165-232): *International Journal of Transgenderism*.
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346-352. doi: 10.1542/peds.2007-3524

Affirmative Care for Gender Minority Youth

Increasingly, families, providers, and researchers alike are realizing that providing supportive, affirmative care to transgender children and adolescents results in better outcomes for youth. This positive development has resulted in a significant increase in the number of families and providers seeking accurate information about appropriate treatment protocols for working with gender minority (transgender and gender diverse) youth, including information about socially transitioning youth, and about medical interventions for adolescents.

It is important to ensure that supportive behavioral health and medical care take an affirmative approach which aims to facilitate in children and adolescents the time and space they need to develop and transition in whatever way that might make sense for them, whenever they are ready.

In this approach, children and adolescents are encouraged to actively explore their gender identity and gender expression at home, with peers, and within the context of supportive therapy. This approach encourages children, adolescents, and families to move away from the gender binary and accept the child’s developing gender identity and sexual orientation at whatever point they are in their own trajectory. With young children, this may include exploring all options related to social transitioning. For example, perhaps the child is assigned male at birth and prefers feminine clothing and toys but is not pushing for a female name and pronouns. Rather than assume the child should undergo a full social transition, an affirmative approach would allow the child to continue sorting out their gender identity over time. For an adolescent uninterested in medical interventions, an affirmative approach might include encouraging them to consider non-body altering ways of living in their affirmed gender and helping them explore the variety of ways to live in their individualized gender identity.

Here are a few key points to keep in mind when considering a supportive and balanced approach for transgender and gender diverse, or gender minority, youth:

- Affirmative work with gender non-conforming young children should consider the option of socially transitioning for each child individually, carefully exploring the pros and cons in a client-centered approach. The existing research should be discussed with parents, with acknowledgement that many gender non-conforming children do not persist to become transgender adolescents and adults.
- Affirmative work with gender minority adolescents involves offering puberty blocking medication (at Tanner Stage 2-3) and cross-sex medical interventions (generally offered around the age of 16). However, the research showing positive effects for these interventions are based on protocols that require supportive, gender-clarifying therapy **and** a psychological/readiness evaluation. Offering these medical interventions in the absence of an interdisciplinary team that provides the mental health component does not have empirical support and carries risks (e.g., greater chance of regret).
- While lowering the age requirement for hormone treatment may be in the best interest of some adolescent patients, this decision carries risks as most adolescents prior to age 16 are still solidifying their identities and have underdeveloped neurological and cognitive functioning that allows for mature long-term decision making. Mental health involvement, most importantly a formal readiness evaluation, is always recommended in these cases.
- Research shows that gender minority children and adolescents are most likely to thrive when they have the support of their parents. For this reason, an affirmative approach should involve parents in the process.
- Medical interventions (puberty blockers and cross-sex hormone therapy) have been shown to be helpful in decreasing gender dysphoria and improving quality of life for transgender and gender minority youth when the youth treated follow a specific protocol that involves two important steps: (1) gender exploring therapy with a qualified mental health provider, and (2) a comprehensive evaluation to determine readiness for a medical intervention.
- Because of the potential impact that hormone therapy may have on fertility, this topic should be discussed at length with any adolescent seeking medical interventions and should occur with both their mental health and medical providers. Parents should also be made aware of these potential side effects. Additionally, because many gender minority young adolescents who are prescribed puberty blocking medication eventually pursue hormone treatment, the conversation about fertility should happen prior to starting blockers as well.
- Although many young adolescents who are prescribed puberty blockers will eventually pursue hormone treatment, blockers are not intended as the first step in the physical/medical transition process. The affirmative client-centered approach reminds parents, youth (and providers) that the primary purpose of the blockers is to give the adolescent more time to continue exploring their gender identity in an effort to help them make the best decision for themselves regarding initiation of other medical interventions in the future. Adults that are unable to or are uncomfortable with the possibility that an adolescent on blockers could change their mind may explicitly or implicitly make an adolescent feel “stuck” in a gender identity.
- Affirmative care encourages providers, patients, and families to critically examine their own values and beliefs about gender and the gender binary specifically. Providers and parents are encouraged to accept a more fluid expression of gender and allow their child or adolescent the freedom to explore their developing gender identity without pressure to select one of two options.

- Due to the complexity that exists for most transgender and gender diverse youth, due to their evolving gender identity and sexual orientation, their rapidly changing and developing bodies and brains, along with a rapidly shifting societal landscape around acceptance of and treatment for transgender and gender diverse people, an affirmative approach recognizes the importance of providing care within an interdisciplinary team, wherein each provider's input is valued and perceived as equally critical to the care of the individual patients served.

Resources

TransYouth Family Allies: www.imatyfa.org/

Trans Youth Equality Foundation: www.transyouthequality.org

PFLAG Transgender Network: <http://community.pflag.org/transgender>

Gender Spectrum: www.genderspectrum.org

Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press.

Ehrensaft, D. (2011). *Gender born, gender made: Raising healthy gender-nonconforming children* (1 ed.). New York: The Experiment.

References

Edwards-Leeper, L. (in press). Affirmative care of transgender and gender non-conforming children and adolescents. In Singh, A. A. & dickey, I. m. (Eds.), *Affirmative Psychological Practice with Transgender and Gender Nonconforming Clients*. Washington, D.C.: American Psychological Association.

Edwards-Leeper, L., Leibowitz, S., Sangganjanavanich, V.F. (in press). Affirmative practice with transgender and gender non-conforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity*.

Hidalgo et al., 2013. The gender affirmative model: What we know and what we aim to learn. *Human Development*, 56, 285-290.

“During my senior year of high school, my English teacher would sit with me every day after school and listen as I told him how confused I was over my sexuality. He was one of the very few I told about being in conversion therapy. He told me that I had to listen to my heart and follow it, and not to try and force any specific outcome. He was the only person in my life at the time who gave me any assurance that I was going to make it through this.”

”

—Mathew

Summary and Conclusion

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority children and youth. To build a healthy and supportive environment for all children and adolescents, families and providers need resources and accurate information to help inform healthy decision making. Two key strategies that can help prevent adverse outcomes and support healthy development for LGBTQ youth are: strong and positive family and community engagement, and appropriate and supportive therapeutic interventions by health and behavioral health care providers.

These strategies are grounded in psychological research. Being a sexual or gender minority, or identifying as LGBTQ, is not a mental disorder. Variations in sexual orientation, gender identity, and gender expression are normal. Sexual and gender minority children have unique health and behavioral health needs, and may experience distress related to their sexual orientation or gender, as well as others' responses to their current, future, or perceived sexual orientation, gender expression, or gender identity. In addition, gender minority youth may experience distress caused by the incongruence between their gender identity and physical body.

The research, clinical expertise, and expert consensus make it clear that conversion therapy efforts to change a child's or adolescent's gender identity, gender expression, or sexual orientation are not an appropriate therapeutic intervention. No evidence supports the efficacy of such interventions to change sexual orientation or gender identity, and such interventions are potentially harmful. Appropriate therapeutic approaches to working with sexual and gender minority youth include: providing accurate information on the development of sexual orientation and gender identity and expression, increasing family and school support, and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Social transition

and medical interventions, including pubertal suppression and hormone therapy, are additional therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation, developmentally-appropriate informed consent of youth and their families, and a weighing of potential risks and benefits are vital when considering interventions with gender minority youth.

Beyond ending potentially harmful practices, it is important to also build greater social acceptance of LGBTQ youth; to adopt appropriate and supportive therapies; and to provide targeted resources and accurate information for children, adolescents, their families, and their providers. Building better supportive environments and working to eliminate negative social attitudes will reduce health disparities and improve the health and well-being of all LGBTQ youth.

“It is nearly impossible to describe walking into a therapist's office after surviving conversion therapy. The problem is that we need help from a system we have only known to hurt us. Hearing that I would be okay and that my new therapist could help me learn to cope with the pain of my conversion therapy experience was like getting a second chance at life.”

—Sam

References

- Adelson, S. L., & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 51(9), 957-974. doi: 10.1016/j.jaac.2012.07.004
- Alanko, K., Santtila, P., Witting, K., Varjonen, M., Jern, P., Johansson, A., . . . Kenneth Sandnabba, N. (2009). Psychiatric symptoms and same-sex sexual attraction and behavior in light of childhood gender atypical behavior and parental relationships. *J Sex Res*, 46(5), 494-504.
- Almeida, J., Johnson, R. M., Corliss, H. L., Molnar, B. E., & Azrael, D. (2009). Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolesc*, 38(7), 1001-1014.
- American Bar Association. (2015). Resolution 112: Commission on sexual orientation and gender identify section of individual rights and responsibilities commission on youth at risk, from <https://www.americanbar.org/content/dam/aba/images/abanews/2015annualresolutions/112.pdf>
- American Medical Association. (2008). Resolution 122 (A-08): Removing Financial Barriers to Care for Transgender Patients, from http://www.tgender.net/taw/ama_resolutions.pdf
- American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5 ed.). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2013b). Principles of Medical Ethics, from <http://www.psychiatry.org/psychiatrists/practice/ethics>
- American Psychological Association. (2002). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. Washington, DC: American Psychological Association.
- American Psychological Association. (2008). Report of the APA task force on gender identity and gender variance (pp. 28). Washington, DC: American Psychological Association.
- American Psychological Association. (2009). Resolution on appropriate therapeutic response to sexual orientation distress and change efforts Retrieved August 26, 2015, from <http://www.apa.org/about/policy/sexual-orientation.aspx>
- American Psychological Association. (2010). Ethical Principles of Psychologists and Code of Conduct from <http://www.apa.org/ethics/code/index.aspx>
- American Psychological Association (2011). Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients. Washington, DC: APA.
- American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *Am Psychol*, 67(1), 10-42.
- American Psychological Association. (2015a). Guidelines for psychological practice with transgender and gender nonconforming people, from <http://www.apa.org/practice/guidelines/transgender.pdf>
- American Psychological Association. (2015b). Standards of accreditation for health service psychology. Washington, DC: American Psychological Association.

- American Psychological Association & National Association of School Psychologists. (2015c). *Resolution on gender and sexual orientation diversity in children and adolescents in schools*. Retrieved from <http://www.apa.org/about/policy/orientation-diversity.aspx>
- Anton, B. S. (2009). Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the Council of Representatives, February 22–24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the Board of Directors. *American Psychologist*, 64(5), 372-453. doi: 10.1037/a0015932
- APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the Task Force on appropriate therapeutic responses to sexual orientation, from <http://www.apa.org/about/policy/sexual-orientation.aspx>
- APA Task Force on Gender Identity and Gender Variance. (2009). Report of the Task Force on gender identity and gender variance. Washington, DC: American Psychological Association.
- Association of American Medical Colleges. (2014). Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD., from <https://www.aamc.org/download/414172/data/lgbt.pdf>
- Bailey, J. M., & Zucker, K. J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology*, 31, 43-55.
- Bartoli, E., & Gillem, A. R. (2008). Continuing to depolarize the debate on sexual orientation and religious identity and the therapeutic process. *Professional Psychology: Research and Practice*, 39, 202-209.
- Ben-Ari, A. (1995). The discovery that an offspring is gay: Parents', gay men's, and lesbians' perspectives. *Journal of Homosexuality*, 30, 89-112.
- Bethea, M. S., & McCollum, E. E. (2013). The disclosure experiences of male-to-female transgender individuals: A Systems Theory perspective *Journal of Couple & Relationship Therapy*, 12, 89-112. doi: 10.1080/15332691.2013.779094
- Bockting, W. O., & Ehrbar, R. (2005). Commentary: Gender variance, dissonance, or identity disorder. *Journal of Psychology and Human Sexuality*, 17(3/4), 125-134.
- Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health*, 103 (5), 943-951.
- Bontempo, D., & D'Augelli, A. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *Journal of Adolescent Health*, 30, 364-374.
- Bouris, A., Guilamo-Ramos, V., Pickard, A., Shiu, C., Loosier, P. S., Dittus, P., & Waldmiller, J. M. (2010). A systematic review of parental influences on the health and well-being of lesbian, gay, and bisexual youth: time for a new public health research and practice agenda. *The Journal of Primary Prevention*, 31(5-6), 273-309.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by design and nature*. Cambridge, MA: Harvard.
- Bronfenbrenner, U. (2005). *Making human beings human: Bioecological perspectives on human development*. Thousand Oaks, CA: Sage.

- Burton, C. M., Marshal, M. P., Chisolm, D. J., Sucato, G. S., & Friedman, M. S. (2013). Sexual minority-related victimization as a mediator of mental health disparities in sexual minority youth: a longitudinal analysis. *J Youth Adolesc*, 42(3), 394-402.
- Byne, W., Bradley, S. J., Coleman, E., Eyler, A. E., Green, R., Menvielle, E. J., . . . Tompkins, D. A. (2012). Report of the APA Task Force on treatment of gender identity disorder. *American Journal of Psychiatry, Suppl. 1*-35.
- Carver, P., Yunger, J., & Perry, D. (2003). Gender identity and adjustment in middle childhood. *Sex Roles*, 49(3-4), 95-109. doi: 10.1023/a:1024423012063
- Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality*, 4, 219-235.
- Cass, V. C. (1996). Sexual orientation identity formation: A western phenomenon. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 227-251). Washington, DC: American Psychiatric Press, Inc.
- Cochran, S. D., Drescher, J., Kismödi, E., Giami, A., García-Moreno, C., Atalla, E., Marais, E. M. V., & Reed, G. M. (2014). Proposed declassification of disease categories related to sexual orientation in the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11). *Bulletin of the World Health Organization*, 92, 672-679. doi: 10.2471/BLT.14.135541
- Cohen-Kettenis, P. T. (2005). *Gender identity disorders*. Cambridge, MA: Cambridge University Press.
- Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., & Gooren, L. J. G. (2008). The treatment of adolescent transsexuals: Changing Insights. *Journal of Sexual Medicine*, 5(8), 1892-1897.
- Cohen-Kettenis, P. T., & Klink, D. (2015). Adolescents with gender dysphoria. *Best Pract Res Clin Endocrinol Metab*, 29(3), 485-495.
- Cohen-Kettenis, P. T., & Pfäfflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence: Making choices*. Thousand Oaks, CA: Sage.
- Cohen-Kettenis, P. T., Schagen, S. E., Steensma, T. D., de Vries, A. L., & Delemarre-van de Waal, H. A., (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow up. *Archives of Sexual Behavior*, 40(4), 843-847.
- Cohen-Kettenis PT, Schagen SE, Steensma TD, de Vries AL, Delemarre-van de Waal HA. Puberty suppression in a gender-dysphoric adolescent: a 22-year follow-up. *Arch Sex Behav*. 2011;40(4):843–847
- Cohen-Kettenis, P. T., & van Goozen, S. H. (1997). Sex reassignment of adolescent transsexuals: a follow-up study. *J Am Acad Child Adolesc Psychiatry*, 36(2), 263-271.
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7 ed., Vol. 13, pp. 165-232): *International Journal of Transgenderism*.
- Corby, B. C., Hodges, E. V. E., & Perry, D. G. (2007). Gender identity and adjustment in Black, Hispanic, and White preadolescents. *Developmental Psychology*, 43(1), 261-266.
- Corliss, H. L., Rosario, M., Wypij, D., Wylie, S. A., Frazier, A. L., & Austin, S. B. (2010). Sexual orientation and drug use in a longitudinal cohort study of U.S. adolescents. *Addictive Behaviors*, 35(5), 517-521. doi: 10.1016/j.addbeh.2009.12.019
- Cotton, S., Zebracki, K., Rosenthal, S. L., Tsevat, J., & Drotar, D. (2006). Religion/spirituality and adolescent health outcomes: a review. *J Adolesc Health*, 38(4), 472-480.

- Crenshaw, K. W. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241-1299.
- D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2006). Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence*, 21, 1-21.
- D'Augelli, A. R., & Patterson, C. J. (2001). *Lesbian, gay, and bisexual identities and youths: Psychological perspectives*. New York: Oxford University Press.
- Daley, A., Solomon, S., Newman, P. A., & Mishna, F. (2008). Traversing the margins: Intersectionalities in the bullying of lesbian, gay, bisexual and transgender youth. *Journal of Gay & Lesbian Social Services*, 19(3-4), 9-29. doi: 10.1080/10538720802161474
- Delemarre-van de Waal, H.A. & Cohen-Kettenis, P.T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, 155(suppl 1):S131-S137.
- de Vries, A., Steensma, T., Doreleijers, T., & Cohen-Kettenis, P. (2011). Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*, 8(8), 2276-2283.
- de Vries, A. L., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *J Child Psychol Psychiatry*, 52(11), 1195-1202.
- de Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *J Autism Dev Disord*, 40(8), 930-936.
- Diamond, L. M. (2015). Sexual fluidity. *The International Encyclopedia of Human Sexuality*, 1115-1354.
- Diamond, L. M., & Butterworth, M. (2008). Questioning gender and sexual identity: Dynamic links over time. *Sex Roles*, 59(5-6), 365-376. doi: 10.1007/s11199-008-9425-3
- Diamond, L. M., & Savin-Williams, R. C. (2000). Explaining diversity in the development of same-sex sexuality among young women. *Journal of Social Issues*, 56, 297-313.
- Diamond, M. L. (2006). Careful what you ask for: Reconsidering feminist epistemology and autobiographical narrative in research on sexual identity development. *Signs: Journal of Women and Culture and Society*, 31, 471-492.
- Diamond, M. L. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology*, 44, 5-14.
- Doty, N. D., & Brian, L. B. (2010). Sexuality related social support among lesbian, gay, and bisexual youth. *Journal of Youth and Adolescence*, 39, 1134-1147.
- Doty, N. D., Willoughby, B. L., Lindahl, K. M., & Malik, N. M. (2010). Sexuality related social support among lesbian, gay, and bisexual youth. *J Youth Adolesc*, 39(10), 1134-1147.
- Drescher, J. (2014). Controversies in gender diagnoses. *LGBT Health*, 1(1), 10-14. doi: 10.1089/lgbt.2013.1500
- Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Dev Psychol*, 44(1), 34-45.
- Dube, E. M., & Savin-Williams, R. C. (1999). Sexual identity development among ethnic sexual-minority male youths. *Developmental Psychology*, 34, 1389-1398.

- Durso, L. E., & Gates, G. J. (2012). *Serving Our Youth: Findings from a National Survey of Service Providers Working with Lesbian, Gay, Bisexual, and Transgender Youth who are Homeless or At Risk of Becoming Homeless*. Los Angeles, CA: The Williams Institute with True Colors Fund and The Palette Fund.
- Edwards-Leeper, L. (in press). Affirmative care of transgender and gender non-conforming children and adolescents. In Singh, A. A. & Dickey, L. M. (Eds.), *Affirmative Psychological Practice with Transgender and Gender Nonconforming Clients*. Washington, D.C.: American Psychological Association.
- Edwards-Leeper, L., Leibowitz, S., & Sangganjanavanich, V. F. (in press). Affirmative practice with transgender and gender non-conforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity*.
- Edwards-Leeper, L., & Spack, N. P. (2012). Psychological evaluation and medical treatment of transgender youth in an interdisciplinary “Gender Management Service” (GeMS) in a major pediatric center. *Journal of Homosexuality*, 59(3), 321-336.
- Egan, S. K., & Perry, D. G. (2001). Gender identity: A multidimensional analysis with implications for psychosocial adjustment. *Developmental Psychology*, 37(4), 451-463.
- Elizur, Y., & Ziv, M. (2001). Family support and acceptance, gay male identity formation, and psychological adjustment: a path model. *Fam Process*, 40(2), 125-144.
- Ferguson v. JONAH, Law Div., Hudson Cy. (Bariso, J.S.C.), HUD-L-5473-12, February 5, 2015.
- Fisher, C. (2015, August 31). Email – “Relevant APA Ethical Standards”.
- Floyd, F. J., & Bakeman, R. (2006). Coming-out across the life course: implications of age and historical context. *Arch Sex Behav*, 35(3), 287-296.
- Friedman, M. S., Marshal, M. P., Guadamuz, T. E., Wei, C., Wong, C. F., Saewyc, E., & Stall, R. (2011). A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *Am J Public Health*, 101(8), 1481-1494.
- Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health*, 38(3), 230-236.
- Goldbach, J. T., Tanner-Smith, E. E., Bagwell, M., & Dunlap, S. (2014). Minority stress and substance use in sexual minority adolescents: a meta-analysis. *Prev Sci*, 15(3), 350-363.
- Goodenow, C., Szalacha, L., & Westheimer, K. (2006). School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools*, 43 573-589.
- Grossman, A., & D’Augelli, A. (2007). Transgender youth and life-threatening behaviors. *Suicide Life Threat Behav*, 375, 527-537.
- Grov, C., Bimbi, D. S., Nanín, J. E., & Parsons, J. T. (2006). Race, ethnicity, gender, and generational factors associated with the coming-out process among gay, lesbian, and bisexual individuals. *Journal of Sex Research*, 43, 115-121.
- Harari, E., Glenwick, D. S., & Cecero, J. J. (2014). The relationship between religiosity/spirituality and well-being in gay and heterosexual Orthodox Jews. *Mental Health, Religion and Culture*, 17(9), 886-897.
- Harper, G. W. (2007). Sex isn’t that simple: culture and context in HIV prevention interventions for gay and bisexual male adolescents *American Psychologist*, 62(8), 806.

- Harper, G. W., Jamil, O. B., & Wilson, B. D. M. (2007). Collaborative community-based research as activism: Giving voice and hope to lesbian, gay, and bisexual youth. *Journal of Lesbian and Gay Psychotherapy*, 11(3/4), 99-119.
- Harper, G. W., & Schneider, M. (2003). Oppression and discrimination among lesbian, gay, bisexual, and Transgendered people and communities: a challenge for community psychology. *Am J Community Psychol*, 31(3-4), 243-252.
- Harrison, J., Grant, J., & Herman, J. L. (2012). A gender not listed here: Genderqueers, gender rebels and otherwise in the National Transgender Discrimination Study *LGBT Policy Journal at the Harvard Kennedy School*, 2, 13-24.
- Hatzenbuehler, M. L. (2011). The Social Environment and Suicide Attempts in Lesbian, Gay, and Bisexual Youth. *Pediatrics*, 127(5), 896-903. doi: 10.1542/peds.2010-3020
- Hatzenbuehler, M. L., Pachankis, J. E., & Wolff, J. (2012). Religious climate and health risk behaviors in sexual minority youths: A population-based study. *American Journal of Public Health*, 102(4), 657-663. doi: 10.2105/ajph.2011.300517
- Hembree, W. C., Cohen-Kettenis, P., Waal, H. A. D.-v. d., Gooren, L. J., Walter J. Meyer, I., Spack, N. P., . . . Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*, 94(9), 3132-3154. doi: doi:10.1210/jc.2009-0345
- Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. . *Professional Psychology: Research and Practice*, 43(5), 460-467. doi: <http://dx.doi.org/10.1037/a0029597>
- Herek, G. M. (2010). Sexual orientation differences as deficits: Science and stigma in the history of American psychology. *Perspectives on Psychological Science*, 5, 693-699.
- Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., . . . Olson, J. (2013). The Gender Affirmative Model: What we know and what we aim to learn. *Human Development*, 56, 285-290.
- Hidalgo, M. A., Kuhns, L. M., Kwon, S., Mustanski, B., & Garofalo, R. (2015). The impact of childhood gender expression on childhood sexual abuse and psychopathology among young men who have sex with men. *Child Abuse & Neglect*, 46, 103-112.
- Horowitz, J. L., & Newcomb, M. D. (2001). A multidimensional approach to homosexual identity. *J Homosex*, 42(2), 1-19.
- Hughes, I. A., Houk, C., Ahmed, S. F., & Lee, P. A. (2006). Consensus statement on management of intersex disorders. *Journal of pediatric urology*, 2(3), 148-162.
- Institute of Medicine. (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: National Academy of Sciences.
- Jarrett, V. (2015). Official White House response to enact Leelah's Law to ban all LGBTQ+ Conversion Therapy from <https://petitions.whitehouse.gov/response/response-your-petition-conversion-therapy>
- Kann, L., Olsen, E., McManus, T., Kinchen, S., Chyen, D., Harris, W., . . . Centers for Disease Control and Prevention (CDC). (2011). Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12--youth risk behavior surveillance, selected sites, United States, 2001-2009. *MMWR Surveill Summ*, 60(7), 1-133.

- Knudson, G., De Cuypere, G., & Bockting, W. (2010). Recommendations for revision of the *DSM* diagnoses of Gender Identity Disorders: Consensus statement of the World Professional Association for Transgender Health. *International Journal of Transgenderism*, 12(2), 115-118.
- Kohlberg, L. (1966). *A cognitive-developmental analysis of children's sex-role concepts and attitudes*. Stanford, CA: Stanford University.
- Kosciw, J. G., & Diaz, E. M. (2006). The 2005 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our schools. . New York: Gay, Lesbian & Straight Education Network (GLSEN).
- Kosciw, J. G., Greytak, E. A., & Diaz, E. M. (2009). Who, what, where, when, and why: Demographic and ecological factors contributing to hostile school climate for lesbian, gay, bisexual, and transgender youth. *Journal of Youth and Adolescence*, 38(7), 976-988. doi: 10.1007/s10964-009-9412-1
- Kosciw, J. G., Greytak, E. A., Diaz, E. M., & Bartkiewicz, M. J. (2010). The 2009 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. New York, NY: GLSEN.
- Kosciw, J. G., Greytak, E. A., Palmer, N. A., & Boesen, M. J. (2014). The 2013 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. New York: Gay, Lesbian & Straight Education Network (GLSEN).
- Kuper, L. E., Nussbaum, R., & Mustanski, B. (2012). Exploring the diversity of gender and sexual orientation identities in an online sample of transgender individuals. *Journal of Sex Research*, 49, 244-254. doi: 10.1080/00224499.2011.596954
- Lease, S. H., Horne, S. G., & Noffsinger-Frazier, N. (2005). Affirming faith experiences and psychological health for caucasian lesbian, gay, and bisexual individuals. *Journal of Counseling Psychology*, 52(3), 378-388. doi: 10.1037/0022-0167.52.3.378
- Lee, P. A. (1980). Normal ages of pubertal events among American males and females. *Journal of Adolescent Health Care*, 1(1), 26-29.
- Leibowitz, S., & Telingator, C. (2012). Assessing gender identity concerns in children and adolescents: evaluation, treatments, and outcomes. *Curr Psychiatry Rep*, 14(2), 111-120.
- Leibowitz, S. F., & Spack, N. P. (2011). The development of a gender identity psychosocial clinic: Treatment issues, logistical considerations, interdisciplinary cooperation, and future initiatives. *Child Adolesc Psychiatric Clin N Am*, 20, 701-724.
- Lev, A. (2005). *Transgender emergence: Therapeutic guidelines for working with gender variant people and their families*. New York: Haworth Clinical Practice Press.
- Liu, R. T., & Mustanski, B. (2012). Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. *Am J Prev Med*, 42(3), 221-228.
- Majd, K., Marksamer, J., & Reyes, C. (2009). Hidden Injustice: Lesbian, gay, bisexual, and transgender youth in juvenile courts. New York: The Equity Project.
- Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., . . . Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health*, 49(2), 115-123. doi: 10.1016/j.jadohealth.2011.02.005
- Maslowe, K.E. & Yarhouse, M.A. (2015). Christian parental reactions when a LGB child comes out. *The American Journal of Family Therapy*, 43, 1-12.

- Mattison, A. M., & McWhirter, D. P. (1995). Lesbians, gay men, and their families: Some therapeutic issues. *Psychiatric Clinics of North America*.
- Meanley, S., Pingel, E. S., & Bauermeister, J. A. (2015). Psychological Well-being Among Religious and Spiritual-identified Young Gay and Bisexual Men. *Sexuality Research and Social Policy*. Advance online publication. 10.1007/s13178-015-0199-4
- Menvielle, E. J., & Tuerk, C. (2002). A support group for parents of gender non-conforming boys. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41, 1010-1013.
- Menvielle, E. J., Tuerk, C., & Perrin, E. C. (2005). To the beat of a different drummer: The gender variant child. *Contemporary Pediatrics*, 22, 38-39, 41, 43, 45-46.
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of health and social behavior*, 38-56.
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, 129(5), 674.
- Minter, S. (2012). Supporting transgender children: new legal, social, and medical approaches. *J Homosex*, 59(3), 422-433.
- Moon, D. (2014). Beyond the dichotomy: six religious views of homosexuality. *J Homosex*, 61(9), 1215-1241.
- Mustanski, B., Birkett, M., Greene, G. J., Hatzenbuehler, M. L., & Newcomb, M. E. (2013). Envisioning an America without sexual orientation inequities in adolescent health. *American Journal of Public Health*, 104(2), 218-225. doi: 10.2105/ajph.2013.301625
- Mustanski, B., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *Am J Public Health*, 100(12), 2426-2432.
- Nakajima, G. A. (2003). The emergence of an international lesbian, gay, and bisexual psychiatric movement. *Journal of Gay & Lesbian Psychotherapy*, 7(1/2), 165-188.
- National Association of Social Workers. (2008). Code of Ethics of the National Association of Social Workers, from <http://www.naswdc.org/pubs/code/code.asp>
- Olson, K., Key, A., & Eaton, N. (2015). Gender cognition in transgender children. *Psychological Science*, 1-8.
- Ott, M. Q., Corliss, H. L., Wypij, D., Rosario, M., & Austin, S. B. (2010). Stability and change in self-reported sexual orientation identity in young people: Application of mobility metrics. *Archives of Sexual Behavior*, 40(3), 519-532. doi: 10.1007/s10508-010-9691-3
- Page, M. J. L., Lindahl, K. M., & Malik, N. M. (2013). The role of religion and stress in sexual Identity and mental health among lesbian, gay, and bisexual youth. *Journal of Research on Adolescence*, 23(4), 665-677. doi: 10.1111/jora.12025
- Parent, M. C., DeBlaere, C., & Moradi, B. (2013). Approaches to research on intersectionality: Perspectives on gender, LGBT, and racial/ethnic identities. *Sex Roles*, 68(11-12), 639-645. doi: 10.1007/s11199-013-0283-2
- Perrin, E. C. (2002). *Sexual orientation in child and adolescent health care*. New York: Kluwer/Plenum.
- Ray, N., & National Gay and Lesbian Task Force. (2006). Lesbian, gay, bisexual, and transgender youth: An epidemic of homelessness. Washington, DC: National Gay and Lesbian Task Force Policy Institute.

- Ream, G. L., & Savin-Williams, R. C. (2005). Reconciling Christianity and positive non-heterosexual identity in adolescence, with implications for psychological well-being. *Journal of Gay & Lesbian Issues in Education*, 2(3), 19-36. doi: 10.1300/J367v02n03_03
- Roberts, A. L., Rosario, M., Corliss, H. L., Koenen, K. C., & Austin, S. B. (2012). Childhood gender nonconformity: A risk indicator for childhood abuse and posttraumatic stress in youth. *Pediatrics*, 129, 410-417. doi: 10.1542/peds.2011-1804
- Roberts, A. L., Rosario, M., Slopen, N., Calzo, J. P., & Austin, S. B. (2013). Childhood gender nonconformity, bullying victimization, and depressive symptoms across adolescence and early adulthood: An 11-year longitudinal study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(2), 143-152. doi: 10.1016/j.jaac.2012.11.006
- Russell, S., Ryan, C., Toomey, R., Diaz, R., & Sanchez, J. (2011). Lesbian, gay, bisexual, and transgender adolescent school victimization: Implications for young adult health and adjustment. *Journal of School Health*, 81, 223-230.
- Russell, S. T. (2003). Sexual minority youth and suicide risk. *American Behavioral Scientist*, 46(9), 1241-1257. doi: 10.1177/0002764202250667
- Russell, S. T., Toomey, R. B., Ryan, C., & Diaz, R. M. (2014). Being out at school: The implications for school victimization and young adult adjustment. *American Journal of Orthopsychiatry*, 84(6), 635-643. doi: 10.1037/ort0000037
- Ryan, C., & Diaz, R. (2005). *Family responses as a source of risk and resiliency for LGBT youth*. Paper presented at the Child Welfare League of America Preconference Institute, Washington, DC.
- Ryan, C., & Futterman, D. (1998). *Lesbian and gay youth: Care and counseling*. New York: Columbia University Press.
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346-352. doi: 10.1542/peds.2007-3524
- Ryan, C., & Rees, R. A. (2012). Supportive families, healthy children: Helping Latter-day Saint families with lesbian, gay, bisexual & transgender children. San Francisco, CA: Family Acceptance Project, Marian Wright Edelman Institute, San Francisco State University.
- Ryan, C., Russell, S., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), 205-213. doi: 10.1111/j.1744-6171.2010.00246.x
- Saewyc, E. M. (2007). Contested conclusions: Claims that can (and cannot) be made from the current research on gay, lesbian, and bisexual teen suicide attempts. *Journal of LGBT Health Research*, 3(1), 79-87.
- Saewyc, E. M. (2011). Research on adolescent sexual orientation: Development, health disparities, stigma, and resilience. *Journal of Research on Adolescence*, 21, 256-272. doi: 10.1111/j.1532-7795.2010.00727
- Safren, S. A., & Heimberg, R. G. (1999). Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *Journal of Consulting and Clinical Psychology*, 67, 859-866.
- Salzburg, S. (2004). Learning that an adolescent child is gay or lesbian: The parent experience. *Social Work*, 49, 109-118.
- Salzburg, S. (2007). Narrative therapy pathways for reauthoring with parents of adolescents coming-out as lesbian, gay, and bisexual. *Contemporary Family Therapy*, 29, 57-69.

- Savin-Williams, R. (1994). Verbal and physical abuse as stressors in the lives of sexual minority youth: Associations with school problems, running away, substance abuse, prostitution, and suicide. *Journal of Consulting and Clinical Psychology*, 62, 261-269. doi: 10.1037/0022-006X.62.2.261
- Savin-Williams, R. C. (2001). *Mom, dad, I'm gay: How families negotiate coming out*. Washington, DC: American Psychological Press.
- Savin-Williams, R. C. (2005). *The New Gay Teenager*. Cambridge, MA.: Harvard University Press.
- Savin-Williams, R. C., & Ream, G. L. (2006). Prevalence and stability of sexual orientation components during adolescence and young adulthood. *Archives of Sexual Behavior*, 36(3), 385-394. doi: 10.1007/s10508-006-9088-5
- Schlatter, E., & Southern Poverty Law Center. (2014, Dec. 13). North Carolina church members indicted for kidnapping and assaulting gay man, *Salon*. Retrieved from http://www.salon.com/2014/12/13/north_carolina_church_members_indicted_for_kidnapping_and_assaulting_gay_man_partner/
- Schope, R. D. (2002). The decision to tell: Factors influencing the disclosure of sexual orientation by gay men. *Journal of Gay and Lesbian Social Services*, 14(1), 1-22.
- Schope, R. D., & Eliason, M. J. (2000). Thinking versus acting: Assessing the relationship between heterosexual attitudes and behaviors towards homosexuals. *Journal of Gay & Lesbian Social Services*, 11, 69-92.
- Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles*, 59, 301-311. doi: doi:10.1007/s11199-008-9501-8
- Siegal, M., & Robinson, J. (1987). Order effects in children's gender-constancy responses *Developmental Psychology*, 23, 283-286. doi: 10.1037/0012-1649.23.2.283
- Simons, L. K., Leibowitz, S. F., & Hidalgo, M. A. (2014). Understanding gender variance in children and adolescents. *Pediatr Ann*, 43(6), 00904481-20140522.
- Siraj, A. (2012). "I Don't Want to Taint the Name of Islam": The Influence of Religion on the Lives of Muslim Lesbians. *Journal of Lesbian Studies*, 16(4), 449-467.
- Smith, T. E., & Leaper, C. (2006). Self-perceived gender typicality and the peer context during adolescence. *Journal of Research on Adolescence*, 16, 91-104.
- Smith, Y. L., van Goozen, S. H., & Cohen-Kettenis, P. T. (2001). Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *J Am Acad Child Adolesc Psychiatry*, 40(4), 472-481.
- Snapp, S. D., Watson, R. J., Russell, S. T., Diaz, R. M., & Ryan, C. (2015). Social support networks for LGBT young adults: Low cost strategies for positive adjustment. *Family Relations*, 64(3), 420-430. doi: 10.1111/fare.12124
- Spack, N. P., Edwards-Leeper, L., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. doi: 10.1542/peds.2011-0907
- Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clin Child Psychol Psychiatry*, 16(4), 499-516.
- Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Gender transitioning before puberty? *Arch Sex Behav*, 40(4), 649-650. doi: 10.1007/s10508-011-9752-2

- Steensma, T. D., Kreukels, B. P., de Vries, A. L., & Cohen-Kettenis, P. T. (2013). Gender identity development in adolescence. *Horm Behav*, 64(2), 288-297.
- Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *J Am Acad Child Adolesc Psychiatry*, 52(6), 582-590.
- Stewart, B. T., Heck, N. C., & Cochran, B. N. (2015). A comparison of sexual minority youth who attend religiously affiliated schools and their nonreligious-school-attending counterparts *Journal of LGBT Youth*, 12(2), 170-188.
- Szalacha, L. A. (2003). Safer sexual diversity climates: Lessons learned from an evaluation of Massachusetts Safe Schools Program for Gay and Lesbian Students. . *American Journal of Education*, 110, 58-88.
- Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology*, 46(6), 1580-1589. doi: 10.1037/a0020705
- Toomey, R. B., Ryan, C., Diaz, R. M., & Russell, S. T. (2011). High school Gay–Straight Alliances (GSAs) and young adult well-being: An examination of GSA presence, participation, and perceived effectiveness. *Applied Developmental Science*, 15(4), 175-185. doi: 10.1080/10888691.2011.607378
- Travers, R., Bauer, G., Pyne, J., Bradley, K., Gale, L., & Papadimitriou, M. (2012). Impacts of strong parental support for trans youth: A report prepared for Children’s Aid Society New York: Children’s Aid Society.
- Troiden, R. R. (1988). Homosexual identity development. *Journal of Adolescent Health Care*, 9, 105-113.
- Troiden, R. R. (1989). The formation of homosexual identities. *Journal of Homosexuality*, 17(1), 43-73.
- Vance, S. R., Jr., Ehrensaft, D., & Rosenthal, S. M. (2014). Psychological and medical care of gender nonconforming youth. *Pediatrics*, 134(6), 1184-1192.
- Vrangalova, Z., & Savin-Williams, R. C. (2012). Mostly heterosexual and mostly gay/lesbian: Evidence for new sexual orientation identities. *Archives of sexual behavior*, 41(1), 85-101.
- Wallace, R., & Russell, H. (2013). Attachment and shame in gender-nonconforming children and their families: toward a theoretical framework for evaluating clinical interventions. *Int J Transgenderism*, 14(3), 113–126.
- Wallien, M. S. C., & Cohen-Kettenis, P. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47(12), 1413-1423.
- Walls, N. E., Kane, S. B., & Wisneski, H. (2010). Gay-straight alliances and school experiences of sexual minority youth. *Youth & Society*, 41, 307–332. doi: DOI: 10.1177/0044118X09334957
- Wilbur, S., Ryan, C., & Marksamer, J. (2006). Serving LGBT youth in out-of-home care: Best practices guide. Washington, DC: Child Welfare League of America.
- Willoughby, B. L., Doty, N. D., & Malik, N. M. (2010). Victimization, family rejection, and outcomes of gay, lesbian, and bisexual young people: the role of negative GLB identity. *Journal of GLBT Family Studies*, 6, 403-424.
- World Health Organization. (1992). The International Classification of Disease 10th Revision (ICD 10). *Classification of mental and behavioural disorders—Clinical descriptions and diagnostic guidelines*. Geneva: WHO.

- World Professional Association for Transgender Health, I., . (2008). WPATH clarification on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A., from http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1352&pk_association_webpage=3947
- Yakushko, O. (2005). Influence of social support, existential well-being, and stress over sexual orientation on self esteem of gay, lesbian, and bisexual individuals. *International Journal for the Advancement of Counselling*, 27(1), 131-143.
- Yarhouse, M. A. (1998). When families present with concerns about an adolescent's experience of same-sex attraction. *The American Journal of Family Therapy*, 26, 321-330.
- Yarhouse, M. A. (2015a, July 7 and August 6). [Family approaches in therapeutic intervention].
- Yarhouse, M.A. (2015b, August. Family and Community Acceptance – focus on conventionally religious communities. Unpublished paper.
- Yarhouse, M.A. (2015c). Understanding gender dysphoria: Navigating transgender issues in a changing culture. Downer's Grove, IL: InterVarsity Press.
- Yarhouse, M. A., & Tan, E. S. N. (2005). Addressing religious conflicts in adolescents who experience sexual identity confusion. *Professional Psychology: Research and Practice*, 6, 530-536.
- Yunger, J. L., Carver, P. R., & Perry, D. G. (2004). Does gender identity influence children's psychological well-being? *Dev Psychol*, 40(4), 572-582.
- Zucker, K. (2004). Gender identity development and issues. *Child Adolesc Psychiatric Clin N Am*, 13, 551-568.
- Zucker, K. (2005). Gender identity disorder in children and adolescents. *Annu Rev Clin Psychol*, 1, 467-492.
- Zucker, K., & Bradley, S. (1995). Gender identity disorder and psychosexual problems in children and adolescents. New York: The Guilford Press.

Appendix A: Glossary of Terms

Cisgender: A person whose gender identity, gender expression, and sex assigned at birth all align.

Conversion therapy: Efforts to change an individual's sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors.

Gender dysphoria: Psychological distress due to the incongruence between one's body and gender identity.

Gender expression: The way a person expresses their gender identity (e.g., through dress, clothing, body movement, etc.). Young children express their gender through choices for personal items such as toys and clothes, as well as hairstyle, colors, etc.

Gender identity: A person's internal sense of being male, female, or something else. Gender identity is internal, so it is not necessarily visible to others. Gender identity is also very personal, so some people may not identify as male or female while others may identify as both male and female.

Gender nonconforming, gender diverse: A person whose gender expression differs from how their family, culture, or society expects them to behave, dress, and act.

Intersex: Individuals with medically defined biological attributes that are not exclusively male or female; frequently "assigned" a gender at birth which may or may not differ from their gender identity later in life.

Questioning: Individuals who are uncertain about their sexual orientation and/or gender identity. Also used as a verb to describe the process of exploring one's sexual orientation and/or gender identity.

Sex assigned at birth: The sex designation given to an individual at birth.

Sexual orientation: A person's emotional, sexual, and/or relational attraction to others. Sexual orientation is usually classified as heterosexual, bisexual, or homosexual (lesbian and gay), and includes components of attraction, behavior, and identity (Laumann et al., 1994). Sexual orientation is expressed in relationship to others to meet basic human needs for love, attachment, and intimacy (Institute of Medicine, 2011). Thus, young people can be aware of their sexual orientation as feelings of attachment and connection to others before they become sexually active. Sexual orientation identity is how someone labels and identifies their sexual orientation either publicly or privately. Sexual orientation, sexual orientation identity, and sexual behaviors are not always congruent.

Transgender: A person who feels that their gender identity does not match their physical body and differs from the gender that others observed and gave them at birth (assigned or birth gender).

Transition: A term used to describe the process of moving from one gender to another; in adolescents and adults, can be characterized by medical intervention such as the use of cross-sex hormone therapy or gender affirming surgeries. For all people, can include social transition, which is the process of outwardly beginning to present as a different gender, which can include changes in name, pronouns, and appearance.

Appendix B: Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Abt Associates under contract number HHSS283200700008I/HHSS28342001T with SAMHSA, U.S. Department of Health and Human Services (HHS). David Lamont Wilson served as the Government Project Officer. Elliot Kennedy served as the Task Lead.

The lead scientific writer for this report was Laura Jadwin-Cakmak, MPH with support from W. Alexander Orr, MPH as the Task Lead from Abt Associates.

The Expert Consensus Panel was convened by the American Psychological Association (APA) from July 7 – 8, 2015 in Washington, DC and funded by a grant by the Federal Agencies Project. The APA activities were coordinated by Clinton W. Anderson, PhD (Associate Executive Director, Public Interest Directorate, Director LGBT Office) and Judith Glassgold, PsyD (Associate Executive Director, Government Relations, Public Interest Directorate).

The Expert Panel consisted of a panel of researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel included experts with a background in family therapy and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B. Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and Mark A. Yarhouse, PsyD.

Endnotes

1. The term “sexual and gender minority” is an umbrella term. “Sexual minority” refers to individuals who have a same-gender (i.e., gay or lesbian) or bisexual orientation. “Gender minority” refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning – is used to be inclusive of individuals who are questioning aspects of their gender or sexual orientation, and is particularly common when youth are the population of focus, as here.
2. Conversion therapy consists of any efforts to change an individual’s sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
3. To be inclusive of transgender populations, the term “same-gender” (as opposed to “same-sex”) is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.
4. This section is based on the consensus statements developed by an expert panel convened by the American Psychological Association, July 2015. These statements are based on the best available research and scholarly material available.
5. Efforts to change an individual’s sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
6. The term “sexual and gender minority” is an umbrella term. “Sexual minority” refers to individuals who have a same-gender (i.e., homosexual) or bisexual orientation. “Gender minority” refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning – is used to be inclusive of individuals who are questioning aspects of their gender or sexual orientation, particularly common when youth are the population of focus.
7. To be inclusive of transgender populations, the term “same-gender” (as opposed to “same-sex”) is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.
8. Secondary sex characteristics refer to sexually dimorphic phenotypic traits that develop due to increased sex hormones in puberty. Changes due to increase in androgens includes growth of the testicles and penis, increased height, increased muscle mass, changes in body shape and weight distribution (e.g., broadening of the shoulders and chest), growth of facial and body hair, and enlargement of the larynx and deepening of the voice. Changes due to increase in estrogens includes breast development, changes in body shape and weight distribution (e.g., widening of the hips and narrowing of the waist), growth of underarm and pubic hair, and the onset of menses (Lee 1980).
9. Homosexuality per se was removed from the International Classification of Diseases and it is explicitly stated that “sexual orientation by itself is not to be considered a disorder.” Certain homosexuality-related diagnoses remain in the ICD, although there is some movement underway to remove them in the next edition of ICD (Cochran, S. D., Drescher, J., Kismödi, Giam, García-Moreno, Atalla, ..., & Reed, 2014).
10. Biological sex is itself a multidimensional construct, as the chromosomal, gonadal, and anatomical indicators of biological sex do not always align, such as in intersex individuals/individuals with disorders of sex development (Hughes et al., 2006).
11. It should be noted that what behaviors, activities, and appearances are considered feminine or masculine, as well as the expected degree of conformity to gender expressions stereotypically associated with one’s assigned sex at birth, varies by culture and over time. The alignment of assigned sex at birth, gender identity, and gender expression has been assumed in many, but not all, cultures and religious traditions. Historically several different cultures have recognized, accepted, and sometimes revered diversity in gender identity and gender expression (American Psychological Association, 2015b). This includes Two Spirit individuals within American Indian communities.

12. The diagnosis of Gender Identity Disorder was eliminated and replaced with the diagnosis of Gender Dysphoria in the Diagnostic and Statistical Manual of Mental Disorders in 2013. Though no longer the current diagnosis, almost all existing research includes participants who were diagnosed using the earlier criteria for Gender Identity Disorder. In addition to the diagnostic category of Gender Dysphoria (capitalized), the term “gender dysphoria” (lowercase) is used to broadly describe the discomfort or distress caused by the discrepancy between a person’s gender identity and that person’s sex assigned at birth and/or primary or secondary sex characteristics. We will use the term “individuals with gender dysphoria” throughout the report as inclusive of individuals diagnosed under both current and earlier diagnostic criteria, while recognizing that future research findings focused on individuals with Gender Dysphoria may differ from that focused on individuals previously diagnosed with Gender Identity Disorder.
13. There is a third trajectory, in which individuals do not experience gender dysphoria or a diverse gender expression in childhood, but experience the onset of gender dysphoria in adolescence or later. This trajectory is discussed in the section on Gender in Adolescence.
14. Scientists now understand that while sexual orientation is not malleable to external pressures to change (American Psychological Association, 2009), some individuals experience internal changes in sexual attraction and/or changes in what sexual orientation identity label they use (e.g., straight, bisexual, gay) throughout adolescence and adulthood; this concept is referred to as sexual fluidity (Diamond & Butterworth, 2008; Savin-Williams & Ream, 2006). For findings related to the stability of sexual orientation identity in adolescence and young adulthood, refer to research by Ott et al. (2010).
15. Though opportunities for sexuality- and gender-related stressors and supports also occur throughout these social systems within the lives of sexual and gender minority children, research in these areas has generally not included pre-pubertal children.
16. This section is based on the statements of professional consensus developed by an expert panel convened by the American Psychological Association, July 2015 at the request of the US Substance Abuse and Mental Health Services Administration. These statements, listed in *Section 2*, are based on the best available research and scholarly material available.
17. See American Psychological Association (2009, 2012, and 2015a)
18. This section is based on reports by American Psychological Association (2012 and 2015a) and APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009).
19. For more information see White House sources [Strengthening Protection against Discrimination](#).
20. For example, “A Practitioner’s Resource Guide: Helping Families to Support Their LGBT Children” <http://store.samhsa.gov/product/A-Practitioner-s-Resource-Guide-Helping-Families-to-Support-Their-LGBT-Children/PEP14-LGBTKIDS>. Another helpful resource is “Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children” http://ncccgorgetown.edu/documents/LGBT_Brief.pdf.
21. See for instance, American Psychological Association (2011). Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients.
22. Association of American Medical Colleges, 2014. Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD. Available at <https://www.aamc.org/download/414172/data/lgbt.pdf>.
23. *Ferguson v. JONAH*, Law Div., Hudson Cy. (Bariso, J.S.C.), HUD-L-5473-12, February 5, 2015.
24. American Bar Association, 2015. Resolution 112., available at <https://www.americanbar.org/content/dam/aba/images/abaneews/2015annualresolutions/112.pdf>.



HHS Publication No. (SMA) 15-4928



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation



Report of the American Psychological Association Task Force on
**Appropriate Therapeutic Responses
to Sexual Orientation**



Task Force Members

Judith M. Glassgold, PsyD, Chair

Lee Beckstead, PhD

Jack Drescher, MD

Beverly Greene, PhD

Robin Lin Miller, PhD

Roger L. Worthington, PhD

Clinton W. Anderson, PhD, Staff Liaison

Report of the American Psychological Association Task Force on
**Appropriate Therapeutic Responses
to Sexual Orientation**

Available online at <http://www.apa.org/pi/lgbc/publications/therapeutic-resp.html>

Printed copies available from:

Lesbian, Gay, Bisexual, and Transgender Concerns Office
Public Interest Directorate
American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
202-336-6041
lgbc@apa.org

Suggested bibliographic reference:

American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Retrieved from <http://www.apa.org/pi/lgbc/publications/therapeutic-resp.html>

Copyright © 2009 by the American Psychological Association. This material may be reproduced in whole or in part without fees or permission provided that acknowledgment is given to the American Psychological Association. This material may not be reprinted, translated, or distributed electronically without prior permission in writing from the publisher. For permission, contact APA, Rights and Permissions, 750 First Street, NE, Washington, DC 20002-4242.

APA reports synthesize current psychological knowledge in a given area and may offer recommendations for future action. They do not constitute APA policy or commit APA to the activities described therein. This particular report originated with the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation.

August 2009
Printed in the USA

CONTENTS

Abstract	v
Executive Summary	1
Preface	8
1. Introduction	11
Laying the Foundation of the Report	13
Psychology, Religion, and Homosexuality	17
2. A Brief History of Sexual Orientation Change Efforts	21
Homosexuality and Psychoanalysis	21
Sexual Orientation Change Efforts	22
Affirmative Approaches: Kinsey; Ford and Beach; and Hooker	22
Decline of Sexual Orientation Change Efforts	24
Sexual Orientation Change Efforts Provided to Religious Individuals	25
3. A Systematic Review of Research on the Efficacy of Sexual Orientation Change Efforts	26
Overview of the Systematic Review	27
Methodological Problems in the Research Literature on Sexual Orientation Change Efforts	28
Summary	34
4. A Systematic Review of Research on the Efficacy of Sexual Orientation Change Efforts: Outcomes	35
Reports of Benefit	35
Reports of Harm	41
Conclusion	42

5. Research on Adults Who Undergo Sexual Orientation Change Efforts.....	44
Demographics.....	45
Why Individuals Undergo Sexual Orientation Change Efforts	45
Reported Impacts of Sexual Orientation Change Efforts.....	49
Remaining Issues.....	52
Summary and Conclusion.....	52
6. The Appropriate Application of Affirmative Therapeutic Interventions for Adults	
Who Seek Sexual Orientation Change Efforts	54
A Framework for the Appropriate Application of Affirmative Therapeutic Interventions.....	55
Conclusion	63
7. Ethical Concerns and Decision Making in Psychotherapy With Adults	65
Bases for Scientific and Professional Judgments and Competence	66
Benefit and Harm	67
Justice and Respect for Rights and Dignity	68
Summary	70
8. Issues for Children, Adolescents, and Their Families.....	71
Task Force Charge and Its Social Context.....	71
Literature Review	72
Appropriate Application of Affirmative Interventions With Children and Adolescents.....	76
Conclusion	79
9. Summary and Conclusions.....	81
Summary of the Systematic Review of the Literature.....	82
Recommendations and Future Directions.....	86
References.....	93
Appendix A: Resolution on Appropriate Affirmative Responses	
to Sexual Orientation Distress and Change Efforts.....	119
Appendix B: Studies Included (<i>N</i> = 55) in the Systematic Review.....	125

ABSTRACT

The American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation conducted a systematic review of the peer-reviewed journal literature on sexual orientation change efforts (SOCE) and concluded that efforts to change sexual orientation are unlikely to be successful and involve some risk of harm, contrary to the claims of SOCE practitioners and advocates. Even though the research and clinical literature demonstrate that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity, the task force concluded that the population that undergoes SOCE tends to have strongly conservative religious views that lead them to seek to change their sexual orientation. Thus, the appropriate application of affirmative therapeutic interventions for those who seek SOCE involves therapist acceptance, support, and understanding of clients and the facilitation of clients' active coping, social support, and identity exploration and development, without imposing a specific sexual orientation identity outcome.



EXECUTIVE SUMMARY

In February 2007, the American Psychological Association (APA) established the Task Force on Appropriate Therapeutic Responses to Sexual Orientation and charged the task force with three major tasks:

1. Review and update the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998).
2. Generate a report that includes discussion of the following:
 - The appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.
 - The appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both.
 - The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.
 - Education, training, and research issues as they pertain to such therapeutic interventions.
- Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.
3. Inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.

As part of the fulfillment of its charge, the task force undertook an extensive review of the recent literature on psychotherapy and the psychology of sexual orientation. There is a growing body of evidence concluding that sexual stigma, manifested as prejudice and discrimination directed at non-heterosexual sexual orientations and identities, is a major source of stress for sexual minorities.* This stress, known as *minority stress*, is a factor in mental health disparities found in some sexual minorities. The minority stress model also provides a framework for considering psychotherapy with sexual minorities, including understanding stress, distress, coping, resilience, and recovery. For instance, the affirmative approach to psychotherapy grew out of an awareness that sexual minorities benefit

* We use the term *sexual minority* (cf. Blumenfeld, 1992; McCarn & Fassinger, 1996; Ullerstam, 1966) to designate the entire group of individuals who experience significant erotic and romantic attractions to adult members of their own sex, including those who experience attractions to members of their own and of the other sex. This term is used because we recognize that not all sexual minority individuals adopt a lesbian, gay, or bisexual identity.

when the sexual stigma they experience is addressed in psychotherapy with interventions that reduce and counter internalized stigma and increase active coping.

The task force, in recognition of human diversity, conceptualized affirmative interventions within the domain of cultural competence, consistent with general multicultural approaches that acknowledge the importance of age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. We see this multiculturally competent and affirmative approach as grounded in an acceptance of the following scientific facts:

- Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they do not indicate either mental or developmental disorders.
- Homosexuality and bisexuality are stigmatized, and this stigma can have a variety of negative consequences (e.g., minority stress) throughout the life span.
- Same-sex sexual attractions and behavior occur in the context of a variety of sexual orientations and sexual orientation identities, and for some, sexual orientation identity (i.e., individual or group membership and affiliation, self-labeling) is fluid or has an indefinite outcome.
- Gay men, lesbians, and bisexual individuals form stable, committed relationships and families that are equivalent to heterosexual relationships and families in essential respects.
- Some individuals choose to live their lives in accordance with personal or religious values (i.e., telic congruence).

Summary of the Systematic Review of the Literature

Efficacy and Safety

In order to ascertain whether there was a research basis for revising the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998) and providing more specific recommendations to licensed mental health practitioners, the public, and policymakers, the task force performed a systematic

review of the peer-reviewed literature to answer three questions:

- Are sexual orientation change efforts (SOCE)** effective at changing sexual orientation?
- Are SOCE harmful?
- Are there any additional benefits that can be reasonably attributed to SOCE?

The review covered the peer-reviewed journal articles in English from 1960 to 2007. Most studies in this area were conducted before 1981, and only a few studies have been conducted in the last 10 years. We found serious methodological problems in this area of research; only a few studies met the minimal standards for evaluating whether psychological treatments such as efforts to change sexual orientation are effective. Few studies—all conducted in the period from 1969 to 1978—could be considered true experiments or quasi-experiments that would isolate and control the factors that might effect change (Birk, Huddleston, Miller, & Cohler, 1971; S. James, 1978; McConaghy, 1969, 1976; McConaghy, Proctor, & Barr, 1972; Tanner, 1974, 1975). Only one of these studies (Tanner, 1974) actually compared people who received a treatment with people who did not and could therefore rule out the possibility that other things, such as being motivated to change, were the true cause of any change the researchers observed in the study participants.

None of the recent research (1999–2007) meets methodological standards that permit conclusions regarding efficacy or safety. The few high-quality studies of SOCE conducted recently are qualitative (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001); although they aid in an understanding of the population that undergoes sexual orientation change, they do not provide the kind of information needed for definitive answers to questions of safety and efficacy. Given the limited amount of methodologically sound research, claims that recent SOCE is effective are not supported.

We concluded that the early high-quality evidence is the best basis for predicting what the outcome of valid interventions would be. These studies show that

** In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

enduring change to an individual's sexual orientation is uncommon. The participants in this body of research continued to experience same-sex attractions following SOCE and did not report significant change to other-sex attractions that could be empirically validated, though some showed lessened physiological arousal to sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and of engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. Thus, the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through SOCE.

We found that there was some evidence to indicate that individuals experienced harm from SOCE. Early studies documented iatrogenic effects of aversive forms of SOCE. These negative side effects included loss of sexual feeling, depression, suicidality, and anxiety. High dropout rates characterized early aversive treatment studies and may be an indicator that research participants experienced these treatments as harmful. Recent research reports on religious and nonaversive efforts indicate that there are individuals who perceive they have been harmed. Across studies, it is unclear what specific individual characteristics and diagnostic criteria would prospectively distinguish those individuals who will later perceive that they been harmed by SOCE.

Individuals Who Seek SOCE and Their Experiences

Although the recent SOCE research cannot provide conclusions regarding efficacy or safety, it does provide some information on those individuals who participate in change efforts. SOCE research identified a population of individuals who experienced conflicts and distress related to same-sex attractions. The vast majority of people who participated in the early studies were adult White males, and many of these individuals were court-mandated to receive treatment. In the research conducted over the last 10 years, the population was mostly well-educated individuals, predominantly men, who consider religion to be an extremely important part of their lives and participate in traditional or conservative faiths (e.g., The Church of Jesus Christ of Latter-Day Saints, evangelical Christianity, and Orthodox Judaism). These recent

studies included a small number of participants who identified as members of ethnic minority groups, and a few studies included women.

Most of the individuals studied had tried a variety of methods to change their sexual orientation, including psychotherapy, support groups, and religious efforts. Many of the individuals studied were recruited from groups endorsing SOCE. The relation between the characteristics of the individuals in samples used in these studies and the entire population of people who seek SOCE is unknown because the studies have relied entirely on convenience samples.

Former participants in SOCE reported diverse evaluations of their experiences: Some individuals perceived that they had benefited from SOCE, while others perceived that they had been harmed. Individuals who failed to change sexual orientation, while believing they should have changed with such efforts, described their experiences as a significant cause of emotional and spiritual distress and negative self-image. Other individuals reported that SOCE was helpful—for example, it helped them live in a manner consistent with their faith. Some individuals described finding a sense of community through religious SOCE and valued having others with whom they could identify. These effects are similar to those provided by mutual support groups for a range of problems, and the positive benefits reported by participants in SOCE, such as reduction of isolation, alterations in how problems are viewed, and stress reduction, are consistent with the findings of the general mutual support group literature. The research literature indicates that the benefits of SOCE mutual support groups are not unique and can be provided within an affirmative and multiculturally competent framework, which can mitigate the harmful aspects of SOCE by addressing sexual stigma while understanding the importance of religion and social needs.

Recent studies of participants who have sought SOCE do not adequately distinguish between *sexual orientation* and *sexual orientation identity*. We concluded that the failure to distinguish these aspects of human sexuality has led SOCE research to obscure what actually can or cannot change in human sexuality. The available evidence of both early and recent studies suggests that although sexual orientation is unlikely to change, some individuals modified their sexual orientation identity (e.g., individual or group membership and affiliation, self-labeling) and other aspects of sexuality (e.g., values and behavior). They did so in a variety of ways and with varied and

unpredictable outcomes, some of which were temporary. For instance, in some research, individuals, through participating in SOCE, became skilled in ignoring or tolerating their same-sex attractions. Some individuals reported that they went on to lead outwardly heterosexual lives, developing a sexual relationship with an other-sex partner, and adopting a heterosexual identity. These results were less common for those with no prior heterosexual experience.

Literature on Children and Adolescents

To fulfill part of the task force charge, we reviewed the limited research on child and adolescent issues and drew the following conclusions: There is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation. The few studies of children with gender identity disorder found no evidence that psychotherapy provided to those children had an impact on adult sexual orientation. There is currently no evidence that teaching or reinforcing stereotyped gender-normative behavior in childhood or adolescence can alter sexual orientation. We have concerns that such interventions may increase self-stigma and minority stress and ultimately increase the distress of children and adolescents.

We were asked to report on adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation. The limited published literature on these programs suggests that many do not present accurate scientific information regarding same-sex sexual orientations to youths and families, are excessively fear-based, and have the potential to increase sexual stigma. These efforts pose challenges to best clinical practices and professional ethics, as they potentially violate current practice guidelines by not providing treatment in the least-restrictive setting possible, by not protecting client autonomy, and by ignoring current scientific information on sexual orientation.

Recommendations and Future Directions

Practice

The task force was asked to report on the appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual

orientation or their behavioral expression of their sexual orientation, or both. The clinical literature indicated that adults perceive a benefit when they are provided with client-centered, multicultural, evidence-based approaches that provide (a) acceptance and support, (b) a comprehensive assessment, (c) active coping, (d) social support, and (e) identity exploration and development. Acceptance and support include unconditional acceptance of and support for the various aspects of the client; respect for the client's values, beliefs, and needs; and a reduction in internalized sexual stigma. Comprehensive assessment involves an awareness of the complete person, including mental health concerns that could impact distress about sexual orientation. Active coping includes both cognitive and emotional strategies to manage stigma and conflicts, including the development of alternative cognitive frames to resolve cognitive dissonance and the facilitation of affective expression and resolution of losses. Social support, which can mitigate distress caused by isolation, rejection, and lack of role models, includes psychotherapy, self-help groups, or welcoming communities (e.g., ethnic communities, social groups, religious denominations). Identity exploration and development include offering permission and opportunity to explore a wide range of options and reducing the conflicts caused by dichotomous or conflicting conceptions of self and identity without prioritizing a particular outcome.

This framework is consistent with multicultural and evidence-based practices in psychotherapy and is built on three key findings:

- Our systematic review of the early research found that enduring change to an individual's sexual orientation was unlikely.
- Our review of the scholarly literature on individuals distressed by their sexual orientation indicated that clients perceived a benefit when offered interventions that emphasize acceptance, support, and recognition of important values and concerns.
- Studies indicate that experiences of stigma—such as self-stigma, shame, isolation and rejection from relationships and valued communities, lack of emotional support and accurate information, and conflicts between multiple identities and between values and attractions—played a role in creating distress in individuals. Many religious individuals desired to live their lives in a manner consistent with their values (telic congruence); however, telic

congruence based on stigma and shame is unlikely to result in psychological well-being.

In terms of formulating the goals of treatment, we propose that, on the basis of research on sexual orientation and sexual orientation identity, what appears to shift and evolve in some individuals' lives is sexual orientation identity, not sexual orientation. Given that there is diversity in how individuals define and express their sexual orientation identity, an affirmative approach is supportive of clients' identity development without an a priori treatment goal concerning how clients identify or live out their sexual orientation or spiritual beliefs. This type of therapy can provide a safe space where the different aspects of the evolving self can be acknowledged, explored, respected, and potentially rewoven into a more coherent sense of self that feels authentic to the client, and it can be helpful to those who accept, reject, or are ambivalent about their same-sex attractions. The treatment does not differ, although the outcome of the client's pathway to a sexual orientation identity does. Other potential targets of treatment are emotional adjustment, including shame and self-stigma, and personal beliefs, values, and norms.

We were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or the behavioral expression of their sexual orientation, or both, or whose parent or guardian expresses a desire for the minor to change. The framework proposed for adults (i.e., acceptance and support, a comprehensive assessment, active coping, social support, and identity exploration and development) is also pertinent—with unique relevant features—to children and adolescents. For instance, the clinical

For parents who are concerned or distressed by their child's sexual orientation, licensed mental health providers (LMHP) can provide accurate information about sexual orientation and sexual orientation identity and can offer anticipatory guidance and psychotherapy that support family reconciliation.

literature stresses interventions that accept and support the development of healthy self-esteem, facilitate the achievement of appropriate developmental milestones—including the development of a positive identity—and reduce internalized sexual stigma.

Research indicates that family interventions that reduce rejection and increase acceptance of their child and adolescent are helpful. For parents who are concerned or distressed by their child's sexual orientation, licensed mental health providers (LMHP) can provide accurate information about sexual orientation and sexual orientation identity and can offer anticipatory guidance and psychotherapy that support family reconciliation (e.g., communication, understanding, and empathy) and maintenance of the child's total health and well-being.

Additionally, the research and clinical literature indicates that increasing social support for sexual minority children and youth by intervening in schools and communities to increase their acceptance and safety is important. Services for children and youth should support and respect age-appropriate issues of self-determination; services should also be provided in the least restrictive setting that is clinically possible and should maximize self-determination. At a minimum, the assent of the youth should be obtained, including whenever possible a developmentally appropriate informed consent to treatment.

Some religious individuals with same-sex attractions experience psychological distress and conflict due to the perceived irreconcilability of their sexual orientation and religious beliefs. The clinical and research literature encourages the provision of acceptance, support, and recognition of the importance of faith to individuals and communities while recognizing the science of sexual orientation. This includes an understanding of the client's faith and the psychology of religion, especially issues such as religious coping, motivation, and identity. Clients' exploration of possible life paths can address the reality of their sexual orientation and the possibilities for a religiously and spiritually meaningful and rewarding life. Such psychotherapy can enhance clients' search for meaning, significance, and a relationship with the sacred in their lives; increase positive religious coping; foster an understanding of religious motivations; help integrate religious and sexual orientation identities; and reframe sexual orientation identities to reduce self-stigma.

LMHP strive to provide interventions that are consistent with current ethical standards. The APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002b) and relevant APA guidelines and resolutions (e.g., APA, 2000, 2002c, 2004, 2005a, 2007b) are resources for psychologists, especially Ethical Principles A (Beneficence and Nonmaleficence), D (Justice), and E (Respect for People's Rights and

Dignity, including self-determination). For instance, LMHP reduce potential harm and increase potential benefits by basing their scientific and professional judgments and actions on the most current and valid scientific evidence, such as the evidence provided in this report (see APA, 2002b, Standard 2.04, Bases for Scientific and Professional Judgments). LMHP enhance principles of social justice when they strive to understand the effects of sexual stigma, prejudice, and discrimination on the lives of individuals, families, and communities. Further, LMHP aspire to respect diversity in all aspects of their work, including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, and socioeconomic status.

Self-determination is the process by which a person controls or determines the course of her or his own life (according to the *Oxford American Dictionary*, 2007). LMHP maximize self-determination by (a) providing effective psychotherapy that explores the client's assumptions and goals, without preconditions on the outcome; (b) providing resources to manage and reduce distress; and (c) permitting the client to decide the ultimate goal of how to self-identify and live out her or his sexual orientation. Although some accounts suggest that providing SOCE increases self-determination, we were not persuaded by this argument, as it encourages LMHP to provide treatment that has not provided evidence of efficacy, has the potential to be harmful, and delegates important professional decisions that should be based on qualified expertise and training—such as diagnosis and type of therapy. Rather, therapy that increases the client's ability to cope, understand, acknowledge, and integrate sexual orientation concerns into a self-chosen life is the measured approach.

Education and Training

The task force was asked to provide recommendations on education and training for LMHP working with this population. We recommend that mental health professionals working with individuals who are considering SOCE learn about evidence-based and multicultural interventions and obtain additional knowledge, awareness, and skills in the following areas:

- Sexuality, sexual orientation, and sexual identity development.
- Various perspectives on religion and spirituality, including models of faith development, religious coping, and the positive psychology of religion.

- Identity development, including integration of multiple identities and the resolution of identity conflicts.
- The intersections of age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status.
- Sexual stigma and minority stress.

We also recommend that APA (a) take steps to encourage community colleges, undergraduate programs, graduate school training programs, internship sites, and postdoctoral programs in psychology to include this report and other relevant material on lesbian, gay, bisexual, and transgender (LGBT) issues in their curriculum; (b) maintain the currently high standards for APA approval of continuing professional education providers and programs; (c) offer symposia and continuing professional education workshops at APA's annual convention that focus on treatment of individuals distressed by their same-sex attractions, especially those who struggle to integrate religious and spiritual beliefs with sexual orientation identities; and (d) disseminate this report widely, including publishing a version of this report in an appropriate journal or other publication.

The information available to the public about SOCE is highly variable and can be confusing and misleading. Sexual minorities, individuals aware of same-sex attractions, families, parents, caregivers, policymakers, the public, and religious leaders can benefit from accurate scientific information about sexual orientation and the appropriate interventions for individuals distressed by their same-sex attractions. We recommend that APA take the lead in creating informational materials for sexual minority individuals, families, parents, and other stakeholders, including religious organizations, on appropriate multiculturally competent and client-centered interventions for those distressed by their sexual orientation and who may seek SOCE. We also recommended that APA collaborate with other relevant organizations, especially religious organizations, to disseminate this information.

Research

The task force was asked to provide recommendations for future research. We recommend that researchers and practitioners investigate multiculturally competent and affirmative evidence-based treatments for sexual

minorities that do not aim to alter sexual orientation. For such individuals, the focus would be on frameworks that include acceptance and support, a comprehensive assessment, active coping, social support, and identity exploration and development without prioritizing one outcome over another.

The research on SOCE has not adequately assessed efficacy and safety. Any future research should conform to best-practice standards for the design of efficacy research. Research on SOCE would (a) use methods that are prospective and longitudinal; (b) employ sampling methods that allow proper generalization; (c) use appropriate, objective, and high-quality measures of sexual orientation and sexual orientation identity; (d) address preexisting and co-occurring conditions, mental health problems, other interventions, and life histories to test competing explanations for any changes; (e) address participants' biases and potential need for monitoring self-impression and life histories; and (f) include measures capable of assessing harm.

Council of Representatives adopt a new resolution, the **Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts**, to address these issues. [The Council adopted the resolution in August 2009.] (See Appendix A.)

Policy

The task force was asked to inform (a) the association's response to groups that promote treatments to change sexual orientation or its behavioral expression and (b) public policy that furthers affirmative therapeutic interventions. We encourage APA to continue its advocacy for LGBT individuals and families and to oppose stigma, prejudice, discrimination, and violence directed at sexual minorities. We recommend that APA take a leadership role in opposing the distortion and selective use of scientific data about homosexuality by individuals and organizations and in supporting the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias. We encourage APA to engage in collaborative activities with religious communities in pursuit of shared prosocial goals when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles.

The 1997 Resolution on Appropriate Responses to Sexual Orientation (APA, 1998) focuses on ethical issues for practitioners and still serves this purpose. However, on the basis of (a) our systematic review of efficacy and safety issues, (b) the presence of SOCE directed at children and adolescents, (c) the importance of religion for those who currently seek SOCE, and (d) the ideological and political disputes that affect this area, the task force recommended that the APA

PREFACE

In February 2007, the American Psychological Association (APA) established the Task Force on Appropriate Therapeutic Responses to Sexual Orientation and charged the task force with three major tasks:

1. Review and update the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998);
2. Generate a report that includes discussion of the following:
 - The appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.
 - The appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both.
 - The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.
 - Education, training, and research issues as they pertain to such therapeutic interventions.
- Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.
3. Inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.

Nominations of task force members were solicited through an open process that was widely publicized through professional publications, electronic media, and organizations. The qualifications sought were (a) advanced knowledge of current theory and research on the development of sexual orientation; (b) advanced knowledge of current theory and research on therapies that aim to change sexual orientation; and (c) extensive expertise in affirmative mental health treatment for one or more of the following populations: children and adolescents who present with distress regarding their sexual orientation, religious individuals in distress regarding their sexual orientation, and adults who present with desires to their change sexual orientation or have undergone therapy to do so. An additional position was added for an expert in research design and methodology.

Nominations were open to psychologists, qualified counselors, psychiatrists, or social workers, including members and nonmembers of APA. Nominations of

ethnic minority psychologists, bisexual psychologists, psychologists with disabilities, transgender psychologists, and other psychologists who are members of underrepresented groups were welcomed. In April 2007, then-APA President Sharon Stephens Brehm, PhD, appointed the following people to serve on the task force: Judith M. Glassgold, PsyD (chair); Lee Beckstead, PhD; Jack Drescher, MD; Beverly Greene, PhD; Robin Lin Miller, PhD; and Roger L. Worthington, PhD.

The task force met face-to-face twice in 2007 and supplemented these meetings with consultation and collaboration via teleconference and the Internet. Initially, we reviewed our charge and defined necessary bodies of scientific and professional literature to review to meet that charge. In light of our charge to review the 1997 resolution, we concluded that the most important task was to review the existing scientific literature on treatment outcomes of sexual orientation change efforts (SOCE).

We also concluded that a review of research before 1997 as well as since 1997 was necessary to provide a complete and thorough evaluation of the scientific literature. Thus, we conducted a review of the available empirical research on treatment efficacy and results published in English from 1960 on and also used common databases such as PsycINFO and Medline, as well as other databases such as the ATLA Religion Database, LexisNexis, Social Work Abstracts, and Sociological Abstracts, to review evidence regarding harm and benefit from SOCE. The literature review for other areas of the report was also drawn from these databases and included lay sources such as GoogleScholar and material found through Internet searches. Due to our charge, we limited our review to sexual orientation and did not address gender identity, because the final report of another task force, the APA Task Force on Gender Identity and Gender Variance, was forthcoming (see APA, 2009).

The task force received comments from the public, professionals, and other organizations and read all comments received. We also welcomed submission of material from the interested public, mental health professionals, organizations, and scholarly communities. All nominated individuals who were not selected for the task force were invited to submit suggestions for articles and other material for us to review. We reviewed all material received. Finally, APA staff met with interested parties to understand their concerns.

The writing of the report was completed in 2008, with editing and revisions occurring in 2009. After a draft report was generated in 2008, we asked for professional

review by noted scholars in the area who were also APA members. Additionally, APA boards and committees were asked to select reviewers to provide feedback. After these reviews were received, the report was revised in line with these comments. In 2009, a second draft was sent to a second group of reviewers, including those who had previously reviewed the report, scholars in the field (including some who were not members of APA), representatives of APA boards and committees, and APA staff. The task force consulted with Nathalie Gilfoyle, JD, of the APA Office of General Counsel, as well as with Stephen Behnke, PhD, JD, of the APA Ethics Office. Other staff members of APA were consulted as needed.

We would like to thank the following two individuals who were essential to the accomplishment of our charge: Clinton W. Anderson, PhD, and Charlene DeLong, Dr. Anderson's knowledge of the field of LGBT psychology as well as his sage counsel, organizational experience, and editorial advice and skills were indispensable. Ms. DeLong was fundamental in providing technological support and aid in coordinating the activities of the task force.

We appreciate the assistance of Maria T. Valenti, MA, in conducting the research review and in organizing the tables. Mary Campbell also provided editorial advice on the report, and Stephanie Liotta provided assistance in preparing the final manuscript. We are grateful to David Spears for designing the report.

We would also like to acknowledge 2007 APA President Sharon Stephens Brehm, PhD, who was supportive of our goals and provided invaluable perspective at our first meeting, and to thank Alan E. Kazdin, PhD, past president, James H. Bray, PhD, president, and Carol D. Goodheart, EdD, president-elect, for their support. Douglas C. Haldeman, PhD, served as the Board of Director's liaison to the task force in 2007–2008 and provided counsel and expertise. Melba J.T. Vasquez, PhD, Michael Wertheimer, PhD, and Armand R. Cerbone, PhD, members of the APA Board of Directors, also reviewed this report and provided feedback.

We would very much like to thank Gwendolyn Puryear Keita, PhD, the executive director of the APA Public Interest Directorate, for her advice, support, and expertise. In addition, we acknowledge Rhea Farberman, executive director, and Kim Mills, associate executive director, of the APA Public and Member Communications office, for their expertise and support. Stephen H. Behnke, PhD, director of the APA Ethics

Office, and Nathalie Gilfoyle, APA Office of the General Counsel, provided valuable feedback on the report.

We acknowledge the following individuals, who served as scholarly reviewers of the first and second drafts of the report; their feedback on the content was invaluable (in alphabetical order): Eleonora Bartoli, PhD; Rosie Phillips Bingham, PhD; Elizabeth D. Cardoso, PhD; June W. J. Ching, PhD; David Michael Corey, PhD; Isiaah Crawford, PhD; Anthony D'Augelli, PhD; Sari H. Dworkin, PhD; Randall D. Ehrbar, PsyD; Angela Rose Gillem, PhD; Terry Sai-Wah Gock, PhD; Marvin R. Goldfried, PhD; John C. Gonsiorek, PhD; Perry N. Halkitis, PhD; Kristin A. Hancock, PhD; J. Judd Harbin, PhD; William L. Hathaway, PhD; Gregory M. Herek, PhD; W. Brad Johnson, PhD; Jon S. Lasser, PhD; Alicia A. Lucksted, PhD; Connie R. Matthews, PhD; Kathleen M. Ritter, PhD; Darryl S. Salvador, PsyD; Jane M. Simoni, PhD; Lori C. Thomas, JD, PhD; Warren Throckmorton, PhD; Bianca D. M. Wilson, PhD; Mark A. Yarhouse, PsyD; and Hirokazu Yoshikawa, PhD.

1. INTRODUCTION

In the mid-1970s, on the basis of emerging scientific evidence and encouraged by the social movement for ending sexual orientation discrimination, the American Psychological Association (APA) and other professional organizations affirmed that homosexuality per se is not a mental disorder and rejected the stigma of mental illness that the medical and mental health professions had previously placed on sexual minorities.¹ This action, along with the earlier action of the American Psychiatric Association that removed *homosexuality* from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*; American Psychiatric Association, 1973), helped counter the social stigma that the mental illness concept had helped to create and maintain. Through the 1970s and 1980s, APA and its peer organizations not only adopted a range of position statements supporting nondiscrimination on the basis of sexual orientation (APA, 1975, 2005a; American Psychiatric Association, 1973; American Psychoanalytic Association, 1991, 1992; National Association of Social Workers [NASW], 2000) but also acted on the basis of those positions to advocate for legal and policy changes (APA, 2003, 2005a, 2008b; NASW, 2000). On the basis of growing scientific evidence (Gonsiorek, 1991), licensed mental health providers

(LMHP)² of all professions increasingly took the perspective throughout this period that homosexuality per se is a normal variant³ of human sexuality and that lesbian, gay, and bisexual (LGB) people deserve to be affirmed and supported in their sexual orientation,⁴ relationships, and social opportunities. This approach to psychotherapy is generally termed *affirmative*, *gay affirmative*, or *lesbian, gay, and bisexual (LGB) affirmative*.

Consequently, the published literature on psychotherapeutic efforts to change sexual orientation that had been relatively common during the 1950s and 1960s began to decline, and approaches to psychotherapy that were not LGB affirmative came under increased scrutiny (cf. Mitchell, 1978; G.T. Wilson & Davison, 1974). The mainstream organizations for psychoanalysis and behavior therapy—the two types of therapeutic orientation most associated with the published literature on sexual orientation change therapies—publicly rejected these practices (American Psychoanalytic Association, 1991, 1992; Davison, 1976, 1978; Davison & Wilson, 1973; D. J. Martin, 2003).

² We use the term *licensed mental health providers* (LMHP) to refer to professional providers of mental health services with a variety of educational credentials and training backgrounds, because state licensure is the basic credential for independent practice.

³ We use the adjective *normal* to denote both the absence of a mental disorder and the presence of a positive and healthy outcome of human development.

⁴ We define sexual orientation as an individual's patterns of erotic, sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics (see pp. 29–32 for a more detailed discussion).

¹ We use the term *sexual minority* (cf. Blumenfeld, 1992; McCarn & Fassinger, 1996; Ullerstam, 1966) to designate the entire group of individuals who experience significant erotic and romantic attractions to adult members of their own sex, including those who experience attractions to members of their own and of the other sex. This term is used because we recognize that not all sexual minority individuals adopt a lesbian, gay, or bisexual identity.

In the early 1990s, some APA members began to express concerns about the resurgence of individuals and organizations that actively promoted the idea of homosexuality as a developmental defect or a spiritual and moral failing and that advocated psychotherapy and religious ministry to alter homosexual feelings and behaviors, because these practices seemed to be an attempt to repathologize sexual minorities (Drescher & Zucker, 2006; Haldeman, 1994; S. L. Morrow & Beckstead, 2004). Many of the individuals and organizations appeared to be embedded within conservative political and religious movements that supported the stigmatization of homosexuality (Drescher, 2003; Drescher & Zucker, 2006; Southern Poverty Law Center [SPLC], 2005).

The concerns led to APA's adoption in 1997 of the Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998). In the resolution, APA reaffirmed the conclusion shared by all mainstream health and mental health professions that homosexuality is not a mental disorder and rejected any form of discrimination based on sexual orientation. In addition, APA highlighted the ethical issues that are raised for psychologists when clients present with a request to change their sexual orientation—issues such as bias, deception, competence, and informed consent (APA, 1998; Schneider, Brown, & Glassgold, 2002). APA reaffirmed in this resolution its opposition to “portrayals of lesbian, gay, and bisexual youths and adults as mentally ill due to their sexual orientation” and defined appropriate interventions as those that “counteract bias that is based in ignorance or unfounded beliefs about sexual orientation” (APA, 1998, p. 934).

In the years since APA's adoption of the 1997 resolution, there have been several developments that have led some APA members to believe that the resolution needed to be reevaluated. First, several professional mental health and medical associations adopted resolutions that opposed sexual orientation change efforts (SOCE)⁵ on the basis that such efforts were ineffective and potentially harmful (e.g., American Counseling Association, 1998; American Psychiatric Association, 2000; American Psychoanalytic Association, 2000; NASW, 1997). In most cases, these statements

were substantially different from APA's position, which did not address questions of efficacy or safety of SOCE.

Second, several highly publicized research reports on samples of individuals who had attempted sexual orientation change (e.g., Nicolosi, Byrd, & Potts, 2000; Shidlo & Schroeder, 2002; Spitzer, 2003) and other empirical and theoretical advances in the understanding of sexual orientation were published (e.g., Blanchard, 2008; Chivers, Seto, & Blanchard, 2007; Cochran & Mays, 2006; Diamond, 2008; Diaz, Ayala, & Bein, 2004; DiPlacido, 1998; Harper, Jernewall, & Zea, 2004; Herek, 2009; Herek & Garnets, 2007; Mays & Cochran, 2001; Meyer, 2003; Mustanski, Chivers, & Bailey, 2002; Rahman & Wilson, 2005; Savic & Lindstrom 2008; Szymanski, Kashubeck-West, & Meyer, 2008).

Third, advocates who promote SOCE as well as those who oppose SOCE have asked that APA take action on the issue. On the one hand, professional organizations and advocacy groups that believe that sexual orientation change is unlikely, that homosexuality is a normal variant of human sexuality, and that efforts to change sexual orientation are potentially harmful⁶ wanted APA to take a clearer stand and to clarify the conflicting media reports about the likelihood of sexual orientation change (cf. Drescher, 2003; Stålström & Nissinen, 2003). On the other hand, the proponents of SOCE that consist of organizations that adopt a disorder model of homosexuality and/or advocate a religious view of homosexuality as sinful or immoral wanted APA to clearly declare that consumers have the right to choose SOCE (Nicolosi, 2003; Nicolosi & Nicolosi, 2002; Rosik, 2001).

For these reasons, in 2007, APA established the Task Force on Appropriate Therapeutic Responses to Sexual Orientation, with the following charge:

1. Revise and update the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998);
2. Generate a report that includes discussion of the following:
 - The appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or

⁵ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

⁶ Two advocacy organizations (Truth Wins Out and Lambda Legal) are encouraging those who feel they were harmed by SOCE to seek legal action against their providers.

whose guardian expresses a desire for the minor to change.

- The appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both.
 - The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.
 - Education, training, and research issues as they pertain to such therapeutic interventions.
 - Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.
3. Inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.

The task force addressed its charge by completing a review and analysis of the broad psychological literature in the field. After reviewing the existing 1997 resolution in light of this literature review, we concluded that a new resolution was necessary. The basis for this conclusion, including a review and analysis of the extant research, is presented in the body of this report, and a new resolution, adopted in August 2009 by the APA Council of Representatives, is presented in Appendix A.

The report starts with a brief review of the task force charge and the psychological issues that form the foundation of the report. The second chapter is a brief history of the evolution of psychotherapy, from treatments based on the idea that homosexuality is a disorder to those that focus on affirmative approaches to sexual orientation diversity. Chapters 3 and 4 are a review of the peer-reviewed research on SOCE: Chapter 3 provides a methodological evaluation of this research, and Chapter 4 reports on the outcomes of this research. Chapter 5 reviews a broader base of literature regarding the experience of individuals who seek SOCE in order to elucidate the nature of clients' distress and identity conflicts. Chapter 6 then examines affirmative approaches for psychotherapy practice with adults and presents a specific framework for interventions. Chapter

7 returns to the 1997 APA resolution and its focus on ethics to provide an updated discussion of the ethical issues surrounding SOCE. Chapter 8 considers the more limited body of research on SOCE and reports of affirmative psychotherapy with children, adolescents, and their families. Chapter 9 summarizes the report and presents recommendations for research, practice, education, and policy. The policy resolution that the task force recommended and that was adopted by the APA Council of Representatives on August, 5, 2009, is in Appendix A.

Laying the Foundation of the Report

Understanding Affirmative Therapeutic Interventions

The task force was asked to report on appropriate application of affirmative psychotherapeutic interventions for those who seek to change their sexual orientation. As some debates in the field frame SOCE and conservative religious values as competing viewpoints to affirmative approaches (cf. Throckmorton, 1998; Yarhouse, 1998a) and imply that there is an alternative "neutral" stance, we considered it necessary to explain the term *affirmative therapeutic interventions*, its history, its relationship to our charge and to current psychotherapy literature, and our application and definition of the term.

The concept of gay-affirmative therapeutic interventions emerged in the early literature on the psychological concerns of sexual minorities (Malyon, 1982; Paul, Weinrich, Gonsiorek, & Hotvedt, 1982), and its meaning has evolved over the last 25 years to include more diversity and complexity (APA, 2000; Bieschke, Perez, & DeBord, 2007; Firestein, 2007; Herek & Garnets, 2007; Perez, DeBord, & Bieschke, 2000; Ritter & Terndrup, 2002). The affirmative approach grew out of a perception that sexual minorities benefit from psychotherapeutic interventions that address the sexual stigma⁷ they experience and the impacts of stigma on their lives (APA, 2000; Brown, 2006; Browning, Reynolds, & Dworkin, 1991; Davison, 1978; Malyon, 1982; Pachankis & Goldfried, 2004; Ritter & Terndrup, 2002; Shannon & Woods, 1991; Sophie, 1987). For example, Garnets, Hancock, Cochran, Goodchilds, and Peplau (1991) proposed that LHMP use an understanding of societal prejudice and

⁷ See p. 15 for the definition of *sexual stigma*.

discrimination to guide treatment for sexual minority clients and help these clients overcome negative attitudes about themselves.

The most recent literature in the field (e.g., APA, 2000, 2002c, 2004, 2005b, 2007b; Bartoli & Gillem, 2008; Brown, 2006; Herek & Garnets, 2007) places affirmative therapeutic interventions within the larger domain of cultural competence, consistent with general multicultural approaches. Multicultural approaches recognize that individuals, families, and communities exist in social, political, historical, and economic contexts (cf. APA, 2002b) and that human diversity is multifaceted and includes age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. Understanding and incorporating these aspects of diversity are important to any intervention (APA, 2000, 2002c, 2004, 2005b, 2007b).

The task force takes the perspective that a multiculturally competent and affirmative approach with sexual minorities is based on the scientific knowledge in key areas: (a) homosexuality and bisexuality are stigmatized, and this stigma can have a variety of negative consequences throughout the life span (D'Augelli & Patterson, 1995, 2001); (b) same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality and are not indicators of either mental or developmental disorders (American Psychiatric Association, 1973; APA, 2000; Gonsiorek, 1991); (c) same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientation identities (Diamond, 2006, 2008; Klein, Sepekoff, & Wolf, 1985; McConaghy, 1999); and (d) lesbians, gay men, and bisexual people can live satisfying lives and form stable, committed relationships and families that are equivalent to heterosexuals' relationships and families in essential respects (APA, 2005c; Kurdek, 2001, 2003, 2004; Peplau & Fingerhut, 2007).

Although affirmative approaches have historically been conceptualized around helping sexual minorities

We define an affirmative approach as supportive of clients' identity development without a priori treatment goals for how clients identify or express their sexual orientations.

identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation identity are

accept and adopt a gay or lesbian identity (e.g., Browning et al., 1991; Shannon & Woods, 1991), the recent research on sexual orientation

labeled and expressed in many different ways, some of which are fluid (e.g., Diamond, 2006, 2008; Firestein, 2007; Fox, 2004; Patterson, 2008; Savin-Williams, 2005; R. L. Worthington & Reynolds, 2009). We define an affirmative approach as supportive of clients' identity development without a priori treatment goals for how clients identify or express their sexual orientations. Thus, a multiculturally competent affirmative approach aspires to understand the diverse personal and cultural influences on clients and enables clients to determine (a) the ultimate goals for their identity process; (b) the behavioral expression of their sexual orientation; (c) their public and private social roles; (d) their gender roles, identities, and expression⁸; (e) the sex⁹ and gender of their partner; and (f) the forms of their relationships.

EVIDENCE-BASED PRACTICE AND EMPIRICALLY SUPPORTED TREATMENTS

Interest in the efficacy,¹⁰ effectiveness, and empirical basis of psychotherapeutic interventions has grown in the last decade. Levant and Hasan (2009) distinguished between two types of treatments: empirically supported treatments (EST) and evidence-based approaches to psychotherapy (EBPP). EST are interventions for individuals with specific disorders; these interventions have been demonstrated to be effective through rigorously controlled trials (Levant & Hasan, 2009). EBPP is, as defined by APA's Policy Statement on Evidence-Based Practice in Psychology¹¹ (2005a), "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 1; see also, Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996).

We were not able to identify affirmative EST for this population (cf. Martell, Safran, & Prince, 2004).

⁸ *Gender* refers to the cultural roles, behaviors, activities, and psychological attributes that a particular society considers appropriate for men and women. *Gender identity* is a person's own psychological sense of identification as male or female, another gender, or identifying with no gender. *Gender expression* is the activities and behaviors that purposely or inadvertently communicate one's gender identity to others, such as clothing, hairstyles, mannerisms, way of speaking, and social roles.

⁹ We define *sex* as biological maleness and femaleness in contrast to gender, defined above.

¹⁰ *Efficacy* is the measurable effect of an intervention, and *effectiveness* aims to determine whether interventions have measurable effects in real-world settings across populations (Nathan, Stuart, & Dolan, 2000).

¹¹ Discussion of the overall implications for practice can be found in Goodheart, Kazdin, and Sternberg (2006) and the *Report of the 2005 Presidential Task Force on Evidence-Based Practice* (APA, 2005b).

The lack of EST is a common dilemma when working with diverse populations for whom EST have not been developed or when minority populations have not been included in trials (Brown, 2006; Martell et al., 2004; Sue & Zane, 2006; Whaley & Davis, 2007). Thus, we provide an affirmative model in Chapter 6 that is consistent with APA's definition of EBPP in that it applies the most current and best evidence available to guide decisions about the care of this population (APA, 2005a; Sackett et al., 1996). We considered the APA EBPP resolution as utilizing a flexible concept of evidence, because it incorporates research based on well-designed studies with client values and clinical expertise. Given that the distress surrounding sexual orientation is not included in psychotherapy research (because it is not a clearly defined syndrome) and most treatment studies in psychology are for specific mental health disorders, not for problems of adjustment or identity relevant to sexual orientation concerns, we saw this flexibility as necessary (Brown, 2006). However, EST for specific disorders can be incorporated into this affirmative approach (cf. Martell et al., 2004). We acknowledge that the model presented in this report would benefit from rigorous evaluation.

Affirmative approaches, as understood by this task force, are evidence-based in three significant ways:

- They are based on the evidence that homosexuality is not a mental illness or disorder, which has a significant empirical foundation (APA, 2000; Gonsiorek, 1991).
- They are based on studies of the role of stigma in creating distress and health disparities in sexual minorities (Balsam & Mohr, 2007; Cochran & Mays, 2006; Omoto & Kurtzman, 2006; Pachankis, 2007; Pachankis, Goldfried, & Ramrattan, 2008; Safren & Heimberg, 1999; Syzanski & Kashubeck-West, 2008).
- They are based on the literature that has shown the importance of the therapeutic alliance and relationship on outcomes in therapy and that these outcomes are linked to empathy, positive regard, honesty, and other factors encompassed in the affirmative perspective on therapeutic interventions (Ackerman & Hilsenroth, 2003; Brown, 2006; Farber & Lane, 2002; Horvath & Bedi, 2002; Norcross, 2002; Norcross & Hill, 2004).

The affirmative approach was the subject of a recent literature review that found that clients describe the safety, affirmation, empathy, and nonjudgmental

acceptance inherent in the affirmative approach as helpful in their therapeutic process (M. King, Semlyen, Killaspy, Nazareth, & Osborn, 2007; see also, M. A. Jones & Gabriel, 1999). M. King et al. concluded that a knowledge base about sexual minorities' lives and social context is important for effective practice.

Sexual Stigma

To understand the mental health concerns of sexual minorities, one must understand the social psychological concept of stigma (Herek & Garnets, 2007). Goffman (1963) defined stigma as an undesirable difference that discredits the individual. Link and Phelan (2001) characterized stigma as occurring when (a) individual differences are labeled; (b) these differences are linked to undesirable traits or negative stereotypes; (c) labeled individuals are placed in distinct categories that separate them from the mainstream; and (d) labeled persons experience discrimination and loss of status that lead to unequal access to social, economic, and political power. This inequality is a consequence of stigma and discrimination rather than of the differences themselves (Herek, 2009). Stigma is a fact of the interpersonal, cultural, legal, political, and social climate in which sexual minorities live.

The stigma that defines sexual minorities has been termed *sexual stigma*¹²: "the stigma attached to any non-heterosexual behavior, identity, relationship or community" (Herek, 2009, p. 3). This stigma operates both at the societal level and the individual level. The impact of this stigma as a stressor may be the unique factor that characterizes sexual minorities as a group (Herek, 2009; Herek & Garnets, 2007; Katz, 1995).

Further, stigma has shaped the attitudes of mental health professions and related institutions toward this population (Drescher, 1998b; Haldeman, 1994;

In the late modern period, the medical and mental health professions added a new type of stigmatization and discrimination by conceptualizing and treating homosexuality as a mental illness or disorder.

LeVay, 1996; Murphy, 1997; Silverstein, 1991). Moral and religious values in North America and Europe provided the initial rationale for criminalization, discrimination, and prejudice against same-

¹² Herek (2009) coined this term, and we use it because of the comprehensive analysis in which it is embedded. There are other terms for the same construct, such as Balsam and Mohr's (2007) *sexual orientation stigma*.

sex behaviors (Katz, 1995). In the late modern period, the medical and mental health professions added a new type of stigmatization and discrimination by conceptualizing and treating homosexuality as a mental illness or disorder (Brown, 1996; Katz, 1995).

Sexual minorities may face additional stigmas, as well, such as those related to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. At the societal level, sexual stigma is embedded in social structures through civil and criminal law, social policy, psychology, psychiatry, medicine, religion, and other social institutions. Sexual stigma is reflected in disparate legal and social treatment by institutions and is apparent in, for example, (a) the long history of criminalization of same-sex sexual behaviors; (b) the lack of legal protection for LGB individuals from discrimination in employment, health care, and housing; and (c) the lack of benefits for LGB relationships and families that would support their family formation, in contrast to the extensive benefits that accrue to heterosexual married couples and even sometimes to unmarried heterosexual couples.¹³ The structural sexual stigma, called *heterosexism* in the scholarly literature, legitimizes and perpetuates stigma against sexual minorities and perpetuates the power differential between sexual minorities and others (Herek, 2007; see also Szymanski et al., 2008).

Expressions of stigma, such as violence, discrimination, rejection, and other negative interpersonal interactions, are *enacted stigma* (Herek, 2009). Individuals' expectations about the probability that stigma will be enacted in various situations is *felt stigma*. Individuals' efforts to avoid enacted and felt stigma may include withdrawing from self (e.g., self-denial or compartmentalization) and withdrawing from others (e.g., self-concealment or avoidance) (e.g., see Beckstead & Morrow, 2004; Drescher, 1998b; Malyon, 1982; Pachankis, 2007; Pachankis et al., 2008; Troiden, 1993).

In Herek's (2009) model, *internalized stigma*¹⁴ is the adoption of the social stigma applied to sexual minorities. Members of the stigmatized groups as well as nonmembers of the group can internalize these values. *Self-stigma* is internalized stigma in those individuals who experience same-sex sexual attractions and whose self-concept matches the stigmatizing interpretations of society. Examples of this self-stigma are (a) accepting society's negative evaluation and (b) harboring negative attitudes toward oneself and one's own same-sex sexual attractions. *Sexual prejudice* is the internalized sexual stigma held by the non-stigmatized majority.

The Impact of Stigma on Members of Stigmatized Groups

One of the assumptions of the stigma model is that social stigma influences the individual through its impact on the different settings, contexts, and relationships in which each human being takes part (D'Augelli, 1994). This assumption is supported by a body of literature comparing sexual minority populations to the general population that has found health disparities between the two (Cochran & Mays, 2006; Mays & Cochran, 2001). The concept of minority stress (e.g., DiPlacido, 1998; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Meyer, 1995, 2003) has been increasingly used to explain these health disparities in much the same way that concepts of racism-derived stress and minority stress have been used to explain health disparities and mental health concerns in ethnic minority groups (Carter, 2007; Harrell, 2000; Mays, Cochran, & Barnes, 2007; Saldana, 1994; Wei, Ku, Russell, Mallinckrodt, & Liao, 2008). Theoretically any minority group facing social stigma and prejudice, including stigma due to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, could develop minority stress.

In theory, minority stress—chronic stress experienced by members of minority groups—causes distress in

¹³ Same-sex sexual behaviors were only recent universally decriminalized in the United States by Supreme Court action in *Lawrence v. Texas* (2003). There is no federal protection from employment and housing discrimination for LGB individuals, and only 20 states offer this protection. Only 6 states permit same-sex couples to marry; 6 states have broad recognition laws; 4 states have limited recognition laws; and 2 states recognize other states' marriages. For more examples, see National Gay and Lesbian Task Force, Reports & Research: [http:// www.thetaskforce.org/reports_and_research/reports](http://www.thetaskforce.org/reports_and_research/reports)).

¹⁴ Herek (2009) defined *internalization* as "the process whereby individuals adopt a social value, belief, regulation, or prescription for conduct as their own and experience it as part of themselves" (p. 7). The internalization of negative attitudes and assumptions concerning homosexuality has often been termed *internalized homophobia* (Malyon, 1982; Sophie, 1987; Weinberg, 1972). However, this term has been criticized because holding negative attitudes does not necessarily involve a phobia, in other words, "an exaggerated usually inexplicable and illogical fear of a particular object, class of objects, situation (Merriam-Webster's Online Dictionary).

certain sexual minority individuals (DiPlacido, 1998; Meyer, 1995, 2003). Meyer (2003) described these stress processes as due to (a) external objective events and conditions, such as discrimination and violence; (b) expectations of such events, and the vigilance that such expectations bring; and (c) internalization of negative social and cultural attitudes. For instance, mental health outcomes among gay men have been found to be influenced by negative appraisals of stigma-related stressors (Meyer, 1995).

The task force sees stigma and minority stress as playing a manifest role in the lives of individuals who seek to change their sexual orientation (Davison, 1978, 1982, 1991; Herek, Cogan, Gillis, & Glunt, 1998; Green, 2003; Silverstein, 1991; Tozer & Hayes, 2004). Davison, in particular, has argued that individuals who seek psychotherapy to change their sexual orientation do so because of the distress arising from the impact of stigma and discrimination. A survey of a small sample of former SOCE clients in Britain supports this hypothesis, as many of the former participants reported that hostile social and family attitudes and the criminalization of homosexual conduct were the reasons they sought treatment (G. Smith, Bartlett, & King, 2004).

One of the advantages of the minority stress model is that it provides a framework for considering the social context of stress, distress, coping, resilience (Allen, 2001; David & Knight, 2008; Herek, Gillis, & Cogan, 2009; Selvidge, Matthews, & Bridges, 2008; Levitt et al., 2009; Pachankis, 2007), and acceptance and goals of treatment (Beckstead & Israel, 2007; Bieschke, 2008; Frost & Meyer, 2009; Glassgold, 2007; Rostosky, Riggle, Horne, & Miller, 2009; Martell et al., 2004; Russell & Bohan, 2007). Some authors have proposed that LGB men and women improve their mental health and functioning through a process of positive coping, termed *stigma competence* (David & Knight, 2008). In this model, it is proposed that through actions such as personal acceptance of one's LGB identity and reduction of internalized stigma, an individual develops a greater ability to cope with stigma (cf. Crawford, Allison, Zamboni, & Soto, 2002; D'Augelli, 1994). For instance, Herek and Garnets (2007) proposed that collective identity (often termed *social identity*)¹⁵ mitigates the impact of minority stress above and beyond the effects of individual factors such as coping skills, optimism, and resiliency. Individuals with a strong sense of positive collective identity integrate their group affiliation into

their core self-concept and have community resources for responding to stigma (Balsam & Mohr, 2007; Crawford et al., 2002; Levitt et al., 2009). In support of this hypothesis, Balsam and Mohr (2007) found that collective identity, community participation, and identity confusion predicted coping with sexual stigma.

Psychology, Religion, and Homosexuality

Most of the recent studies on SOCE focus on populations with strong religious beliefs (e.g., Beckstead & Morrow, 2004; Nicolosi et al., 2000; Ponticelli, 1999; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Spitzer, 2003; Tozer & Hayes, 2004; Wolkomir, 2001). Beliefs about sexual behavior and sexual orientation rooted in interpretations of traditional religious doctrine also guide some efforts to change others' sexual orientation as well as political opposition to the expansion of civil rights for LGB individuals and their relationships (Burack & Josephson, 2005; S. L. Morrow & Beckstead, 2004; Olyam & Nussbaum, 1998; Pew Forum on Religion and Public Life, 2003; Southern Poverty Law Center, 2005). Some authors have documented an increase in the provision of religiously-based SOCE (Burack & Josephson, 2005; Cianciotto & Cahill, 2006). Religious beliefs, motivations, and struggles play a role in the motivations of individuals who currently engage in SOCE (Beckstead & Morrow, 2004; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001; Yarhouse, Tan, & Pawlowski, 2005). Thus, we considered an examination of issues in the psychology of religion to be an important part of fulfilling our charge.

Intersections of Psychology, Religion, and Sexual Orientation

World religions regard homosexuality from a spectrum of viewpoints. It is important to note that some religious denominations' beliefs and practices have changed over time, reflecting evolving scientific and civil rights perspectives on homosexuality and sexual orientation (see, e.g., Dorff, Nevins, & Reisner, 2006; Olyam & Nussbaum, 1998; see also Hebrew Union College, Institute for Judaism & Sexual Orientation [<http://www.huc.edu/ijso>], and Ontario Consultants on Religious Tolerance [<http://www.religioustolerance.org>]). A number of religious denominations in the United States welcome LGB laity, and a smaller

¹⁵ A collective or social identity refers to an individual's sense of belonging to a group (the collective), and the collective or social identity forms a part of his or her personal identity.

number ordain LGB clergy (e.g., Reconstructionist Judaism, Reform Judaism, Conservative Judaism, Buddhist Peace Fellowship, Buddhist Churches of America, Episcopal Church of America, Friends General Conference, Unitarian Society, United Church of Christ Congregational) (Greenberg, 2004; Olyam & Nussbaum, 1998; see also Hebrew Union College, Institute for Judaism & Sexual Orientation [http://www.huc.edu/ijso], and Ontario Consultants on Religious Tolerance [http://www.religioustolerance.org]). However, others view homosexuality as immoral and sinful (e.g., Christian Reformed Church of North America, Church of Jesus Christ of Latter-Day Saints, Eastern Orthodox Christianity, Orthodox Judaism, Presbyterian Church in American, Roman Catholicism, Southern Baptist Convention, United Methodist Church) (see Ontario Consultants on Religious Tolerance: http://www.religioustolerance.org). These issues are being discussed within numerous denominations (e.g., Van Voorst, 2005), and some views are in flux (e.g., the Presbyterian Church [USA]) (see Ontario Consultants on Religious Tolerance: http://www.religioustolerance.org).

Several professional publications (e.g., *Journal of Gay and Lesbian Psychotherapy*, 2001, 5[3/4]; *Professional Psychology*, 2002, 33[3]; *Archives of Sexual Behavior*,

Some difficulties arise because the professional psychological community considers same-sex sexual attractions and behaviors to be a positive variant of human sexuality, while some traditional faiths continue to consider it a sin, a moral failing, or a disorder that needs to be changed.

psychological community considers same-sex sexual attractions and behaviors to be a positive variant of human sexuality, while some traditional faiths continue to consider it a sin, a moral failing, or a disorder that needs to be changed.

The conflict between psychology and traditional faiths may have its roots in different philosophical viewpoints. Some religions give priority to *telic congruence* (i.e., living consistently within one's valuative goals¹⁶) (W.

¹⁶ These conflicts are not unique to religious individuals but are applicable to individuals making commitments and decisions about how

Hathaway, personal communication, June 30, 2008; cf. Richards & Bergin, 2005). Some authors propose that for adherents of these religions, religious perspectives and values should be integrated into the goals of psychotherapy (Richards & Bergin, 2005; Throckmorton & Yarhouse, 2006). Affirmative and multicultural models of LGB psychology give priority to *organismic congruence* (i.e., living with a sense of wholeness in one's experiential self¹⁷) (W. Hathaway, personal communication, June 30, 2008; cf. Gonsiorek, 2004; Malyon, 1982). This perspective gives priority to the unfolding of developmental processes, including self-awareness and personal identity.

This difference in worldviews can impact psychotherapy. For instance, individuals who have strong religious beliefs can experience tensions and conflicts between their ideal self and beliefs and their sexual and affectional needs and desires (Beckstead & Morrow, 2004; D. F. Morrow, 2003). The different worldviews would approach psychotherapy for these individuals from dissimilar perspectives: The telic strategy would prioritize values (Rosik, 2003; Yarhouse & Burkett, 2002), whereas the organismic approach would give priority to the development of self-awareness and identity (Beckstead & Israel, 2007; Gonsiorek, 2004; Haldeman, 2004).

It is important to note that the organismic worldview can be congruent with and respectful of religion (Beckstead & Israel, 2007; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Mark, 2008; Ritter & O'Neil, 1995), and the telic worldview can be aware of sexual stigma and respectful of sexual orientation (Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). Understanding this philosophical difference may improve the dialogue between these two perspectives represented in the literature, as it refocuses the debate not on one group's perceived rejection of homosexuals or the other group's perceived minimization of religious viewpoints but on philosophical differences that extend beyond this particular subject matter. However, some of the differences between these philosophical assumptions may be difficult to bridge.

Contrasting views exist within psychology regarding religious views about homosexuality. One way in which psychology has traditionally examined the

to live according to specific ethics and ideals (cf. Baumeister & Exline, 2000; Diener, 2000; Richards & Bergin, 2005; B. Schwartz, 2000).

¹⁷ Such naturalistic and empirically based models stress the organization, unity, and integration of human beings expressed through each individual's inherent growth or developmental tendency (see, e.g., Rogers, 1961; R. M. Ryan, 1995).

intersections between religion and homosexuality is by studying the impact of religious beliefs and motivations on attitudes and framing the discussion in terms of tolerance and prejudice (Fulton, Gorsuch, & Maynard, 1999; Herek, 1987; Hunsberger & Jackson, 2005; Plugge-Foust & Strickland, 2000; J. P. Schwartz & Lindley, 2005). For instance, one finding is that religious fundamentalism is correlated with negative views of homosexuality, whereas a quest orientation is associated with decreased discriminatory or prejudicial attitudes (Batson, Flink, Schoenrade, Fultz, & Pych, 1986; Batson, Naifeh, & Pate, 1978; Fulton et al., 1999; Plugge-Foust & Strickland, 2000). However, some authors have argued, in contrast to this approach, that conservative religious moral beliefs and evaluations about same-sex sexual behaviors and LGB individuals and relationships should be treated as religious diversity rather than as sexual prejudice (e.g., Rosik, 2007; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002).

APA Policies on the Intersection of Religion and Psychology

APA has addressed the interactions of religion and psychology in two recent resolutions: the Resolution Rejecting Intelligent Design as Scientific and Reaffirming Support for Evolutionary Theory (APA, 2008a) and the Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice (2008c). The first resolution articulates psychology's epistemological commitment: Hypothesis testing through rigorous scientific methods is the best means to gain new knowledge and to evaluate current practices, and psychologists base their theories on such research:

While we are respectful of religion and individuals' right to their own religious beliefs, we also recognize that science and religion are separate and distinct. For a theory to be taught as science it must be testable, supported by empirical evidence and subject to disconfirmation. (APA, 2007a)

This is in contrast to viewpoints based on faith, as faith does not need confirmation through scientific evidence. Further, science assumes that some ideas can be rejected when proven false; faith and religious beliefs cannot be falsified in the eyes of adherents.

The APA Council of Representatives also passed a Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice (2008c). This resolution acknowledges the existence of two forms of prejudice

related to religion: one derived from religious beliefs and another directed at religions and their adherents. The APA strongly condemns both forms of prejudice. The resolution affirms APA's position that prejudices directed at individuals because of their religious beliefs and prejudices derived from or justified by religion are harmful to individuals, society, and international relations.

In areas of conflicts between psychology and religion, as the APA Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice (2008c) states, psychology has no legitimate function in "arbitrating matters of faith and theology" or to "adjudicate religious or spiritual tenets" (p. 432) and psychologists are urged to limit themselves to speak to "psychological

implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist" (p. 433). Further, the resolution states that faith traditions "have no legitimate place arbitrating behavioral or other sciences" or to "adjudicate empirical scientific issues in psychology" (p. 432).

The APA (2002b, 2008c) recommends that psychologists acknowledge the importance of religion and spirituality as forms of meaning-making, tradition, culture, identity, community, and diversity. Psychologists do not discriminate against individuals based on those factors. Further, when devising interventions and conducting research, psychologists consider the importance of religious beliefs and cultural values and, where appropriate, consider religiously and culturally sensitive techniques and approaches (APA, 2008c).

Psychology of Religion

Historically, some in psychology and psychiatry have held negative views of religion (Wulff, 1997). Yet, with the development of more sophisticated methodologies and conceptualizations, the field of the psychology of religion has flourished in the last 30 years (Emmons & Paloutzian, 2003), culminating in new interest in a diverse field (e.g., Koenig & Larson, 2001; Paloutzian & Park, 2005; Pargament, 2002; Pargament & Mahoney,

2005; Richards & Bergin, 2005; Sperry & Shafranske, 2004; Spilka, Hood, Hunsberger, & Gorsuch, 2003).

Many scholars have attempted to elucidate what is significant and unique about religious and spiritual faith, beliefs, and experiences (e.g., George, Larson, Koenig, & McCullough, 2000; McClennon, 1994). Pargament, Maygar-Russell, and Murray-Swank (2005) summarized religion's impact on people's lives as a unique form of motivation regarding how to live one's life and how to respond to self, others, and life events; a source of significance regarding what aspects of life one imbues with meaning and power; a contributor to mortality and health; a form of positive and negative coping; and a source of fulfillment and distress. Others, such as Fowler (1981, 1991) and colleagues (Oser, 1991; Streib, 2001, 2005) have posited developmental models of religious identity that are helpful in understanding personal faith.

Additionally, there is a growing literature on integrating spirituality into psychotherapy practice (Richards & Bergin, 2000, 2004, 2005; Shafranske, 2000; Sperry & Shafranske, 2004; E. L. Worthington, Kurusu, McCullough, & Sandage, 1996). These approaches include delineating how LMHP can work effectively with individuals from diverse religious traditions (Richards & Bergin, 2000, 2004; Sperry & Shafranske, 2004). Many of these techniques can be effective (McCullough, 1999) and improve outcomes in clinical treatment with religious clients (Probst, Ostrom, Watkins, Dean, & Mashburn, 1992; Richards, Berrett, Hardman, & Eggett, 2006; E. L. Worthington et al., 1996), even for clients in treatment with secular LMHP (Mayers, Leavey, Vallianatou, & Barker, 2007). These innovations point to ways that psychology can explore and understand religious beliefs and faith in an evidence-based and respectful manner.

There have been claims that some LMHP do not address the issues of conservative religious individuals who are distressed by their same-sex sexual attractions (e.g., Yarhouse, 1998a; Throckmorton, 2002; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002). One of the problems in the field has been an either/or perspective in which sexual orientation and religion are seen as incompatible (Phillips, 2004). Certainly, some individuals may perceive their religion and their sexual orientation as incompatible, because in some faiths homosexuality is perceived as sinful and immoral. However, there is a growing body of evidence illustrating that many individuals do integrate their religious and sexual orientation identities (Coyle & Rafalin, 2000; Kerr, 1997; Mahaffy, 1996; Rodriguez,

2006; Rodriguez & Ouellete, 2000; Thumma, 1991; Yip, 2002, 2003, 2005). Thus, this dichotomy may be enabling a discourse that does not fully reflect the evidence and may be hindering progress to find a variety of viable solutions for clients.

Recently, some authors have suggested alternative frameworks, many of which are drawn from a variety of models of psychotherapy, such as multicultural views of psychology and the psychology of religion, that provide

We take the perspective that religious faith and psychology do not have to be seen as being opposed to each other. Further, psychotherapy that respects faith can also explore the psychological implications and impacts of such beliefs.

frames for appropriate psychotherapeutic interventions seeking to bridge this divide (Bartoli & Gillem, 2008; Beckstead & Israel, 2007; Buchanon, Dzelme, Harris, & Hecker, 2001; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Lasser & Gottlieb, 2004;

S. L. Morrow & Beckstead, 2004; Ritter & O'Neill, 1989; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). For instance, a growing number of authors address the religious and spiritual needs of LGBT individuals from integrative and affirmative perspectives that provide resources for LMHP working with this population (Astramovich, 2003; Beckstead & Israel, 2007; Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 1996, 2004; Horne & Noffsinger-Frazier, 2003; Mark, 2008; D. F. Morrow, 2003; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). On the basis of these scholarly contributions, we take the perspective that religious faith and psychology do not have to be seen as being opposed to each other. Further, psychotherapy that respects faith can also explore the psychological implications and impacts of such beliefs.

We support affirmative and multiculturally competent approaches that integrate concepts from the psychology of religion and the modern psychology of sexual orientation. These perspectives are elaborated later in this report. In the next chapter we review the history of SOCE in order to provide a perspective on the foundation and evolution of these approaches.

2. A BRIEF HISTORY OF SEXUAL ORIENTATION CHANGE EFFORTS

Sexual orientation change efforts (SOCE)¹⁸ within mental health fields originally developed from the science of sexuality in the middle of the 19th century (Katz, 1995). At that time, same-sex eroticism and gender-nonconforming behaviors came under increased medical and scientific scrutiny. New terms such as *urnings*, *inversion*, *homosexual*, and *homosexuality* emerged as scientists, social critics, and physicians sought to make sense of what was previously defined as sin or crime (Katz, 1995). This shift to a scientific approach did not challenge the underlying social values, however, and thus continued to reflect the existing sexual stigma, discrimination, criminalization, and heterosexism. Much of the medical and scientific work at that time conceptualized homosexual attractions and behaviors as abnormal or as an illness (Katz, 1995).

In that era, homosexuality was predominantly viewed as either a criminal act or a medical problem, or both (Krafft-Ebing, 1886/1965). Homosexuality was seen as caused by psychological immaturity (i.e., as a passing phase to be outgrown on the road to adult heterosexuality) or pathology (e.g., genetic defects, gender-based confusions, intrauterine hormonal exposure, too much parental control, insufficient parenting, hostile parenting, seduction, molestation, or

decadent lifestyles) (Drescher, 1998b, 2002). The first treatments attempted to correct or repair the damage done by pathogenic factors or to facilitate maturity (Drescher, 1998b, 2002; LeVay, 1996; Murphy, 1992, 1997). These perspectives on homosexuality lasted into the first half of the 20th century, shaping the views of psychoanalysis, the dominant psychiatric paradigm of that time (Drescher, 1998b).

Homosexuality and Psychoanalysis

Initial psychotherapeutic approaches to homosexuality in the first half of the 20th century reflected psychoanalytic theory. Freud's own views on sexual orientation and homosexuality were complex. Freud viewed homosexuality as a developmental arrest and heterosexuality as the adult norm (Freud, 1905/1960). However, in a now-famous letter, Freud (1935/1960) reassured a mother writing to him about her son that homosexuality was "nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness, but a variation of sexual function" (p. 423). He further went on to say that psychoanalysts could not promise to "abolish homosexuality and make normal heterosexuality take its place" (p. 423), as the results of treatment could not be determined. Freud's only report (1920/1960) about his deliberate attempt to change someone's sexual orientation described his unsuccessful efforts at changing the sexual orientation of a young woman brought for involuntary treatment by her

¹⁸ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

parents. At the end of this case, Freud concluded that attempts to change homosexual sexual orientation were likely to be unsuccessful.¹⁹

In the psychoanalysis that dominated the mental health fields after Freud, especially in the United States, homosexuality was viewed negatively, considered to be abnormal, and believed to be caused by family dynamics (Bieber et al., 1962; Rado, 1940; Socarides, 1968). Other approaches based loosely on psychoanalytic ideas advocated altering gender-role behaviors to increase conformity with traditional gender roles (Moberly, 1983; Nicolosi, 1991). Significantly impacting psychiatric thought in the mid-20th century, these theories were part of the rationale for including homosexuality as a mental illness in both the first (1952) and second (1968) editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, thus reinforcing and exacerbating sexual stigma and sexual prejudice. It was during this period that the first attempts to study the efficacy of SOCE were conducted (e.g., Bieber et al., 1962).

Sexual Orientation Change Efforts

The pathologizing psychiatric and psychological conception of homosexuality and concomitant efforts to alter sexual orientation through psychoanalytic and behavior therapy were prevalent through the 1960s and into the early 1970s. Although behavior therapy emerged in the 1960s, adding a different set of techniques to psychotherapy, the goals of SOCE did not change. For example, Ovesey (1969) based his behavioral interventions on the belief that homosexuality developed from a phobia of taking on the normal qualities of one's gender and that sexual intercourse with the other²⁰ sex would cure the so-called phobia.

Behavior therapists tried a variety of aversion treatments, such as inducing nausea, vomiting, or paralysis; providing electric shocks; or having the

individual snap an elastic band around the wrist when the individual became aroused to same-sex erotic images or thoughts. Other examples of aversive behavioral treatments included covert sensitization, shame aversion, systematic desensitization, orgasmic reconditioning, and satiation therapy (Beckstead & Morrow, 2004; S. James, 1978; Katz, 1995; Langevin, 1983; LeVay, 1996; Murphy, 1992, 1997). Some nonaversive treatments used an educational process of dating skills, assertiveness, and affection training with physical and social reinforcement to increase other-sex sexual behaviors (Binder, 1977; Greenspoon & Lamal, 1987; Stevenson & Wolpe, 1960). Cognitive therapists attempted to change gay men's and lesbians' thought patterns by reframing desires, redirecting thoughts, or using hypnosis, with the goal of changing sexual arousal, behavior, and orientation (e.g., Ellis, 1956, 1959, 1965).

Affirmative Approaches: Kinsey; Ford and Beach; and Hooker

At the same time that the pathologizing views of homosexuality in American psychiatry and psychology were being codified, countervailing evidence was accumulating that this stigmatizing view was ill founded. The publication of *Sexual Behavior in the Human Male* (Kinsey, Pomeroy, & Martin, 1948) and *Sexual Behavior in the Human Female* (Kinsey, Pomeroy, Martin, & Gebhard, 1953) demonstrated that homosexuality was more common than previously assumed, thus suggesting that such behaviors were part of a continuum of sexual behaviors and orientations. C. S. Ford and Beach (1951) revealed that same-sex behaviors and homosexuality were present in a wide range of animal species and human cultures. This finding suggested that there was nothing unnatural about same-sex behaviors or homosexual sexual orientation.

Psychologist Evelyn Hooker's (1957) research put the idea of homosexuality as mental disorder to a scientific test. She studied a nonclinical sample of homosexual men and compared them with a matched sample of heterosexual men. Hooker found, among other things, that based on three projective measures (the Thematic Apperception Test, the Make-a-Picture Story test, and the Rorschach), the homosexual men were comparable to their matched heterosexual peers on ratings of adjustment. Strikingly, the experts who examined the Rorschach protocols could not

¹⁹ Analyses of this case have focused on Freud's intense negative reactions to this young woman and his attempts to enforce social conformity—especially with regard to traditional female gender roles and sexuality (e.g., Lesser & Schoenberg, 1999; O'Connor & Ryan, 1993).

²⁰ We use *other sex* instead of *opposite sex*, as the latter term makes assumptions regarding the binary nature of male and female that are unsupported. We acknowledge that this term also has limitations, as there are fluid and diverse representations of sex and gender in many cultures.

distinguish the protocols of the homosexual cohort from the heterosexual cohort, a glaring inconsistency with the then-dominant understanding of homosexuality and projective assessment techniques. Armon (1960) performed research on homosexual women and found similar results.

In the years following Hooker's (1957) and Armon's (1960) research, inquiry into sexuality and sexual orientation proliferated. Two major developments marked an important change in the study of homosexuality. First, following Hooker's lead, more researchers conducted studies of nonclinical samples of homosexual men and women. Prior studies primarily included participants who were in distress or incarcerated. Second, quantitative methods to assess human personality (e.g., Eysenck Personality

Research conducted with these newly developed measures indicated that homosexual men and women were essentially similar to heterosexual men and women in adaptation and functioning.

Inventory, Cattell's Sixteen Personality Factor Questionnaire [16PF]) and mental disorders (Minnesota Multiphasic Personality Inventory [MMPI]) were developed and were

a vast psychometric improvement over prior measures, such as the Rorschach, Thematic Apperception Test, and House-Tree-Person Test. Research conducted with these newly developed measures indicated that homosexual men and women were essentially similar to heterosexual men and women in adaptation and functioning (Siegelman, 1979; M. Wilson & Green, 1971; see also the review by Gonsiorek, 1991). Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation (e.g., Bell, Weinberg, & Hammersmith, 1981; Bene, 1965; Freund & Blanchard, 1983; Freund & Pinkava, 1961; Hooker, 1969; McCord, McCord, & Thurber, 1962; D. K. Peters & Cantrell, 1991; Siegelman, 1974, 1981; Townes, Ferguson, & Gillem, 1976). This research was a significant challenge to the model of homosexuality as psychopathology.

Homosexuality Removed From the Diagnostic and Statistical Manual

In recognition of the legal nexus between psychiatric diagnosis and civil rights discrimination, especially for government employees, activists within the

homophile²¹ rights movement, including Frank Kameny and the Mattachine Society of Washington, DC, launched a campaign in late 1962 and early 1963 to remove homosexuality as a mental disorder from the American Psychiatric Association's *DSM* (D'Emilio, 1983; Kameny, 2009). This campaign grew stronger in the aftermath of the Stonewall riots in 1969. Those riots were a watershed, as the movement for gay and lesbian civil rights was embraced openly by thousands rather than limited to small activist groups (D'Emilio, 1983; Katz, 1995). In the area of mental health, given the results of research, activists within and outside of the professions led a large and vocal advocacy effort directed at mental health professional associations, such as the American Psychiatric Association, the American Psychological Association, and the American Association for Behavior Therapy, and called for the evaluation of prejudice and stigma within mental health associations and practices (D'Emilio, 1983; Kameny, 2009). At the same time, some LGB professionals and their allies encouraged the field of psychotherapy to assist sexual minority clients to accept their sexual orientation (Silverstein, 2007).

As a result of the research and the advocacy outside of and within the American Psychiatric Association, that association embarked upon an internal process of evaluating the literature to address the issue of homosexuality as a psychiatric disorder (Bayer, 1981; Drescher 2003; Drescher & Merlino, 2007; Sbordone, 2003; Silverstein, 2007). On the recommendation of its committee evaluating the research, the American Psychiatric Association Board of Trustees and general membership voted to remove homosexuality per se²² from the *DSM* in December 1973 (Bayer, 1981). The American Psychiatric Association (1973) then issued a position statement supporting civil rights protection for gay people in employment, housing, public accommodation, and licensing, and the repeal of all sodomy laws.

In December 1974, the American Psychological Association (APA) passed a resolution affirming the resolution of the American Psychiatric Association. APA concluded:

²¹ *Homophile* is an early term for what would become the gay rights or gay and lesbian rights movement.

²² The diagnoses of sexual orientation disturbance and ego-dystonic homosexuality sequentially replaced homosexuality. These diagnoses, however, were ultimately removed, due to conceptual problems and psychiatry's evolving evidence-based approach to delineating a mental disorder (Drescher, Stein, & Byne, 2005).

Homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities. Further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations. (APA, 1975, p. 633)

Since that time, the APA has passed numerous resolutions supporting LGB civil rights and psychological well-being (see APA, 2005a).

Other mental health associations, including the National Association of Social Workers and the American Counseling Association, and medical associations, including the American Medical Association and the American Academy of Pediatrics, have passed similar resolutions. Gradual shifts began to take place in the international mental health community as well. In 1992, the World Health Organization removed homosexuality per se from the *International Classification of Diseases* (Nakajima, 2003).

Decline of Sexual Orientation Change Efforts

Following the removal of homosexuality from the *DSM*, the publication of studies of SOCE decreased dramatically, and nonaffirming approaches to psychotherapy came under increased scrutiny. Behavior therapists became increasingly concerned that aversive therapies designed as SOCE for homosexuality were inappropriate, unethical, and inhumane (Bancroft, 2003; Davison, 1976, 1978; Davison & Wilson, 1973; M. King, Smith, & Bartlett, 2004; D. J. Martin, 2003; Silverstein, 1991, 2007). The Association for Behavioral and Cognitive Therapies (formerly the Association for Advancement of Behavior Therapy) as well as other associations affiliated with cognitive and behavior therapies currently reject the use of SOCE (D. J. Martin, 2003). Behavior therapy for LGB individuals now focuses on issues of increasing adjustment, as well as on addressing a variety of their mental health concerns (Campos & Goldfried, 2001; Hart & Heimberg, 2001; Martell et al., 2004; Pachankis & Goldfried, 2004; Safren & Rogers, 2001).

Prominent psychoanalytic practitioners (see, e.g., Mitchell, 1978, 1981) began questioning SOCE within their own profession and challenged therapies that started with assumptions of pathology. However, such a movement did not take hold until the late 1980s

and early 1990s (Drescher, 1998a, 1998b; Glassgold & Iasenza, 1995). In 1991, the American Psychoanalytic Association (ApsaA) effectively ended stigmatization of homosexuality by mainstream psychoanalysis when it adopted a sexual orientation nondiscrimination policy regarding the selection of candidates for psychoanalytic training. This policy was revised in 1992 to include selection of faculty and training analysts as well (ApsaA, 1991, 1992). In 2000, ApsaA adopted a policy against SOCE, attempting to end that practice within the field:

As in all psychoanalytic treatments, the goal of analysis with homosexual patients is understanding. Psychoanalytic technique does not encompass purposeful efforts to “convert” or “repair” an individual’s sexual orientation. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized homophobic attitudes. (¶ 1)

Numerous publications document the theoretical limitations and problems with SOCE within psychoanalysis (Drescher, 1998a, 1998b; O’Connor & Ryan, 1993). In the last decade, many psychoanalytic publications have described an affirmative approach to sexual orientation variation and diversity.²³

Currently, mainstream mental health professional associations support affirmative approaches that focus on helping sexual minorities cope with the impact of minority stress and stigma (American Counseling Association Governing Council, 1998; American Psychiatric Association, 2000; APA, 1997, 2000; NASW, 1997). The literature on affirmative psychotherapy has grown enormously during this time (e.g., Bieschke et al., 2007; Eubanks-Carter, Burckell, & Goldfried, 2005; Ritter & Terndrup, 2002). Included in this literature are publications that aim to support individuals with strong religious beliefs and same-sex sexual orientation in exploring ways to integrate the two (e.g., Astramovich, 2003; Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 1996, 2004; Horne & Noffsinger-Frazier, 2003; Mark, 2008; D. F. Morrow, 2003; O’Neill & Ritter, 1992; Ritter & O’Neill, 1989, 1995; Ritter & Terndrup, 2002; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). These changes within the mental health fields are reflected in the larger society, where there have been increasing shifts in acceptance of LGB

²³ ApsaA and Divisions 39 (Psychoanalysis) and 44 (Society for the Psychological Study of Lesbian, Gay, & Bisexual Concerns) have collaborated on a bibliography of affirmative resources in psychoanalysis.

individuals (see National Gay and Lesbian Task Force: <http://www.thetaskforce.org>). For instance, in 2003, the U.S. Supreme Court made a landmark ruling in *Lawrence v. Texas* that declared as unconstitutional the sodomy laws of the 13 states that still criminalized homosexuality. However, issues such as same-sex marriage are still controversial (Phy-Olsen, 2006).

However, SOCE is still provided by LMHP. Some LMHP (Nicolosi, 2003; Nicolosi & Nicolosi, 2002; Rosik, 2001) advocate for SOCE to be provided to distressed individuals, and an organization was founded to advocate for these types of treatments (National Association for Research and Treatment of Homosexuality). Additionally, a survey of randomly selected British LMHP (psychologists, counselors, and psychiatrists) completed in 2003 found that 17% of the total sample of 1,328 had provided SOCE in the past and that 4% would consider providing such therapy upon client request in the future (Bartlett, King, & Phillips, 2001; cf. Liszcz & Yarhouse, 2005). Among those who provided such services, the number of clients provided SOCE had remained constant over time (Bartlett et al., 2001; cf. M. King et al., 2004).

their families that portray homosexuality as negative (Burack & Josephson, 2005; Cianciotto & Cahill, 2006; Wolkomir, 2006). These efforts include religious outreach, support groups, and psychotherapy (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006).

Debates between those who advocate SOCE and those who oppose it have at times become polemical, with charges that professional psychology has not reflected the concerns of religious individuals,²⁴ and both supporters and opponents of SOCE have presented themselves as advocates for consumers (cf. Brooke, 2005). Despite the polarization, there have been recent attempts to envision alternate frameworks to address these issues (e.g., Bartoli & Gillem, 2008; Beckstead & Israel, 2007; Benoit, 2005; Haldeman, 2004; McMinn, 2005; Phillips, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006).

We concluded that these debates can only be resolved through an evidence-based appraisal of the potential benefits and harm of SOCE. In the next two chapters, we consider the research evidence on SOCE. In Chapter 3 we discuss methodological concerns, and in Chapter 4, the results that can be drawn from this literature.

Sexual Orientation Change Efforts Provided to Religious Individuals

The visibility of SOCE has increased in the last decade (Drescher, 2003; Drescher & Zucker, 2006; Herek, 2003). From our survey of recent publications and research, most SOCE currently seem directed to those holding conservative religious and political beliefs, and recent research on SOCE includes almost exclusively individuals who have strong religious beliefs (e.g., Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Shidlo & Schroeder, 2002; Spitzer, 2003). In an evolution for some religious communities, sexual minorities are not automatically expelled or shunned (Drescher & Zucker, 2006; Sanchez, 2007; SPLC, 2005). Instead, individuals with a same-sex sexual orientation are embraced for renouncing their homosexuality and seeking “healing” or change (Burack & Josephson, 2005; Erzen, 2006; Ponticelli, 1999). This development has led to a movement of religiously based self-help groups for distressed individuals who often refer to themselves as ex-gay (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006). Individuals and organizations that promote religion-based efforts to change sexual orientation often target messages to adults, adolescents, and

²⁴ APA has received correspondence from individuals and organizations asserting this point.



3. A SYSTEMATIC REVIEW OF RESEARCH ON THE EFFICACY OF SEXUAL ORIENTATION CHANGE EFFORTS: OVERVIEW AND METHODOLOGICAL LIMITATIONS

Although the charge given to the task force did not explicitly call for a systematic review of research on the efficacy and safety of sexual orientation change efforts (SOCE),²⁵ we decided in our initial deliberations that such a review was important to the fulfillment of our charge. First, the debate over SOCE has centered on the issues of efficacy, benefit, and harm. Thus, we believe it was incumbent on us to address those issues in our report. We attempted to answer the following questions in this review:

- Do SOCE alter sexual orientation?
- Are SOCE harmful?
- Do SOCE result in any outcomes other than changing sexual orientation?

Second, systematic literature reviews are frequently used to answer questions about the effectiveness of interventions in health care to provide the basis for informed treatment decisions (D. J. Cook, Mulrow, & Haynes, 1998; Petticrew, 2001). Current criteria for effective treatments and interventions are specific in stating that to be considered effective, an intervention has consistent positive effects without serious harmful side effects (Beutler, 2000; Flay et al., 2005). Based on Lilienfeld's (2007) comprehensive review of the issue of

harm in psychotherapy, our systematic review examines harm in the following ways:

- Negative side effects of treatment (iatrogenic effects)
- Client reports of perceptions of harm from treatment
- High drop-out rates
- Indirect harm such as the costs (time, energy, money) of ineffective interventions

Finally, we were given the charge to “inform APA’s response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.” We decided that a systematic review²⁶ would likely be the only effective basis for APA’s response to advocacy groups for SOCE.

In our review, we considered only peer-reviewed research, in keeping with current standards for conducting scientific reviews (see Khan, Kunz, Kleijnen, & Antes, 2003), which exclude the grey literature²⁷ and lay material. In this chapter, we provide an overview of the review and a detailed report on the methodological concerns that affect the validity²⁸ of the conclusions

²⁵ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person’s same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

²⁶ A systematic review starts with a clear question to be answered, strives to locate all relevant research, has clear inclusion and exclusion criteria, carefully assesses study quality, and synthesizes study results (Petticrew, 2001).

²⁷ Grey literature refers to any publication in any format published outside of peer-reviewed scientific journals.

²⁸ *Validity* is defined as the extent to which a study or group of studies produce information that is useful for a specific purpose. It also includes an overall evaluation of the plausibility of the intended

derived from the research. In the next chapter, we present our review of the outcomes of the research.

Overview of the Systematic Review

Our review included peer-reviewed empirical research on treatment outcomes published from 1960 to 2007. Studies were identified through systematic searches of scholarly databases, including PsycINFO and Medline, using such search terms as *reparative therapy*, *sexual orientation*, *homosexuality*, and *ex-gays* cross-referenced with treatment and therapy. Reference lists from all identified articles were searched for additional nonindexed, peer-reviewed material. We also obtained review articles and commentaries and searched the reference lists of these articles to identify refereed publications of original research investigations on SOCE that had not been identified via the aforementioned procedures. As noted earlier, in keeping with standards for systematic reviews, only empirically based, peer-reviewed articles addressing the key questions of this review regarding SOCE efficacy, safety, and harm were included in this section. Other research studies of children, adolescents, and adults, including the grey literature and clinical accounts, are included in other sections of this report, most notably Chapter 5 (Research on Adults Who Undergo Sexual Orientation Change Efforts) and Chapter 8 (Issues for Children, Adolescents, and Their Families). The studies that met our criteria and are mentioned in this chapter on the systematic review are listed in Appendix B.²⁹

The vast majority of research on SOCE was conducted prior to 1981. This early research predominantly focused on evaluating behavioral interventions, including those using aversive methods. Following the declassification of homosexuality as a mental disorder in 1973 (American Psychiatric Association, 1973) and subsequent statements of other mental health

interpretations—in this case, does SOCE produce a change in sexual orientation (see American Educational Research Association, APA, & National Council on Measurement in Education, 1999).

²⁹ A meta-analytic review of 14 research articles (Byrd & Nicolosi, 2002) is not discussed in this report. The review suffers from significant methodological shortcomings and deviations from recommended meta-analytic practice (see, e.g., Durlak, Meerson, & Ewell Foster, 2003; Lipsey & Wilson, 2001) that preclude reliable conclusions being drawn from it. However, studies that were included in the meta-analysis and were published in refereed journals between 1960 and the present are included and described in the current review. Additionally, a recent study (Byrd, Nicolosi, & Potts, 2008) is not included, as it was published after the review period and appears to be a reworking of an earlier study by Nicolosi, Byrd, and Potts (2000).

professional associations, including APA (Conger, 1975), research on SOCE declined dramatically. Indeed, we found that the peer-reviewed empirical literature after 1981 contains no rigorous intervention trials on changing same-sex sexual attractions.

There is a small, more recent group of studies conducted since 1999 that assess perceived effects of SOCE among individuals who have participated in psychotherapy as well as efforts based in religious beliefs or practices, including support groups, faith healing, and prayer. There are distinct types of research within this recent literature. One type focused on evaluating individuals' positive accounts of sexual orientation change (Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003). Another type examined potential harm of SOCE and experiences of those who seek sexual orientation change (Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002). A third type is high-quality³⁰ qualitative research investigations that provide insight into people's experiences of efforts aimed at altering their same-sex sexual attractions (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkimur, 2001).³¹

In all areas of intervention evaluation, the quality of the methods used in the research affects the validity and credibility of any claims the researcher can make about whether the intervention works, for whom it

Overall, we found that the low quality of the research on SOCE is such that claims regarding its effectiveness and widespread applicability must be viewed skeptically.

works, and under what circumstances it works. Many have described methodological concerns regarding the research literature on sexual

orientation change efforts (e.g., Cramer, Golom, LoPresto, & Kirkley, 2008; Haldeman, 1994; S. L. Morrow & Beckstead, 2004; Murphy, 1992; Sandfort, 2003). Overall, we found that the low quality of the research on SOCE is such that claims regarding its effectiveness and widespread applicability must be viewed skeptically.

As shown in Appendix B, few studies on SOCE produced over the past 50 years of research rise to current scientific standards for demonstrating the efficacy of psychological interventions (cf. Chambless & Hollon, 1998; Chambless & Ollendick, 2001;

³⁰ These studies meet the standards of research rigor that are used for the qualitative research paradigms that informed each of the studies (e.g., grounded theory, ethnomethodology, phenomenology).

³¹ These studies are discussed more thoroughly in later sections of the report.

Flay et al., 2005; Shadish, Cook, & Campbell, 2002; Society for Prevention Research, 2005) or provide for unambiguous causal evidence regarding intervention outcomes. Indeed, only six studies, all conducted in the early period of research, used rigorous experimental³² procedures. Only one of these experiments (Tanner, 1974) assessed treatment outcomes in comparison to an untreated control group. Only three additional studies used strong quasi-experimental procedures such as a nonequivalent comparison group (see Appendix B). All of these studies were also from the early period. The rest of the studies that we reviewed are nonexperimental (see Appendix B). We thus concluded that there is little in the way of credible evidence that could clarify whether SOCE does or does not work in changing same-sex sexual attractions.

The studies in this area also include a highly select group of people who are unique among those who experience same-sex sexual attractions. Thus, psychologists should be extremely cautious in attributing success to SOCE and assuming that the findings of the studies of it can be applied to all sexual minorities. An overview of the methodological problems in determining the effects of SOCE and making treatment decisions based on findings from these studies follows.

Methodological Problems in the Research Literature on Sexual Orientation Change Efforts

Problems in Making Causal Claims

A principal goal of the available research on SOCE was to demonstrate that SOCE consistently and reliably produce changes in aspects of sexual orientation. Overall, due to weaknesses in the scientific validity of research on SOCE, the empirical research does not

provide a sound basis for making compelling causal claims. A detailed analysis of these issues follows.

INTERNAL VALIDITY CONCERNS

Internally valid research convincingly demonstrates that a cause (such as SOCE) is the only plausible explanation for an observed outcome such as change

Research on SOCE has rarely used designs that allow for confident conclusions regarding cause-and-effect relationships between exposure to SOCE and outcomes.

in same-sex sexual attractions. Lack of internal validity limits certainty that observed changes in people's attitudes, beliefs, and behaviors are a function of the

particular interventions to which they were exposed. A major limitation to research on SOCE, both the early and the recent research, stems from the use of weak research designs that are prone to threats to internal validity. Research on SOCE has rarely used designs that allow for confident conclusions regarding cause-and-effect relationships between exposure to SOCE and outcomes.

As noted previously, true experiments and rigorous quasi-experiments are rare in the SOCE research. There are only a few studies in the early period that are experiments or quasi-experiments, and no true experiments or quasi-experiments exist within the recent research. Thus, none of these recent studies meet current best practice standards for experimental design and cannot establish whether SOCE is efficacious.

In early studies, comparison and no-treatment control groups were uncommon procedures, and early studies rarely employed multiple baseline assessments, randomization to condition, multiple long-term follow-up assessments, or other procedures to aid in making causal inferences. These procedures are widely accepted as providing the most compelling basis for ruling out the possibility that an alternative source is responsible for causing an observed or reported treatment effect.

Common threats to internal validity in early studies include history (i.e., other events occurring over the same time period as the treatment that could produce the results in the absence of the intervention), regression (i.e., extreme scores are typically less extreme on retest in the absence of intervention), and testing (i.e., taking a test once influences future scores on the test in the absence of intervention). Within-subject and patient case studies are the most common designs in the early SOCE research (see Appendix

³² True experiments have more methodological rigor because study participants are randomly assigned to treatment groups such that individual differences are more equally distributed and are not confounded with any change resulting from the treatment. Experiments are also rigorous because they include a way for the researcher to determine what would have happened in the absence of any treatment (e.g., a counterfactual) through the use of a no-treatment control group. Quasi-experimental designs do not have random assignment but do incorporate a comparison of some kind. Although they are less rigorous than experiments, quasi-experiments, if appropriately designed and conducted, can still provide for reasonable causal conclusions to be made.

B). In these designs, an individual's scores or clinical status prior to treatment is compared with his or her scores or status following treatment. These designs are particularly vulnerable to internal validity threats.

Sample attrition

Early research is especially vulnerable to threats to internal validity related to sample attrition. The proportions of participants in these studies who dropped out of the intervention and were lost to follow-up are unacceptably high; drop-out rates go as high as 74% of the initial study sample. Authors also reported high rates of refusal to undergo treatment after participants were initially enrolled in the studies. For instance, 6 men in Bancroft's (1969) study refused to undergo treatment, leaving only 10 men in the study. Callahan and Leitenberg (1973) reported that of 23 men enrolled, 7 refused and 2 dropped out of treatment; 8 also showed inconsistent baseline responses in penile arousal to the experimental stimuli so could not be included in the analysis, leaving only 6 subjects on whom treatment analyses could be performed. Of 37 studies reviewed by H. E. Adams and Sturgis (1977), 31 studies lost from 36% to 58% of the sample. In many studies, therefore, what appear to be intervention effects may actually reflect systematic changes in the composition of the study sample; in the handful of available comparison group studies, differences between the groups in the studies in the rate of dropout and in the characteristics of those who drop out may be the true cause of any observed differences between the groups. Put simply, dropout may undermine the comparability of groups in ways that can bias study outcomes.

Retrospective pretest

With the exception of prospective ethnographic studies (e.g., Ponticelli, 1999; Wolkomir, 2001), the recent research (e.g., Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003) relies exclusively on uncontrolled retrospective pretest designs. In these studies, people who have been exposed to SOCE are asked to recall and report on their feelings, beliefs, and behaviors at an earlier age or time and are then asked to report on these same issues at present. Change is assessed by comparing contemporary scores with scores provided for the earlier time period based on retrospective recall. In a few studies, LMHP who perform SOCE reported their view of how their clients had changed. The design is problematic because all of the pretest measures are not true pretests but retrospective accounts of pretest status. Thus, the

recent research studies on SOCE have even weaker designs than do nonexperimental studies from the early period of research on SOCE. Again, none of these recent studies can establish whether SOCE is efficacious.

An extensive body of research demonstrates the unreliability of retrospective pretests. For example, retrospective pretests are extremely vulnerable to response-shift biases resulting from recall distortion and degradation (C. E. Schwartz & Rapkin, 2004; Schwarz & Clore, 1985). People find it difficult to recall and report accurately on feelings, behaviors, and occurrences from long ago and, with the passage of time, will often distort the frequency, intensity, and salience of things they are asked to recall.

Retrospective pretests are also vulnerable to biases deriving from impression management (Fisher & Katz, 2000; Schwarz, Hippler, Deutsch, & Strack, 1985; A. E. Wilson & Ross, 2001), change expectancy (Hill & Betz, 2005; Lam & Bengo, 2003; Norman, 2003; M. A. Ross, 1989; Sprangers, 1989), and effort justification (Aronson & Mills, 1959; Beauvois & Joule, 1996; Festinger, 1957). Individuals tend to want to present themselves in a favorable light. As a result, people have a natural tendency to report on their current selves as improved over their prior selves (impression management). People will also report change under circumstances in which they have been led to expect that change will occur, even if no change actually does occur (change expectancy). In addition, people will seek to justify the time and effort that they have made in treatment to reduce any dissonance they may feel at experiencing no change or less than they had expected by overestimating the effectiveness of the treatment (effort justification). Effort justification has been demonstrated to become stronger as intervention experiences become more unpleasant. In combination, these factors lead to inaccurate self-reports and inflated estimates of treatment effects, distortions that are magnified in the context of retrospective pretest designs.

CONSTRUCT VALIDITY CONCERNS

Construct validity is also a significant concern in research on SOCE. Construct validity refers to the degree to which the abstract concepts that are investigated in the study are validly defined, how well these concepts are translated into the study's treatments and measures, and, in light of these definitional and operational decisions, whether the study findings are appropriately interpreted. For

instance, do the researchers adequately define and measure sexual orientation? Are their interpretations of the study results regarding change in sexual orientation appropriate, given how the constructs were defined and translated into measures? On the whole, research on SOCE presents serious concerns regarding construct validity.

Definition of sexual orientation

Sexual orientation is a complex human characteristic involving attractions, behaviors, emotions, and identity. Research on sexual orientation is usually seen as beginning with the Kinsey studies (Kinsey et al., 1948, 1953). Kinsey used a unidimensional, 7-category taxonomic continuum, from 0 (*exclusively heterosexual*) to 6 (*exclusively homosexual*), to classify his participants. As the research has developed since the Kinsey studies, the assessment of sexual orientation has focused largely on measuring three variables—identity, behavior, and attraction. Many studies measure only one or two, but very seldom all three, of these variables.

A key finding in the last 2 decades of research on sexual orientation is that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways (Carrillo, 2002; Diamond, 2003, 2006; Dunne, Bailey, Kirk, & Martin, 2000; Laumann, Gagnon, Michael, & Michaels, 1994; Savin-Williams, 2005). For instance, individuals with sexual attractions may not act on them or may understand, define, and label their experiences differently than those with similar desires, because of the unique cultural and historical constructs regarding ethnicity, gender, and sexuality (Harper et al., 2004; Mays & Cochran, 1998; Walters, Simoni, & Horwath, 2001; Weinrich & Williams, 1991).

Further, a subset of individuals who engage in same-sex sexual behaviors or have same-sex sexual attractions do not self-identify as LGB or may remain unlabeled, and some self-identified lesbian and gay individuals may engage in other-sex sexual behaviors without self-identifying as bisexual or heterosexual (Beckstead, 2003; Carrillo, 2002; Diamond, 2003, 2008; Diamond & Savin-Williams, 2000; Dunne et al., 2000; Fox, 2004; Gonsiorek, Sell, & Weinrich, 1995; Hoberg, Konik, Williams, & Crawford, 2004; Kinsey et al., 1948, 1953; Klein et al., 1985; Masters & Johnson, 1979; McConaghy, 1987, 1999; McConaghy, Buhrich, & Silove, 1994; Storms, 1980; Thompson & Morgan, 2008). Thus, for some individuals, personal and social identities differ from sexual attraction, and sexual orientation

identities may vary due to personal concerns, culture, contexts, ethnicity, nationality, and relationships.

As a result, a number of scholars have argued that the construct of sexual orientation would be more easily and reliably assessed and defined if it were disentangled from sexual orientation identity (e.g., Chang & Katayama, 1996; Drescher, 1998a, 1998b; Drescher, Stein, & Byne, 2005; Rust, 2003; Stein, 1999; R. L. Worthington, Savoy, Dillon, & Vernaglia, 2002). Recent research has found that distinguishing the constructs of sexual orientation and sexual orientation identity adds clarity to an understanding of the variability inherent in reports of these two variables (R. L. Worthington et al., 2002; R. L. Worthington & Reynolds, 2009).

We adopted this current understanding of sexuality to clarify issues in the research literature. For instance, *sexual orientation* refers to an individual's patterns of sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics. Sexual orientation is tied to physiological drives and biological systems that are beyond conscious choice and involve profound emotional feelings, such as "falling in love." Other dimensions commonly attributed to sexual orientation (e.g., sexual behavior with men and/or women, social affiliations with LGB or heterosexual individuals and communities, emotional attachment preferences for men or women, gender role and identity, lifestyle choices) are potential correlates of sexual orientation rather than principal dimensions of the construct.

Sexual orientation identity refers to acknowledgment and internalization of sexual orientation and reflects self-exploration, self-awareness, self-recognition, group membership and affiliation, culture, and self-stigma. Sexual orientation identity involves private and public ways of self-identifying and is a key element in determining relational and interpersonal decisions, as it creates a foundation for the formation of community, social support, role models, friendship, and partnering (APA, 2003; Jordan & Deluty, 1998; McCarn & Fassinger, 1996; Morris, 1997; Ponticelli, 1999; Wolkowicz, 2001).

Given this new understanding of sexual orientation and sexual orientation identity, a great deal of debate surrounds the question of how best to assess sexual orientation in research (Gonsiorek et al., 1995; Kinsey et al., 1948, 1953; Masters & Johnson, 1979; Sell, 1997). For example, some authors have criticized the Kinsey scale for dichotomizing sexual orientation—with heterosexuality and homosexuality as opposites along a single dimension and bisexuality in between—

thus implying that in increasing desire for one sex represents reduced desire for the other sex (Gonsiorek et al., 1995; Sell, 1997; R. L. Worthington, 2003; R. L. Worthington & Reynolds, 2009). An alternative that has been proposed suggests that same-sex and other-sex attractions and desires may coexist relatively independently and may not be mutually exclusive (Diamond, 2003, 2006; 2008; Fox, 2004; Klein et al., 1985,³³ Sell, 1997; Shively & DeCecco, 1977; Storms, 1980; R. L. Worthington, 2003; R. L. Worthington & Reynolds, 2009). Models with multiple dimensions that permit the rating of the intensity of an individual's sexual desire or arousal for other-sex individuals separately from the intensity of that individual's sexual desire or arousal for same-sex individuals allow individuals to have simultaneous levels of attractions. Some commentators believe such models allow for greater understanding of sexual diversity and its interactions with other aspects of identity and culture (Mays & Cochran, 1998; R. L. Worthington et al. 2002).

Considered in the context of the conceptual complexities of and debates over the assessment of sexual orientation, much of the SOCE research does not adequately define the construct of sexual orientation, does not differentiate it from sexual orientation identity, or has misleading definitions that do not accurately assess or acknowledge bisexual individuals. Early research that focuses on sexual arousal may be more precise than that which relies on self-report of behavior. Overall, recent research may actually measure sexual orientation identity (i.e., beliefs about sexual orientation, self-report of identity or group affiliation, self-report of behavior, and self-labeling) rather than sexual orientation.

Study treatments

In general, what constitutes SOCE in empirical research is quite varied. As we show in Appendix B, early studies tested a variety of interventions that

include aversive conditioning techniques (e.g., electric shock, deprivation of food and liquids, smelling salts, chemically induced nausea), biofeedback, hypnosis, masturbation reconditioning, psychotherapy, systematic desensitization, and combinations of these approaches. A small number of early studies compare approaches alone or in combination. The more recent research includes an even wider variety of interventions (e.g., gender role reconditioning, support groups, prayer, psychotherapy) and providers (e.g., licensed and unlicensed LMHP in varied disciplines, pastoral counselors, laypersons). The recent studies were conducted in such a way that it is not possible to attribute results to any particular intervention component, approach, or provider. For instance, these interventions were provided simultaneously or sequentially, without specific separate evaluations of each intervention. The recent research and much of the early research cannot provide clarity regarding which specific efforts are associated with which specific outcomes.

Outcome measures

Regarding assessment mode, outcomes in early studies were assessed by one or more of the following: gauging an individual's physiological responses when presented with sexual stimuli, obtaining the person's self-report of recent sexual behavior and attractions, and using clinical opinion regarding improvement. In men especially, physiological measures are considered more dependable than self-report of sexual arousal or attraction (Freund, 1976; McConaghy, 1999). However, these measures have important limitations when studying sexual orientation. Some men are incapable of sexual arousal to any stimuli in the laboratory and must be excluded from research investigations in which the measure is the sole outcome measure. More recent research indicates that some penile circumference gauges are less consistent than penile volume gauges (Kuban, Barbaree, & Blanchard, 1999; McConaghy, 1999; Quinsey & Lalumiere, 2001; Seto, 2004) and that some men can intentionally produce false readings on the penile circumference gauges by suppressing their standard sexual arousal responses (Castonguay, Proulx, Aubut, McKibben, & Campbell, 1993; Lalumiere & Harris, 1998) or consciously making themselves aroused when presented with female erotic stimuli (Freund, 1971, 1976; Freund, Watson, & Rienzo, 1988; Lalumiere & Earls, 1992; McConaghy, 1999, 2003). The physiological measure used in all the SOCE experiments was the penile circumference gauge.

³³ Although Klein advanced the notion of sexual orientation as a multidimensional variable, his Sexual Orientation Grid confounds constructs of sexual orientation and sexual orientation identity, as it includes attraction; behavior; identification; and emotional, political, and social preferences.

McConaghy (1999) has questioned the validity of the results of SOCE research using this gauge and believes that data illustrating a reduction in same-sex sexual attraction should be viewed skeptically.

In recent research on SOCE, overreliance on self-report measures and/or on measures of unknown validity and reliability is common. Reliance on self-reports is especially vulnerable to a variety of reactivity biases such that shifts in an individual's score will reflect factors other than true change. Some of these biases are related to individual motivations, which have already been discussed, and others are due to features of the experimental situation. Knowing that one is being studied and what the experimenter hopes to find can heighten people's tendency to self-report in socially desirable ways and in ways that please the experimenter.

Measures used in early studies vary tremendously in their psychometric acceptability, particularly for attitudinal and mental health measures, with a limited number of studies using well-validated measures. Recent research has not advanced significantly in using psychometrically sound measures of important study variables such as depression, despite the widespread use of measures that permit accurate assessment of these variables in other studies. Measures in these studies are also sources of bias due to problems such as item wording and response anchors from which participants may have inferred that other-sex attraction is a normative standard, as well as from the exclusion of items related to healthy homosexual functioning to parallel items that ask for reports on healthy heterosexual functioning.

Study operations

Regarding the adequacy of study operations, few of the early studies attempted to overcome the demand characteristics associated with the interventionists' obtaining measures of change themselves. In other words, few studies sought to minimize the possibility that people receiving treatment would be motivated to please their treatment providers by providing them with reports that were consistent with what the providers were perceived to desire and expect. Issues in recruitment of participants may also contribute to this effect; subjects were aware of the goals of the study, were recruited by individuals with that knowledge, or were participating in treatment to avoid legal and/or religious sanction. Novelty effects associated with exposure to an experimental laboratory situation

may also have influenced study results. People may become excited and energized by participating in a research investigation, and these reactions to being in the research environment may contribute to change in scores. Recent research is also vulnerable to demand characteristics as a function of how individuals are recruited into samples, which is discussed in more detail in the section on sampling concerns.

CONCLUSION VALIDITY CONCERNS

Conclusion validity concerns the validity of the inferences about the presence or absence of a relationship among variables that are drawn from statistical tests. Small sample sizes, sample heterogeneity, weak measures, and violations to the assumptions of statistical tests (e.g., non-normally distributed data) are central threats to drawing valid conclusions. In this body of research, conclusion validity is often severely compromised. Many of the studies from the early period are characterized by samples that are very small, containing on the average about 9 subjects (see Appendix B; see also H. E. Adams & Sturgis, 1977). Combined with high rates of attrition, skewed distributions, unreliable measures, and infrequent use of statistical tests designed for small and skewed samples, confidence in the statistical results of many of these studies may be misplaced. The recent research involved unreliable measures and inappropriate selection and performance of statistical tests, which are threats to their statistical conclusion validity,³⁴ even though these studies involved larger samples than the early research.

³⁴ For instance, to assess whether sexual orientation had changed, Nicolosi et al. (2000) performed a chi-square test of association on individuals' prior and current self-rated sexual orientation. Several features of the analysis are problematic. Specifically, the nature of the data and research question are inappropriate to a chi-square test of association, and it does not appear that the tests were properly performed. Chi-square tests of association assume that data are independent, yet these data are not independent because the row and column scores represent an individual's rating of his or her past and present self. Chi-square tests ought not to be performed if a cell in the contingency table includes fewer than five cases. Other tests, such as the nonparametric McNemar's test for dichotomous variables (McNemar, 1969) or the sign (Conover, 1980) or Wilcoxon signed-rank tests (Wilcoxon, 1945) for nominal and ordinal data, respectively, are used to assess whether there are significant differences between an individual's before and after score and are appropriate when data fail to meet the assumptions of independence and normality, as these data do and would have been more appropriate choices. Paired *t* tests for mean differences could also have been performed on these data. There are procedural problems in how Nicolosi et al. conducted the chi-square test, such as missing data, and the analyses were conducted without adjustment for chance, with different numbers of subjects responding to each item, and without corrections to the gain scores to address regression artifacts. Taken together, the problems associated with running so many tests without adjusting for chance associations

Problems in Generalizing Findings

A significant challenge to interpreting the research on SOCE is establishing external validity—that is, judging to whom and to what circumstances the results of any particular study might reasonably be generalized.

SAMPLE COMPOSITION

Concerns regarding the sample composition in these studies are common in critiques (e.g., Cramer et al., 2008). The studies from the early period are characterized by samples that are narrow in their demographic characteristics, composed almost exclusively of Caucasian males over the age of 18. No investigations are of children and adolescents exclusively, although adolescents are included in a very few study samples. Few SOCE studies in the early period include women. Although more recent research

The research findings from early and recent studies may have limited applicability to non-Whites, youth, or women.

includes women and respondents of diverse ethnic and racial backgrounds (e.g., Moran, 2007; Nicolosi et al., 2000;

Ponticelli, 1999; Schaeffer et al., 2000; Spitzer, 2003; Wolkomir, 2001), White men continue to dominate recent study samples. Thus, the research findings from early and recent studies may have limited applicability to non-Whites, youth, or women. The samples in the recent research have been narrowly defined in other respects, focusing on well-educated, middle-class individuals to whom religion is extremely important (e.g., Beckstead & Morrow, 2004; Nicolosi et al., 2000; Pattison & Pattison, 1980; Schaeffer et al., 2000; Spitzer, 2003; Wolkomir, 2001). Same-sex sexual attraction and treatments are confounded with these particular demographic characteristics across the recent literature. These research findings may be most applicable to educated White men who consider themselves highly religious.

The early research sometimes included men who were receiving intervention involuntarily (e.g., Barlow, Agras, Abel, Blanchard, & Young, 1975; Callahan & Leitenberg, 1973; S. James, 1978; MacCulloch & Feldman, 1967; MacCulloch et al., 1965; McConaghy, 1969, 1976; McConaghy et al., 1972), usually men who were court referred as a result of convictions on charges

or correcting for regression artifacts and having different respondents in nearly every test make it difficult to assess what changes in scores across these items actually reflect.

related to criminalized acts of homosexual sex.³⁵ The samples also include men who were not receiving intervention because of same-sex sexual attractions; rather, some of the men receiving intervention are described as pedophiles, exhibitionists, transvestites, and fetishists (Callahan & Leitenberg, 1973; Conrad & Wincze, 1976; Fookes, 1960; Hallam & Rachman, 1972; Marquis, 1970; Thorpe, Schmidt, Brown, & Castell, 1964; Thorpe, Schmidt, & Castell, 1963). Thus, the early samples are notable for including men who may not be same-sex attracted at all or have been distressed by their attractions but who had to undergo intervention by court order or out of fear of being caught by law enforcement in the future.

Moreover, in the early research—to the extent that it was assessed—the samples contained individuals who varied widely along the spectrum of same-sex sexual orientation prior to intervention, so that the studies included men who were other-sex sexually attracted to varying degrees alongside men who were primarily or exclusively same-sex sexually attracted (Bancroft, 1969; Barlow et al., 1975; Birk, 1974; Conrad & Wincze, 1976; Fookes, 1960; Hallman & Rachman, 1972; Kendrick & MacCulloch, 1972; LoPiccolo, Stewart, & Watkins, 1972; Marquis, 1970; McCrady, 1973). Additionally, study samples included men with and without histories of current and prior sexual contact with men and women (Bancroft, 1969; Colson, 1972; Curtis & Presly, 1972; Fookes, 1960; Freeman & Meyer, 1975; Gray, 1970; Hallman & Rachman, 1972; Herman, Barlow, & Agras, 1974; Larson, 1970; Levin, Hirsch, Shugar, & Kapche, 1968; LoPiccolo et al., 1972; MacCulloch & Feldman, 1967; McConaghy, 1969; McConaghy, Armstrong, & Blaszcynski, 1981; McConaghy & Barr, 1973; McConaghy et al., 1972; Segal & Sims, 1972; Thorpe et al., 1964), so that men who were or had been sexually active with women and men, only women, only men, or neither were combined. Some recent studies of SOCE have similar problems (e.g., Spitzer, 2003). Including participants with attractions, sexual arousal, and behaviors to both sexes in the research on SOCE makes evaluating change more difficult (Diamond, 2003; Rust, 2003; Vasey & Rendell, 2003; R. L. Worthington, 2003).

Data analyses rarely adjust for preintervention factors such as voluntary pursuit of intervention, initial degree of other-sex attraction, or past and current other-sex and same-sex behaviors; in very few studies did investigators perform and report subgroup analyses to clarify how

³⁵ Shidlo and Schroeder (2002) found that roughly 24% of their respondents perceived that SOCE was imposed on them rather than pursued voluntarily.

subpopulations fared as a result of intervention. The absence of these analyses obscures results for men who are primarily same-sex attracted and seeking intervention regarding these attractions versus any other group of men in these studies, such as men who could be characterized as bisexual in their attractions and behaviors or those on whom treatment was imposed. For these reasons, the external validity (generalizability) of the early studies is unclear, with selection–treatment interactions of particular concern. It is uncertain which effects observed in these studies would hold for which groups of same-sex attracted people.

SAMPLING AND RECRUITMENT PROCEDURES

Early and recent study samples are typically of convenience, so it is unclear precisely what populations these samples represent. Respondents in the recent studies were typically recruited through ex-gay ministries and advocates of SOCE rather than through population-based probability sampling strategies designed to obtain a representative sample of same-sex attracted people or the subset who experience their attractions as distressing and have sought and been exposed to SOCE. Additionally, study respondents are often invited to participate in these studies by LMHP who are proponents of SOCE, introducing unknown selection biases into the recruitment process (cf. Beckstead, 2003; Shidlo & Schroeder, 2002).

Qualitative studies have been more successful in applying a variety of purposive stratified sampling strategies (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001) and developing appropriate comparison samples. However, the qualitative studies were not undertaken with the purpose of determining if SOCE interventions are effective in changing sexual orientation. These studies focused on understanding aspects of the experience of participating in SOCE from the perspective of same-sex attracted people in distress.

As noted previously, recent research has used designs that are incapable of making attributions of intervention effects. In many of the recent studies, the nature of the procedures for recruiting samples is likely to have accentuated response-shift biases rather than to have minimized them, because study recruiters were open proponents of the techniques under scrutiny; it cannot be assumed that the recruiters sought to encourage the participation of those individuals whose experiences ran counter to their own view of the value of these approaches. Proponents of these efforts may also have limited access to the research for

former clients who were perceived to have failed the intervention or who experienced it as harmful. Some of the recent research to assess harm resulting from these interventions (Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002) suffers from sampling weaknesses and biases of a similar nature.

Treatment Environments

Clinically trained professionals using reasonably well-described change efforts generally conducted early research in clinical laboratory settings. By contrast, the recent research included a wide variety of change efforts, providers, and settings in which these efforts may take place. The recent research has not been performed in a manner that permits examination of the interactions among characteristics of change efforts, providers, settings, and individuals seeking to change, nor does the research associate these patterns with outcomes.

Summary

Our analysis of the methodology of SOCE reveals substantial deficiencies. These deficiencies include limitations in making causal claims due to threats to internal validity (such as sample attrition, use of retrospective pretests); lack of construct validity,

The recent empirical literature provides little basis for concluding whether SOCE has any effect on sexual orientation.

including definition and assessment of sexual orientation; and variability of study treatments and outcome measures.

Additional limitations with recent research include problems with conclusion validity (the ability to make inferences from the data) due to small or skewed samples, unreliable measures, and inappropriate selection and performance of statistical tests. Due to these limitations, the recent empirical literature provides little basis for concluding whether SOCE has any effect on sexual orientation. Any reading of the literature on SOCE outcomes must take into account the limited generalizability of the study samples to the population of people who experience same-sex sexual attraction and are distressed by it. Taking into account the weaknesses and limitations of the evidence base, we next summarize the results from research in which same-sex sexual attraction and behavior have been treated.

4. A SYSTEMATIC REVIEW OF RESEARCH ON THE EFFICACY OF SEXUAL ORIENTATION CHANGE EFFORTS: OUTCOMES

In Chapter 3, we provided an overview of our systematic review of research on sexual orientation change efforts (SOCE)³⁶ and the results of the review for methodological concerns. In this chapter, we describe the evidence on outcomes associated with SOCE, whether beneficial or harmful. No studies reported effect size estimates or confidence intervals, and many studies did not report all of the information that would be required to compute effect sizes. As a result, statistical significance and methodology are considered in interpreting the importance of the findings. As the report will show, the peer-refereed empirical research on the outcomes of efforts to alter sexual orientation provides little evidence of efficacy and some evidence of harm. We first summarize the evidence of efficacy and then the evidence of unintended harmful effects.

Reports of Benefit

Sexual orientation change efforts have aimed to address distress in individuals with same-sex sexual attractions by achieving a variety of outcomes:

- Decreased interest in, sexual attraction to, and sexual behavior with same-sex sexual partners.

- Increased interest in, sexual attraction to, and sexual behavior with other-sex sexual partners.
- Increased healthy relationships and marriages with other-sex partners.
- Improved quality of life and mental health.

Although not all of these aims are equally well studied, these are the outcomes that have been studied frequently enough to be reported in this systematic review. One general point that we wish to emphasize as we begin the discussion of the outcomes that have been reported in this literature is that nonexperimental studies often find positive effects that do not hold up under the rigor of experimentation. The literature on SOCE is generally consistent with this point. In other words, the least rigorous studies in this body of research generally provide a more positive assessment of efficacy than do studies that meet even the most minimal standards of scientific rigor.

Decreasing Same-Sex Sexual Attraction

EARLY STUDIES

A number of investigators have assessed aversion therapy interventions to reduce physiological and self-reported sexual arousal in response to same-sex stimuli and self-reports of same-sex sexual attraction (see Appendix B).

³⁶ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved

Experimental studies

Results from the experimental studies of aversive techniques provide some evidence that these treatments can reduce self-reported and physiological sexual arousal for some men. The experimental studies that we reviewed showed lower rates of change in sexual arousal toward the same sex than did the quasi-experimental and nonexperimental studies. This finding was consistent with H. E. Adams and Sturgis's (1977) review of studies published through 1976.

In their review, H. E. Adams and Sturgis (1977) found that across the seven studies that they classified as controlled studies, 34% of the 179 subjects that were retained in these studies decreased their same-sex sexual arousal. McConaghy (1976) found that roughly half of the men who received one of four treatment regimens reported less intense sexual interest in men at 6 months. McConaghy et al. (1972) found reductions in penile response in the laboratory following treatment. Penile response to female nudes also declined for those men who initially responded to female stimuli. McConaghy (1969) similarly reported a decline in sexual arousal to all stimuli as a result of treatment for some men and that treatment also increased same-sex sexual arousal for some men. Overall, however, a majority of participants showed decreases in same-sex sexual arousal immediately following treatment. McConaghy and Barr (1973) found that about half of men reported that their same-sex sexual attractions were reduced. Tanner (1975) found that aversive shock could lessen erectile response to male stimuli.

An important caveat in considering the results of these experiments is that none compared treatment outcomes to an untreated control group. That is, these studies compared treatments to one another. The fact that four of these studies also involved men who were being treated by court referral should also be considered in interpreting the findings. These experiments cannot address whether men would have changed their sexual arousal pattern in the absence of treatment. Only one of the experiments that we identified compared treatment outcomes against the outcomes for an untreated control group. Tanner (1974) examined change in sexual arousal among 8 men receiving electric shock therapy. Tanner found that physiological arousal to male stimuli in the laboratory had declined at the 8-week follow-up, when scores among the 8 men in the treatment were compared with those of the 8 men in a control group. Changes were not achieved for all of the men, and there were no

differences between the experimental and control groups in the frequency of same-sex sexual behavior.

The results of the experimental studies suggest that some men who participate in clinical treatment studies may be conditioned to control their sexual arousal response to sexual stimuli, although McConaghy's (cf. McConaghy, 1999) studies suggest that aversive treatments may affect sexual arousal indiscriminately. These studies found that not all men reduce their sexual arousal to these treatments and that changes in sexual arousal in the lab are not necessarily associated with changes in sexual behavior.

Quasi-experimental studies

The three quasi-experiments listed in Appendix B all compare treatment alternatives for nonequivalent groups of men. Birk et al. (1971) found that 5 (62%) of the 8 men in the aversive treatment condition reported decreased sexual feelings following treatment; one man out of the 8 (12%) demonstrated reduced sexual arousal at long-term follow-up. In comparing groups, the researchers found that reports of same-sex "cruising," same-sex sexual "petting," and orgasm declined significantly for men receiving shocks when compared with men receiving associative conditioning. McConaghy and colleagues (1981) found that 50% of respondents reported decreased sexual feelings at 1 year. S. James (1978) reported that anticipatory avoidance learning was relatively ineffective when compared with desensitization. In their review, H. E. Adams and Sturgis (1977) found that 50% of the 124 participants in what they termed uncontrolled studies reported reduced sexual arousal.

Nonexperimental studies

Nonexperimental studies, which lack sufficient rigor to assess efficacy but which may be useful in identifying potential treatment approaches, offer a similar view of the impact of aversive treatment on reductions in sexual arousal. For instance, Bancroft (1969), in a within-subject study without a comparison group, delivered electric shocks based on males' penile volume responses to photographs of nude men as they were fantasizing about homosexual sexual encounters. Research subjects underwent a minimum of 30 treatment sessions. Bancroft reported that of the men who were initially sexually attracted to both sexes, 30% ($n = 3$) of these men lessened their same-sex sexual interest over the long-term. Among those with no initial other-sex sexual attraction, no lasting changes were observed in sexual

arousal and attraction. Several other uncontrolled studies found reductions in participants' self-reported sexual attraction and physiological response under laboratory conditions (range = 7%–100%; average = 58%) (Callahan & Leitenberg, 1973; Feldman & MacCulloch, 1965; Fookes, 1960; Hallam & Rachman, 1972; MacCulloch & Feldman, 1967; Sandford, Tustin, & Priest, 1975).

As is typically found in intervention research, the average proportion of men who are reported to change in uncontrolled studies is roughly double the average proportion of men who are reported to change in controlled studies. For instance, as noted previously, results from controlled studies show that far less change can be produced in same-sex sexual arousal by aversion techniques. H.E. Adams and Sturgis (1977) reported that in the nonexperimental studies in their review, 68% of 47 participants reduced their same-sex sexual arousal, compared with 34% of participants in experimental studies.

The studies of nonaversive techniques as the primary treatment, such as biofeedback and hypnosis, were only assessed in the nonexperimental within-subject and patient case studies. For example, Blicht and Haynes (1972) treated a single female who was heterosexually experienced and whom they described as strongly committed to reducing her same-sex sexual attractions. Using relaxation, rehearsal, and masturbation reconditioning, she was reported to be able to masturbate without female fantasies 2 months after intervention. Curtis and Presly (1972) used covert sensitization to treat a married man who experienced guilt about his attraction to and extramarital engagement with men. After intervention, he showed reduced other-sex and same-sex sexual interest, as measured by questionnaire items. Huff (1970) treated a single male who was interested in becoming sexually attracted to women. Following desensitization, his journal entries showed that his same-sex sexual fantasies continued, though the ratio of other-sex to same-sex sexual fantasies changed by the 6-month follow-up to favor other-sex sexual fantasies. His MMPI scores showed improvement in his self-concept and reductions in his distress.

By contrast, among the 4 men exposed to orgasmic reconditioning by Conrad and Wincze (1976), all reported decreased same-sex sexual attractions immediately following intervention, but only one demonstrated a short-term measurable alteration in physiological responses to male stimuli. Indeed, one subject's sexual arousal to same-sex sexual stimuli

increased rather than decreased, a result that was obtained for some men in the experimental studies. In a study by Barlow and colleagues (1975), among 3 men who were each exposed to unique biofeedback treatment regimens, all maintained same-sex sexual arousal patterns at follow-up, as measured by penile circumference change in response to photos of male stimuli.

Mintz (1966) found that 8 years after initiating group and individual therapy, 5 of his 10 research participants (50%) had dropped out of therapy. Mintz perceived that among those who remained, 20% ($n = 1$) were distressed, 40% ($n = 2$) accepted their same-sex sexual

Overall, the low degree of scientific rigor in these studies is likely to lead to overestimates of the benefits of these treatments on reductions in same-sex sexual arousal and attraction and may also explain the contradictory results obtained in nonexperimental studies.

attractions, and 40% ($n = 2$) were free from conflict regarding same-sex sexual attractions. Birk (1974) assessed the impact of behavioral therapy on 66 men, of whom 60% ($n = 40$) had dropped out of intervention by 7 months. Among those

who remained in the study, a majority shifted toward heterosexual scores on the Kinsey scale by 18 months.

Overall, the low degree of scientific rigor in these studies is likely to lead to overestimates of the benefits of these treatments on reductions in same-sex sexual arousal and attraction and may also explain the contradictory results obtained in nonexperimental studies.

RECENT STUDIES

Recent studies have investigated whether people who have participated in efforts to change their sexual orientation report decreased same-sex sexual attractions (Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003) or how people evaluate their overall experiences of SOCE (Beckstead & Morrow 2004; Pattison & Pattison, 1980; Ponticelli, 1999; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Wolkomir, 2001). These studies all use designs that do not permit cause-and-effect attributions to be made. We conclude that although these studies may be useful in describing people who pursue SOCE and their experiences of SOCE, none of the recent studies can address the efficacy of SOCE or its promise as an intervention. These studies are therefore described elsewhere in the

report in places where they contribute to understanding respondents' motivations for and experiences of SOCE.

SUMMARY

Overall, early studies suggest that modest short-term effects on reducing same-sex sexual arousal in the laboratory may be obtained for a minority of study participants through some forms of SOCE, principally interventions involving aversion procedures such as electric shock. Short-term reductions in sexual arousal to other-sex stimuli were also reported for some treatments. When outcomes were described for individual participants or subgroups of participants, short-term reductions in same-sex sexual arousal patterns were more commonly reported for people described as having other-sex sexual attractions prior to intervention and high levels of motivation to change. Initial and sustained reductions in sexual arousal were reported less commonly for people who were described as having no other-sex sexual attraction prior to intervention. The results from the uncontrolled studies are more positive than those from the controlled studies, as would be expected. Yet these studies also found that reduction in sexual arousal may not occur for study participants. Recent studies provide no sound scientific basis for determining the impact of SOCE on decreasing same-sex sexual attraction.

Decreasing Same-Sex Sexual Behavior

EARLY STUDIES

Early studies show that SOCE have limited impact on same-sex sexual behavior, even in cases in which lab results show some reduction in same-sex sexual arousal.³⁷

Experimental studies

In their review, H. E. Adams and Sturgis (1977) found that across the seven controlled studies published between 1960 and 1976, 18% of 179 subjects in these studies were reported to have decreased same-sex sexual behavior; the percentage reporting reductions in sexual arousal was nearly double that percentage, at 34%. In our review, we found that the results of

³⁷ In considering the results of early studies on this outcome, readers are advised that data on this outcome are not always reported. In some cases, not all research participants in these studies had engaged in sexual activity with same-sex partners prior to treatment, though they may have fantasized about doing so. In other studies, reducing sexual arousal under lab conditions was examined and not behavior in daily life.

the experimental studies that we reviewed provided a picture of the effects of aversive forms of SOCE similar to that painted by H. E. Adams & Sturgis.

For instance, in his study comparing aversion and aversion relief therapies,³⁸ McConaghy (1969) reported that about 20% of men had engaged in same-sex sexual behavior within 2 weeks following treatment. No longer-term follow-up data were reported. McConaghy (1976) found that 50% of men had reduced the frequency of their same-sex behavior, 25% had not changed their same-sex behavior, and 25% reported no same-sex behavior at 1 year. McConaghy and Barr (1973) reported that 25% of men had reduced their same-sex sexual behavior at 1-year. Tanner (1975) reported a significant decline in same-sex behavior across treatments. In the only untreated control group study that we identified, Tanner (1974) found that intervention had no effect on rates of same-sex behavior, even though the intervention did reduce changes in penile circumference in response to male stimuli in the lab.

Quasi-experimental studies

Birk and colleagues (1971) found that 2 of 18 men (11%) had avoided same-sex behavior at 36 months. McConaghy et al. (1981) reported that among the 11 men who were sexually active with same-sex partners, about 25% reduced their same-sex behavior. S. James (1978) did not report on behavior. In their review, H. E. Adams and Sturgis (1977) found that 50% of the 124 participants in what they called uncontrolled group studies reported reduced sexual arousal, and 42% reported less frequent same-sex sexual behavior. Among the quasi-experiments that we reviewed, the reported reductions in sexual behavior were lower (i.e., 11% and 25%) than what was reported by H. E. Adams and Sturgis. These differences may be due to our more rigorous criteria of what constitutes a quasi-experiment than the criteria employed by Adams and Sturgis.

Nonexperimental studies

Among the case and single-group within-subject studies, the results are mixed. Some studies found that people reported having abstained from same-sex behavior in the months immediately following intervention or having decreased its frequency. Bancroft (1969) found that 4 of the 10 men in his study had reduced their behavior at follow-up. Freeman and Meyer (1975) found that 7 of the 9 men in their study were abstinent at 18

³⁸ Aversion therapy involves the application of a painful stimulus; aversion relief therapy involves the cessation of an aversive stimulus.

months. Other single-subject and case study subjects reported declines in or no same-sex behavior (Gray, 1970; Huff, 1970; B. James, 1962, 1963; Kendrick & McCullough, 1972; Larson, 1970; LoPiccolo, 1971; Segal & Sims, 1972).

Not all individuals, however, successfully abstained on every occasion of sexual opportunity (Colson, 1972; Rehm & Rozensky, 1974), and some relapse occurred within months following treatment (Bancroft, 1969; Freeman & Meyer, 1975; Hallam & Rachman, 1972; Levin et al., 1968; MacCulloch et al., 1965; Marquis, 1970). In other studies, the proportion reporting that they changed their sexual behavior was a minority. For instance, among Barlow et al.'s (1975) research participants, 2 of the 3 men demonstrated no change in their same-sex behavior. In the case studies, clients who were described as exclusively attracted to the same sex prior to treatment were most commonly reported to have failed to avoid same-sex sexual behavior following treatment.

RECENT STUDIES

As we have noted, recent studies provide no sound basis for attributing individual reports of their current behavior to SOCE. No results are reported for these studies.

SUMMARY

In the early studies with the greatest rigor, it appears that SOCE may have decreased short-term same-sex sexual behavior for a minority of men. However, in the only randomized control group trial, the intervention had no effect on same-sex sexual behavior. Quasi-experimental results found that a minority of men reported reductions in same-sex sexual behavior following SOCE. The nonexperimental studies found that study participants often reported reduced behavior but also found that reductions in same-sex sexual behavior, when reported, were not always sustained.

Increasing Other-Sex Sexual Attraction

Early studies provide limited evidence for reductions in sexual arousal to same-sex stimuli and for reductions in same-sex sexual behavior following aversive treatments. The impact of the use of aversive treatments for increasing other-sex sexual arousal is negligible.

EARLY STUDIES

Experimental studies

In many of the early experiments on aversive treatments, sexual arousal to female sexual stimuli was a desired outcome. McConaghy (1969) found that about 16% of 40 men increased their sexual arousal to female stimuli immediately following treatment and that 5% increased their sexual arousal to male stimuli. It is unclear how the 50% of men in this study who were aroused by females prior to the treatment were distributed among the men who increased their sexual arousal and among those who did not. In other words, it is possible that most of the men who changed were sexually aroused by women initially. In interviews following treatment, McConaghy (1976) reported that 25% of 157 men indicated that they felt more sexual arousal toward females than they did before treatment. McConaghy et al. (1972) found no change in rates of sexual arousal to female stimuli. McConaghy et al.'s (1972) research participants showed no change in penile volume in response to female stimuli after intervention.

In a randomized control trial, Tanner's (1974) 8 research participants reported increases in sexual fantasizing about other-sex partners after aversive conditioning. However, penile circumference data showed no increased sexual arousal to female stimuli. H. E. Adams and Sturgis (1977) found that 26% of 179 participants in the controlled studies that they reviewed increased their sexual arousal toward the other-sex.

Quasi-experimental studies

Birk and colleagues (1971) found no difference between their treatment groups in reported sexual arousal to women. Two men (11% of 18 participants) in the study reported sustained sexual interest in women following treatment. McConaghy and colleagues (1981) reported no significant improvement in attraction to females. S. James (1978) reported little impact of treatment on participants in anticipatory avoidance learning. He noted a general improvement among 80% of the 40 men undergoing desensitization to other-sex situations.

Nonexperimental studies

Among the nonexperimental studies, for men who were described as having some degree of other-sex sexual attraction and experience before the intervention, the balance of studies showed an increase in other-sex sexual attraction over time, although given the nonexperimental nature of these studies, this change

cannot be validly attributed to SOCE. For men with little or no preintervention other-sex sexual attraction, the research provides little evidence of increased other-sex sexual attraction.

As in some of the experimental studies, the results reported in the nonexperiments were not always in the desired direction. Studies occasionally showed that reductions in sexual arousal and interest may occur for same- and other-sex partners, suggesting the possibility that treatments may lower sexual arousal to sexual stimuli in general. For instance, Curtis and Presly's (1972) married male subject reported slightly lower rates of sexual arousal in response to women than before intervention, in addition to reduced same-sex sexual arousal.

Among early studies, many found little or no increases in other-sex sexual attraction among participants who showed limited or no other-sex sexual attraction to begin with. For instance, 2 of the 3 men in Barlow et al.'s (1975) within-subject biofeedback investigation reported little or no other-sex sexual interest prior to intervention. As measured by penile circumference, one of these men demonstrated negligible increases in other-sex sexual attraction; one other individual showed stable low other-sex sexual attraction, which contradicted his self-report.

In contrast, a handful of the early single-patient case studies found increases in other-sex attraction. For instance, Hanson and Adesso's (1972) research participant, who was reported to be primarily same-sex sexually attracted at the onset of intervention, increased his sexual arousal to women and ultimately reported that he enjoyed sex with women. Huff's (1970) male research participant also reported increased other-sex sexual attraction at 6 months following desensitization.

RECENT STUDIES

As we have noted, recent studies provide no sound basis for attributing individual reports of their current other-sex sexual attraction to SOCE. No results are reported for these studies.

SUMMARY

Taken together, the research provides little support for the ability of interventions to develop other-sex sexual attraction where it did not previously exist, though it may be possible to accentuate other-sex sexual attraction among those who already experience it.

Increasing Other-Sex Sexual Behavior

Studies on whether interventions can lead to other-sex sexual activity show limited results. These studies show more success for those who had some other-sex sexual orientation (e.g., sexual arousal) and were sexually experienced with members of the other sex prior to intervention than for those who had no other-sex sexual orientation and no history of other-sex sexual behavior. The results for this outcome suggest that some people can initiate other-sex sexual behavior whether or not they have any observed other-sex sexual orientation.

As previously noted, in the early studies many people were described as heterosexually experienced. From the data provided by H.E. Adam and Sturgis in their 1977 review, 61%–80% of male research participants appeared to have histories of dating women, and 33%–63% had sexual intercourse with women prior to intervention. Additionally, some of the men were married at the time of intervention. Because so many of the research participants in these studies had other-sex sexual attractions or intimate relationships at the outset, it is unclear how to interpret changes in their levels of other-sex sexual activity.

EARLY STUDIES

Experimental studies

According to H. E. Adams and Sturgis (1977), only 8% of participants in controlled studies are reported to have engaged in other-sex sexual behavior following SOCE. Among those studies we reviewed, only 2 participants showed a significant increase in other-sex sexual activity (McConaghy & Barr, 1973; Tanner, 1974). In Tanner's randomized controlled trial, men increased the frequency of intercourse with females but maintained the frequency of intercourse with males.

Quasi-experimental studies

McConaghy et al. (1981) found no difference in the frequency of other-sex sexual behavior following SOCE.

Nonexperimental studies

Among within-subject patient studies in which aversion techniques were used, some studies reported that a subset of 12%–40% of people in the multiple-subject studies and all people in single-patient studies engaged in other-sex sexual behavior following intervention (e.g., Bancroft, 1969; Fookes, 1960; Hallam & Rachman, 1972; Hanson & Adesso, 1972; Kendrick & McCullough, 1972; Larson, 1970). Regarding other techniques

studied in early intervention research, Barlow et al. (1975) reported that 1 of 3 research participants began to date women after biofeedback. Huff's (1970) research participant also began to date women after desensitization training. LoPiccolo (1971) used orgasmic reconditioning to treat a male–female couple. The male could not achieve an erection with his female partner and found sex with women dissatisfying. At 6 months, he was able to develop and maintain an erection and ejaculate intravaginally.

RECENT STUDIES

As previously noted, recent studies provide no sound basis for attributing individual reports of their current sexual behavior to SOCE. No results are reported for these studies.

SUMMARY

In general, the results from studies indicate that while some people who undergo SOCE do engage in other-sex sexual behavior afterward, the balance of the evidence suggests that SOCE is unlikely to increase other-sex sexual behavior. Findings show that the likelihood of having sex with other-sex partners for those research participants who possess no other-sex sexual orientation prior to the intervention is low.

Marriage

One outcome that some proponents of efforts to change sexual orientation are reported to value is entry into heterosexual marriage. Few early studies reported on whether people became heterosexually married after intervention. In a quasi-experimental study, Birk et al. (1971) found that 2 of 18 respondents (11%) were married at 36 months. Two uncontrolled studies (Birk, 1974; Larson, 1970) indicated that a minority of research participants ultimately married, though it is not clear what role, if any, intervention played in this outcome. Recent research provides more information on marriage, though research designs do not permit any attribution of marital outcomes to SOCE.

Improving Mental Health

The relationship between mental health, psychological well-being, sexual orientation, sexual orientation identity, and sexual behavior is important. Few studies report health and mental health outcomes, and those that do report outcomes tend to use psychometrically

weak measures of these constructs and weak study designs. Among the early studies that report on mental health, three nonexperimental single-patient case studies report that clients were more self-assured (Blitch & Haynes, 1972) or less fearful and distressed (Hanson & Adesso, 1972; Huff, 1970).

Overall, the lack of high-quality data on mental health outcomes of efforts to change sexual orientation provide no sound basis for claims that people's mental health and quality of life improve. Indeed, these studies add little to understanding how SOCE affects people's long-term mental health.

Reports of Harm

Determining the efficacy of any intervention includes examination of its side effects and evidence of its harm (Flay et al., 2005; Lilienfeld, 2007). A central issue in the debates regarding efforts to change same-sex sexual attractions concerns the risk of harm to people that may result from attempts to change their sexual orientation. Here we consider evidence of harm in early and recent research.

EARLY STUDIES

Early research on efforts to change sexual orientation focused heavily on interventions that include aversion techniques. Many of these studies did not set out to investigate harm. Nonetheless, these studies provide some suggestion that harm can occur from aversive efforts to change sexual orientation.

EXPERIMENTAL STUDIES

In McConaghy and Barr's (1973) experiment, 1 respondent of 46 subjects is reported to have lost all sexual feeling and to have dropped out of the treatment as a result. Two participants reported experiencing severe depression, and 4 others experienced milder depression during treatment. No other experimental studies reported on iatrogenic effects.

QUASI-EXPERIMENTAL STUDIES

None reported on adverse events.

NONEXPERIMENTAL STUDIES

A majority of the reports on iatrogenic effects are provided in the nonexperimental studies. In the study conducted by Bancroft (1969), the negative outcomes reported include treatment-related anxiety (20% of 16

participants), suicidal ideation (10% of 16 participants), depression (40% of 16 participants), impotence (10% of 16 participants), and relationship dysfunction (10% of 16 participants). Overall, Bancroft reported the intervention had harmful effects on 50% of the 16 research subjects who were exposed to it. Quinn, Harbison, and McAllister (1970) and Thorpe et al. (1964) also reported cases of debilitating depression, gastric distress, nightmares, and anxiety. Herman and Prewett (1974) reported that following treatment, their research participant began to engage in abusive use of alcohol that required his rehospitalization. It is unclear to what extent and how his treatment failure may have contributed to his abusive drinking. B. James (1962) reported symptoms of severe dehydration (acetonuria), which forced treatment to be suspended.

Overall, although most early research provides little information on how research participants fared over the longer term and whether interventions were associated with long-term negative effects, negative effects of treatment are reported to have occurred for some people during and immediately following treatment.

High dropout rates characterize early treatment studies and may be an indicator that research participants experience these treatments as harmful. Lilienfeld's (2007) review of harm in psychotherapy identified dropout as not only an indicator of direct harm but also of treatment ineffectiveness.

RECENT STUDIES

Although the recent studies do not provide valid causal evidence of the efficacy of SOCE or of its harm, some recent studies document that there are people who perceive that they have been harmed through SOCE (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; G. Smith et al., 2004), just as other recent studies document that there are people who perceive that they have benefited from it (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Pattison & Pattison, 1980; Schaeffer et al., 2000; Spitzer, 2003). Among those studies reporting on the perceptions of harm, the reported negative social and emotional consequences include self-reports of anger, anxiety, confusion, depression, grief, guilt, hopelessness, deteriorated relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation, self-hatred, and sexual dysfunction. These reports of perceptions of harm are countered by accounts of

perceptions of relief, happiness, improved relationships with God, and perceived improvement in mental health status, among other reported benefits. Many participants in studies by Beckstead and Morrow (2004) and Shidlo and Schroeder (2002) described experiencing first the positive effects and then experiencing or acknowledging the negative effects later.

Overall, the recent studies do not give an indication of the client characteristics that would lead to perceptions of harm or benefit. Although the nature of these studies precludes causal attributions for harm or benefit to SOCE, these studies underscore the diversity of and range in participants' perceptions and evaluations of their SOCE experiences.

Summary

We conclude that there is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the

Studies from both periods indicate that attempts to change sexual orientation may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts. The lack of rigorous research on the safety of SOCE represents a serious concern, as do studies that report perceptions of harm.

prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE. However, studies from both periods indicate

that attempts to change sexual orientation may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts. The lack of rigorous research on the safety of SOCE represents a serious concern, as do studies that report perceptions of harm (cf. Lilienfeld, 2007).

Conclusion

The limited number of rigorous early studies and complete lack of rigorous recent prospective research on SOCE limits claims for the efficacy and safety of SOCE. Within the early group of studies, there are a small number of rigorous studies of SOCE, and those focus on the use of aversive treatments. These studies show that

enduring change to an individual's sexual orientation is uncommon and that a very small minority of people in these studies showed any credible evidence of reduced

Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life.

same-sex sexual attraction, though some show lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and increased

attraction to and engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. We found that nonaversive and recent approaches to SOCE have not been rigorously evaluated. Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective.

We found that there was some evidence to indicate that individuals experienced harm from SOCE. Early studies do document iatrogenic effects of aversive forms of SOCE. High dropout rates characterize early aversive treatment studies and may be an indicator that research participants experience these treatments as harmful. Recent research reports indicate that there are individuals who perceive they have been harmed and others who perceive they have benefited from nonaversive SOCE. Across studies, it is unclear what specific individual characteristics and diagnostic criteria would prospectively distinguish those individuals who will later perceive that they have succeeded and benefited from nonaversive SOCE from those who will later perceive that they have failed or been harmed. In the next chapter, we explore the literature on individuals who seek to change their sexual orientation to better understand their concerns.

5. RESEARCH ON ADULTS WHO UNDERGO SEXUAL ORIENTATION CHANGE EFFORTS

In the preceding three chapters, we have focused on sexual orientation change efforts (SOCE),³⁹ because such interventions have been the primary focus of attention and contention in recent decades. Now we turn from the problem of sexual orientation change, as it has been defined by “expert” narratives of sin, crime, disorder, and dysfunction in previous chapters, to the problem of sexual orientation distress, as it exists in the lives of individuals who seek and participate in sexual orientation change. We try to present what the research literature reveals—and clarify what it does not—about the natural history of the phenomenon of people who present to LMHP seeking SOCE.

We do this for two major reasons. The first is to provide a scholarly basis for responding to the core task force charge: “the appropriate application of affirmative therapeutic interventions” for the population of those individuals who seek sexual orientation change. The second is our hope to step out of the polemic that has defined approaches to sexual orientation distress. As discussed in the introduction, some professional articles (e.g., Rosik, 2001, 2003; Yarhouse & Burkett, 2002), organizations, and accounts of debates (cf. Drescher, 2003) have argued that APA and mainstream psychology are ignoring the needs of those for whom same-sex sexual attractions are unwanted, especially

We hope that an empathic and comprehensive review of the scholarly literature of the population that seeks and participates in SOCE can facilitate an increased understanding of the needs of this population so that an affirmative therapeutic approach may be developed.

the needs of this population so that an affirmative therapeutic approach may be developed.

We decided to expand our review beyond empirical literature to have a fuller view of the population in question. Because of the lack of empirical research in this area, the conclusions must be viewed as tentative. The studies that are included in this discussion are (a) surveys and studies of individuals who participated in SOCE and their perceptions of change, benefit, and harm (e.g., S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003; Throckmorton & Welton, 2005)⁴⁰; (b) high-quality qualitative studies of the concerns of participants and the dynamics of SOCE (e.g., Beckstead & Morrow, 2004; Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006); (c) case reports, clinical articles, dissertations, and reviews in

for religious populations. We hope that an empathic and comprehensive review of the scholarly literature of the population that seeks and participates in SOCE can facilitate an increased understanding of

³⁹ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person’s same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

⁴⁰ As previously noted, these studies, due to their significant methodological issues, cannot assess whether actual sexual orientation change occurred.

which sexual orientation or sexual orientation identity change were considered or attempted (e.g., Borowich, 2008; Drescher, 1998b; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Horlacher, 2006; Karten, 2006; Mark, 2008; Tan, 2008, Yarhouse et al., 2005; Yarhouse, 2008); and (d) scholarly articles, case reports, dissertations, and reviews on the concerns of religious individuals who are conflicted by their same-sex sexual attractions, some of whom accept their same-sex sexual orientation (e.g., Coyle & Rafalin, 2000, Horlacher, 2006; Kerr, 1997; Mahaffy, 1996; Mark, 2008, Moran, 2007; O'Neill & Ritter, 1992; Shallenberger, 1998; Tan, 2008; Thumma, 1991; Yarhouse, 2008; Yarhouse et al., 2005; Yip, 2000, 2002, 2003, 2005). We also reviewed a variety of additional scholarly articles on subtopics such as individuals in other-sex marriages and general literature on sexual orientation concerns.

Demographics

The majority of participants in research studies on SOCE have been Caucasian men. Early studies included some men who were court-referred and whose participation was not voluntary (S. James, 1978; McConaghy, 1969, 1976; McConaghy et al., 1972), but more recent research primarily included men who indicated that their religion is of central importance (Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Wolkomir, 2001). Some studies included small numbers of women (22%–29%; Nicolosi et al., 2000; S. L. Jones & Yarhouse, 2007; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003), and two studies focused exclusively on women (Moran, 2007; Ponticelli, 1999). However, these studies do not examine if there are potential differences between the concerns of men and women.

To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals who have sought SOCE.

sample in other studies (S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003). In the recent studies, no comparisons were reported between the

Members of racial-ethnic groups are not included in some samples (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001) and are a small percentage (5%–14%) of the

ethnic minorities in the sample and others. Thus, there is no evidence that can elucidate concerns of ethnic minority individuals who have sought SOCE. To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals who have sought SOCE.

Samples in recent SOCE studies have been composed predominantly of individuals from conservative Christian denominations (Beckstead & Morrow, 2004; Erzen, 2006; Nicolosi et al., 2000; Ponticelli, 1999; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003; Wolkomir, 2001). These studies included very few nonreligious individuals, and the concerns of religious individuals of faiths other than Christian are not described. Thus, the existing literature limits information to the concerns of a particular group of religious individuals. Finally, most individuals in studies of SOCE have tried multiple ways to change their sexual orientation, ranging from individual psychotherapy to religiously oriented groups, over long periods of time and with varying degrees of satisfaction and varying perceptions of success (Beckstead & Morrow, 2004; Comstock, 1996; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Mark, 2008; Nicolosi et al., 2000; Shidlo & Schroeder, 2002).

Why Individuals Undergo Sexual Orientation Change Efforts

Because no research provides prevalence estimates of those participating in SOCE, we cannot determine how prevalent the wish to change sexual orientation is among the conservative Christian men who have predominated in the recent research, or among any other population. Clients' motivations to seek out and participate in SOCE seem to be complex and varied and may include mental health and personality issues, cultural concerns, religious faith, internalized stigma, as well as sexual orientation concerns (Beckstead & Morrow, 2004; Drescher, 1998b; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Lasser & Gottlieb, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000). Some of the factors influencing a client's request for SOCE that have been identified in the literature include the following:

- Confusion or questions about one's sexuality and sexual orientation (Beckstead & Morrow, 2004; G. Smith et al., 2004)
- Religious beliefs that consider homosexuality sinful or unacceptable (Erzen, 2006; Haldeman, 2004; S. L. Jones & Yarhouse, 2007; Mark, 2008; Ponticelli, 1999; Tan, 2008; Tozer & Hayes, 2004; Wolkomir, 2001, 2006; Yarhouse, 2008)
- Fear, stress, and anxiety surrounding the implications of an LGB identity (especially the illegitimacy of such an identity within the client's religious faith or community) (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008; Shidlo & Schroeder, 2002)
- Family pressure to be heterosexual and community rejection of those who are LGB (Haldeman, 2004; Glassgold, 2008; Mark, 2008; Shidlo & Schroeder, 2002; G. Smith et al., 2004)

Some individuals who have pursued SOCE report having had only unsuccessful or unfulfilling same-sex sexual experiences in venues such as bars or sexual "cruising" areas (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). These experiences reflected and re-created restricted views that the "gay lifestyle" is nonspiritual, sexually desperate, or addicted, depressive, diseased, and lonely (Drescher, 1998b; Green, 2003; Rosik, 2003; Scasta, 1998). Many sexual minority individuals who do not seek SOCE are also affected by these factors. Thus, these findings do not explain why some people seek SOCE and others do not.

There are some initial findings that suggest differences between those who seek SOCE and those who resolve their sexual minority stress through other means. For example, Ponticelli (1999) and S. L. Jones and Yarhouse (2007) reported higher levels of self-reported family violence and sexual abuse in their samples than were reported by Laumann et al. (1994) in a population-based sample. Beckstead and Morrow (2004) and S. L. Jones and Yarhouse reported high levels of parental rejection or authoritarianism among their religious samples (see also G. Smith et al., 2004). Wolkomir (2001) found that distress surrounding nonconformity to traditional gender roles distinguished the men in her sample who did not accept their sexual orientation from those who did. Similarly, Beckstead and Morrow found that distress and questions about masculinity were an important appeal of SOCE; some men who sought SOCE described feeling distress about

not acting more traditionally masculine. In reviewing the SOCE literature, Miville and Ferguson (2004) proposed that White, conservatively religious men might not feel adept at managing a minority status and thus seek out SOCE as a resolution.

The views of LMHP concerning SOCE and homosexuality appear to influence clients' decision making in choosing SOCE; some clients reported being urged by their provider to participate in SOCE (M. King et al. 2004; Schroeder & Shidlo, 2001; G. Smith et al., 2004). For example, G. Smith et al. (2004) found that some who had received SOCE had not requested it. These individuals stated they had presented with confusion and distress about their orientation due to cultural and relational conflicts and were offered SOCE as the solution.

Specific Concerns of Religious Individuals

In general, the participants in research on SOCE have come from faiths that believe heterosexuality and other-sex relationships are part of the natural order and are morally superior to homosexuality (Beckstead & Morrow, 2004; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001, 2006). The literature on SOCE suggests that individuals reject or fear their same-sex sexual attractions because of the internalization of the values and attitudes of their religion that characterize homosexuality negatively and as something to avoid (Beckstead & Morrow, 2004; Erzen, 2006; Glassgold, 2008; Mark, 2008; Nicolosi et al., 2000; Ponticelli, 1999; Wolkomir, 2001, 2006).

The experiences of some conservative religious individuals with same-sex sexual attractions who undergo SOCE appear to involve significant stress due to the struggle to live life congruently with their religious beliefs (S. L. Jones & Yarhouse, 2007; Yarhouse et al., 2005; Yarhouse & Tan, 2004). These individuals perceive homosexuality to be irreconcilable with their faith and do not wish to surrender or change their faith (Wolkomir, 2006). Some report fearing considerable shifts or losses in their core identity, role, purpose, and sense of order if they were to pursue an outward LGB identity (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Wolkomir, 2006). Some report difficulty coping with intense guilt over the failure to live a virtuous life and inability to stop committing unforgivable sins, as defined by their

religion (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008). Some struggled with their belief in God, perceiving that God was punishing or abandoning them—or would if they acted on their attractions; some expressed feelings of anger at the situation in which their God had placed them (Beckstead & Morrow, 2004; Glassgold, 2008; cf. Exline, 2002; Pargament, Smith, Koenig, & Perez, 1998; Pargament et al., 2005).

Some individuals' distress took the form of a crisis of faith in which their religious beliefs that a same-sex sexual orientation and religious goodness are

The distress experienced by religious individuals appeared intense, for not only did they face sexual stigma from society at large but also messages from their faith that they were deficient, sinful, deviant, and possibly unworthy of salvation unless they changed sexual orientation.

diametrically opposed led them to question their faith and themselves (Glassgold, 2008; Moran, 2007; Tozer & Hayes, 2004). Spiritual struggles also occurred for religious sexual

minorities due to struggling with conservatively religious family, friends, and communities who thought differently than they did. The distress experienced by religious individuals appeared intense, for not only did they face sexual stigma from society at large but also messages from their faith that they were deficient, sinful, deviant, and possibly unworthy of salvation unless they changed sexual orientation (Beckstead & Morrow, 2004).

These spiritual struggles had mental health consequences. Clinical publications and studies of religious clients (both male and female) (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008) have described individuals who felt culpable, unacceptable, unforgiven, disillusioned, and distressed due to the conflict between their same-sex sexual attractions and religion. The inability to integrate religion and sexual orientation into a religiously sanctioned life (i.e., one that provides an option for positive self-esteem and religiously sanctioned sexuality and family life) has been described as causing great emotional distress (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008; D. F. Morrow, 2003). These spiritual struggles were sometimes associated with anxiety, panic disorders, depression, and suicidality, regardless of the level of religiosity or the perception of religion as a source of comfort and coping (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Horlacher, 2006). The emotional

reactions reported in the literature on SOCE among religious individuals are consistent with those reported in the psychology of religion literature that describes both the impact of an inability to live up to religious motivations and the effects of religion and positive and negative religious coping (Ano & Vasconcelles, 2005; Exline, 2002; Pargament & Mahoney, 2002; Pargament et al., 2005; Trenholm, Trent, & Compton, 1998).

Some individuals coped by trying to compartmentalize their sexual orientation and religious identities and behaviors or to suppress one identity in favor of another (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008). Relief came as some sought repentance from their "sins," but others continued to feel isolated and unacceptable in both religious and sexual minority communities (Shidlo & Schroeder, 2002; Yarhouse & Beckstead, 2007). As an alternative, some with strong religious motivations and purpose were willing to make sexual abstinence a goal and to limit sexual and romantic needs in order to achieve congruence with their religious beliefs (S. L. Jones & Yarhouse, 2007; Yarhouse et al., 2005; Yarhouse, 2008). These choices are consistent with the psychology of religion that emphasizes religious motivations and purpose (cf. Emmons, 1999; Emmons & Paloutzian, 2003; Hayduk, Stratkotter, & Rovers, 1997; Roccas, 2005). Success with this choice varied greatly and appeared successful in a minority of participants of studies, although not always in the long term, and both positive and negative mental health effects have been reported (Beckstead & Morrow, 2004; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Shidlo & Schroeder, 2002).

Some conservatively religious individuals felt a need to change their sexual orientation because of the positive benefits that some individuals found from religion (e.g., community, mode of life, values, sense of purpose) (Beckstead & Morrow, 2004; Borowich, 2008; Glassgold, 2008; Haldeman, 2004; Mark, 2008; Nicolosi et al., 2000; Yarhouse, 2008). Others hoped that being heterosexual would permit them to avoid further negative emotions (e.g., self-hatred, unacceptability, isolation, confusion, rejection, and suicidality) and expulsion from their religious community (Beckstead & Morrow, 2004; Borowich, 2008; Glassgold, 2008; Haldeman, 2004; Mark, 2008).

The literature on non-Christian religious denominations is very limited, and no detailed literature was found on most faiths that differed from the descriptions cited previously. There is limited information on the specific concerns of observant

and Orthodox Jews⁴¹ (e.g., Blechner, 2008; Borowich, 2008; Glassgold, 2008; Mark, 2008; Wolowelsky & Weinstein, 1995). This work stresses the conflicts that emerge within a communal and insular culture that values obedience to religious law and separates itself from mainstream society and other faiths, including mainstream LGB communities, thus isolating those in conflict and distress (Glassgold, 2008; Mark, 2008). As marriage, family, and community are the central units of life within such a religious context, LGB individuals do not have a place in Orthodox Judaism and traditional Jewish society and may fear losing contact with family and society or bringing shame and negative consequences to their family if their sexual orientation is disclosed.⁴² Many of the responses and concerns of the conservative Christian population appear relevant to those who are Orthodox Jews, especially those that arise from the conflicts of faith and sexual orientation, such as feelings of guilt, doubt, crisis of faith, unworthiness, and despair (Glassgold, 2008; Mark, 2008).

We found no scholarly psychological literature on sexual minority Muslims who seek SOCE. There is some

It is important to note that not all sexual minorities with strong religious beliefs experience sexual orientation distress, and some resolve such distress in other ways than SOCE.

literature on debates about homosexuality within Islam and cultural conflicts for those Muslims who live in Western societies with more progressive attitudes

toward homosexuality (Halstead & Lewicka, 1998; Hekma, 2002; de Jong & Jivraj, 2002; Massad, 2002; Nahas, 2004). Additionally, there is some literature on ways in which individuals integrate LGBT identities with their Muslim faith (Minwalla, Rosser, Feldman, & Varga, 2005; Yip, 2005). We did not find scholarly articles about individuals from other faiths who sought SOCE, except for one article (Nicolosi et al., 2000) that did not report any separate results for individuals from non-Christian faiths.

It is important to note that not all sexual minorities with strong religious beliefs experience sexual orientation distress, and some resolve such distress

⁴¹ Among Jewish traditions, Orthodox Judaism is the most conservative and does not have a role for same-sex relationships or sexual orientation identities within its faith (Mark, 2008). Individuals in other denominations (e.g., Conservative, Reform, Reconstructionist) may not face this type of conflict or this degree of conflict.

⁴² These conflicts may also be relevant to those whose religion and community are similarly intertwined and separate from larger society; see Cates (2007), for instance, regarding an individual from an Old Amish community.

in other ways than SOCE (Coyle & Rafalin, 2000; Mahaffy, 1996; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Yip, 2000, 2002, 2003, 2005). For instance, some individuals are adherents of more accepting faiths and thus experience less distress. Some end their relationship with all religious institutions, although they may retain the religious and spiritual aspects of their original faiths that are essential to them. Others choose another form of religion or spirituality that is affirming of sexual minorities (Lease, Horne, & Noffsinger-Frazier, 2005; Ritter & O'Neill, 1989, 1995; Ritter & Terndrup, 2002; Rodriguez & Ouellette, 2000; Yip, 2000, 2002, 2003, 2004).

Conflicts of Individuals in Other-Sex Marriages or Relationships

There is indication that some individuals with same-sex sexual attractions in other-sex marriages or relationships may request SOCE. Many subjects in the early studies were married (H. E. Adams & Sturgis, 1977). In the more recent research, some individuals were married (e.g., Horlacher, 2006; Spitzer, 2003), and there are clinical reports of experiences of SOCE among other-sex married people (e.g., Glassgold, 2008; Isay, 1998). For some, the marriage to an other-sex person was described as based on socialization, religious views that deny same-sex sexual attractions, lack of awareness of alternatives, and hopes that marriage would change them (Gramick, 1984; Higgins, 2006; Isay, 1998; Malcolm, 2000; Ortiz & Scott, 1994; M. W. Ross, 1989). Others did not recognize or become aware of their sexuality, including same-sex sexual attractions, until after marriage, when they became sexually active (Bozett, 1982; Carlsson, 2007; Schneider et al., 2002). Others had attractions to both men and women (Brownfain, 1985; Coleman, 1989; Wyers, 1987).

For those who experienced distress with their other-sex relationship, some were at a loss as to how to decide what to do with their conflicting needs, roles, and responsibilities and experienced considerable guilt, shame, and confusion (Beckstead & Morrow, 2004; Bozett, 1982; Buxton, 1994, 2004, 2007; Gochros, 1989; Hays & Samuels, 1989; Isay, 1998; Shidlo & Schroeder, 2002; Yarhouse & Seymore, 2006). Love for their spouse conflicted with desires to explore or act on same-sex romantic and sexual feelings and relationships or to connect with similar others (Bridges & Croteau, 1994; Coleman, 1981/1982; Yarhouse & Seymore, 2006).

However, many individuals wished to maintain their marriage and work at making that relationship last (Buxton, 2007; Glassgold, 2008; Yarhouse, Pawlowski, & Tan, 2003; Yarhouse & Seymore, 2006). Thus, the sexual minority individual sometimes felt frustrated and hopeless in facing feelings of loss and guilt that result from trying to decide whether to separate from or remain in the marriage as he or she balanced hopes and ambiguities (e.g., the chances of finding a same-sex romantic or sexual partner or the possibilities of experiencing further intimacy with one's heterosexual spouse) (Hernandez & Wilson, 2007).

Reported Impacts of Sexual Orientation Change Efforts

Perceived Positives of SOCE

In this section we review the perceptions of individuals who underwent SOCE in order to examine what may be perceived as being helpful or detrimental by such individuals, distinct from a scientific evaluation of the efficacy or harm associated with sexual orientation change efforts, as reported in Chapter 4.

Individuals have reported that SOCE provided several benefits: (a) a place to discuss their conflicts (Beckstead & Morrow, 2004; Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001); (b) cognitive frameworks that permitted them to reevaluate their sexual orientation identity, attractions, and selves in ways that lessened shame and distress and increased self-esteem (Erzen, 2006; Karten, 2006; Nicolosi et al., 2000; Ponticelli, 1999; Robinson, 1998; Schaeffer et al., 2000; Spitzer, 2003; Throckmorton, 2002); (c) social support and role models (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006); and (d) strategies for living consistently with their religious faith and community (Beckstead & Morrow, 2004; Erzen, 2006; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Robinson, 1998; Throckmorton & Welton, 2005; Wolkomir, 2001, 2006).

For instance, participants reporting beneficial effects in some studies perceived changes to their sexuality, such as in their sexual orientation, gender identity, sexual behavior, sexual orientation identity (Beckstead, 2001; Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003; Throckmorton & Welton, 2005), or improving nonsexual relationships with men (Karten, 2006). These changes in sexual self-views were described in a variety of ways (e.g., ex-

gay, heterosexual, heterosexual with same-sex sexual attractions, heterosexual with a homosexual past) and with varied and unpredictable outcomes, some of which were temporary (Beckstead, 2003; Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). McConaghy (1999) reported that some men felt they had more control in their sexual behavior and struggled less with their attractions after interventions, although same-sex sexual attractions still existed (cf. Beckstead & Morrow, 2004). Additionally, some SOCE consumers noted that trying and failing to change their same-sex sexual orientation actually allowed them to accept their same-sex attractions (Beckstead & Morrow, 2004; G. Smith et al., 2004).

Participants described the social support aspects of SOCE positively. Individuals reported as positive that their LMHP accepted their goals and objections and had similar values (i.e., believing that a gay or lesbian identity is bad, sick, or inferior and not supporting same-sex relationships) (Nicolosi et al., 2000; Throckmorton & Welton, 2005). Erzen (2006), Ponticelli (1999), and Wolkomir (2001) described these religiously oriented ex-gay groups as a refuge for those who were excluded from conservative churches and from their

... such groups built hope, recovery, and relapse into an ex-gay identity, thus expecting same-sex sexual behaviors and conceiving them as opportunities for repentance and forgiveness.

families because of their same-sex sexual attractions, as well as from gay organizations and social networks because of their conservative religious beliefs. In Erzen's

experiences with these men, these organizations seemed to provide options for individuals to remain connected to others who shared their religious beliefs, despite ongoing same-sex sexual feelings and behaviors. Wolkomir (2006) found that ex-gay groups recast homosexuality as an ordinary sin, and thus salvation was still achievable. Erzen observed that such groups built hope, recovery, and relapse into an ex-gay identity, thus expecting same-sex sexual behaviors and conceiving them as opportunities for repentance and forgiveness.

Some participants of SOCE reported what they perceived as other positive values and beliefs underlying SOCE treatments and theories, such as supporting celibacy, validating other-sex marriage, and encouraging and supporting other-sex sexual behaviors (Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Throckmorton & Welton, 2005). For instance, many SOCE theories

and communities focus on supporting clients' values and views, often linked to religious beliefs and values (Nicolosi et al., 2000; Schaeffer et al., 2000; Throckmorton & Welton, 2005). According to Ponticelli (1999), ex-gay support groups provide alternate ways of viewing same-sex attractions that permit individuals to see themselves as heterosexual, which provided individuals a sense of possibility.

Participants' interpretations of their SOCE experiences and the outcomes of their experiences appeared to be shaped by their religious beliefs and by their motivations to be heterosexual. In Schaeffer

These findings underscore the importance of the nature and strength of participants' motivations, as well as the importance of religious identity in shaping self-reports of perceived sexual orientation change.

et al. (2000), people whose motivation to change was strongly influenced by their Christian beliefs and convictions were more likely to perceive themselves as having a heterosexual sexual orientation after

their efforts. Schaeffer et al. also found that those who were less religious were more likely to perceive themselves as having an LGB sexual orientation after the intervention. Some of the respondents in Spitzer's (2003) study concluded that they had altered their sexual orientation, although they continued to have same-sex sexual attractions. These findings underscore the importance of the nature and strength of participants' motivations, as well as the importance of religious identity in shaping self-reports of perceived sexual orientation change.

A number of authors (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001; Yarhouse et al., 2005; Yarhouse & Tan, 2004) have found that identity exploration and reinterpretation were important parts of SOCE. Beckstead and Morrow (2004) described the identity development of their research participants who were or had been members of the Church of Jesus Christ of Latter-Day Saints and had undergone therapy to change their sexual orientation to heterosexual. In this research, those who experienced the most satisfaction with their lives seemed to undergo a developmental process that included the following aspects: (a) becoming disillusioned, questioning authorities, and reevaluating outside norms; (b) wavering between ex-gay, "out" gay, heterosexual, or celibate identities that depended on cultural norms and fears rather than on internally self-informed choices; and (c) resolving their conflicts through developing self-acceptance, creating

a positive self-concept, and making decisions about their relationships, religion, and community affiliations based on expanded information, self-evaluations, and priorities. The participants had multiple endpoints, including LGB identity, "ex-gay" identity, no sexual orientation identity, and a unique self-identity. Some individuals chose actively to *disidentify* with a sexual minority identity so the individual's sexual orientation identity and sexual orientation could be incongruent (Wolkomir, 2001, 2006; Yarhouse, 2001; Yarhouse & Tan, 2004; Yarhouse et al., 2005).

Further, the findings suggest that some participants may have reconceptualized their *sexual orientation identity* as heterosexual but *not* achieved sexual orientation change, as they still experienced same-sex sexual attractions and desires (for a discussion of the distinction between sexual orientation and sexual orientation identity, see Chapter 3; see also R. L. Worthington, 2003; R. L. Worthington et al., 2002). For these individuals, sexual orientation identity may not reflect underlying attractions and desires (Beckstead, 2003; Beckstead & Morrow, 2004; McConaghy, 1999; Rust, 2003; Shidlo & Schroeder, 2002).

Perceived Negatives of SOCE

Participants in the studies by Beckstead and Morrow (2004) and Shidlo and Schroeder (2002) described the harm they experienced as (a) decreased self-esteem and authenticity to others; (b) increased self-hatred and negative perceptions of homosexuality; (c) confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, and suicidality; (d) anger at and a sense of betrayal by SOCE providers; (e) an increase in substance abuse and high-risk sexual behaviors; (f) a feeling of being dehumanized and untrue to self; (g) a loss of faith; and (h) a sense of having wasted time and resources. Interpreting SOCE failures as individual failures was also reported in this research, in that individuals blamed themselves for the failure (i.e., weakness, and lack of effort, commitment, faith, or worthiness in God's eyes). Intrusive images and sexual dysfunction were also reported, particularly among those who had experienced aversion techniques.

Participants in these studies related that their relationships with others were also harmed in the following ways: (a) hostility toward and blame of parents, believing their parents "caused" their homosexuality; (b) anger at and a sense of betrayal by SOCE providers; (c) loss of LGB friends and potential romantic partners because of the belief that they should

avoid sexual minority people; (d) problems in sexual and emotional intimacy with other-sex partners; (e) stress due to the negative emotions of spouses and family members because of expectations that SOCE would work (e.g., disappointment, self-blame for failure of change, perception of betrayal by partner) (see also J. G. Ford, 2001); and (f) guilt and confusion when they were sexually intimate with other same-sex members of the ex-gay groups to which they had turned for help in avoiding their attractions.

LMHP working with former participants in SOCE noted that when clients who formerly engaged in SOCE consider adopting an LGB identity or experience same-sex romantic and sexual relationships later in life, they have more difficulty with identity development due to delayed developmental tasks and dealing with any harm associated with SOCE (Haldeman, 2001; Isay, 2001). Such treatments can harm some men's understanding of their masculine identity (Haldeman, 2001; Schwartzberg & Rosenberg, 1998) and obscure other psychological issues that contribute to distress (Drescher, 1998b).

Schroeder and Shidlo (2001) identified aspects of SOCE that their participants perceived as negative, which included (a) receiving pejorative or false information regarding sexual orientation and the lives of LGB individuals; (b) encountering overly directive treatment (told not to be LGB) or to repress sexuality; (c) encountering treatments based on unsubstantiated theories or methods; (d) being misinformed about the likelihood of treatment outcomes (i.e., sexual orientation change); (e) receiving inadequate information about alternative options; and (f) being blamed for lack of progress of therapy. Some participants in Schroeder and Shidlo's (2001) study reported feeling coerced by their psychotherapist or religious institution to remain in treatment and pressured to represent to others that they had achieved a "successful reorientation" to heterosexuality.

Religiously Oriented Mutual Support Groups

Much of the literature discusses the specific dynamics and processes of religiously oriented mutual self-help groups. A reduction of distress through sexual orientation identity reconstruction or development is described in the literature of self-help or religious groups, both for individuals who reject (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006) and for

individuals who accept a minority sexual orientation identity (Kerr, 1997; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Thumma, 1991; Wolkomir, 2006).

Ponticelli (1999) and Wolkomir (2001, 2006) found several emotional and cognitive processes that seemed central to the sexual orientation "identity reconstruction" (i.e., recasting oneself as ex-gay, heterosexual, disidentifying as LGB) (Ponticelli, 1999, p. 157) that appeared to relieve the distress caused by conflicts between religious values and sexual orientation (Ponticelli, 1999). Ponticelli identified certain conditions necessary for resolving identity conflicts, including (a) adopting a new discourse or worldview, (b) engaging in a biographical reconstruction, (c) embracing a new explanatory model, and (d) forming strong interpersonal ties. For those rejecting a sexual minority identity, these changes occurred by participants taking on "ex-gay" cultural norms and language and finding a community that enabled and reinforced their primary religious beliefs, values, and concerns. For instance, participants were encouraged to rely on literal interpretations of the Bible, Christian psychoanalytic theories about the causes of homosexuality, and "ex-gay" social relationships to guide and redefine their lives.

Interesting counterpoints to the SOCE support groups are LGB-affirming religious support groups. These groups employ similar emotional and cognitive strategies to provide emotional support, affirming ideologies, and identity reconstruction. Further, they appear to facilitate integration of same-sex sexual attractions and religious identities into LGB-affirming identities (Kerr, 1997; Thumma, 1991; Wolkomir, 2001, 2006).

Both sexual-minority-affirming and ex-gay mutual help groups potentially appear to offer benefits to their participants that are similar to those claimed for self-help groups, such as social support, fellowship, role models, and new ways to view a problem through unique philosophies or ideologies (cf. Levine, Perkins, & Perkins, 2004).

The philosophy of mutual help groups often gives a normalizing meaning to the individual's situation and may act as an "antidote" to a sense of deficiency (Antze, 1976). New scripts can shape how a member views and shares her or his life story by replacing existing personal or cultural scripts with the group ideology (Humphreys, 2004; Mankowski, 1997, 2000; Maton, 2000). For instance, individuals who are involved in SOCE or LGB-affirming groups may adopt a new explanation for their homosexuality that permits reconceptualizing themselves as heterosexual or acceptable as LGB people (Ponticelli, 1999; Wolkomir, 2001, 2006).

Remaining Issues

Ponticelli (1999) ended her article with the following questions: “What leads a person to choose Exodus and a frame that defined them as sinful and in need of change?” (p. 170). Why do some individuals choose SOCE over sexual-minority-affirming groups, and why are some individuals attracted to and able to find relief in a particular ideology or group over other alternatives?

There are some indications that the nature and type of religious motivation and faith play a role. In comparing individuals with intrinsic⁴³ and quest religious motivations, Tozer and Hayes (2004) proposed that those with a greater intrinsic religiosity may be motivated to seek out SOCE more than those with the quest motivation. However, within both groups (intrinsic and quest motivation), internalized stigma influenced who sought SOCE; those who sought SOCE had higher levels of internalized stigma. Tozer and Hayes (2004) and Mahaffy (1996) found that individuals in earlier stages of sexual minority identity development (see, e.g., Cass, 1979; Troiden, 1993) were more likely to pursue SOCE.

Wolkomir (2001, 2006) found some evidence that biographical factors may be central to these choices. Wolkomir (2006) found that motivations for participation in faith distinguished individuals who joined ex-gay groups from sexual-minority-affirming groups. For instance, men who joined conservative Christian communities as a solution to lives that had been lonely and disconnected and those who turned to faith when they felt overwhelmed by circumstance were more likely to join ex-gay groups. Wolkomir hypothesized that these men perceived homosexuality as a threat to the refuge that conservative faith provided (cf. Glassgold, 2008).

The other common path to an ex-gay (as well as, to some degree, to a sexual-minority-affirming) group was remaining in the community of faith in which one was raised and meeting the expectations of that faith, such as heterosexuality. The loss of a personal relationship or a betrayal by a loved one might influence an individual's choice of a group, and the stress of loss and the self-blame that accompany such a loss may constitute factors that lead someone to seek SOCE (Wolkomir, 2001, 2006).

Additionally, Wolkomir found that a sense of gender inadequacy (see also “gender role strain”; Levant, 1992;

Pleck, 1995) made groups that embraced traditional gender roles and gender-based models of homosexuality appealing to some men. Gender-based internalized stigma and self-stigma increased distress in these men.

Finally, “contractual promises” to God (Wolkomir, 2001, p. 332) regarding other concerns (e.g., drug/alcohol abuse) increased the likelihood that men would choose ex-gay groups. However, these issues are as yet underresearched and remain unresolved.

Very little is known about the concerns of other religious faiths and diverse ethnicities and cultures (Harper et al., 2004; Miville & Ferguson, 2004). There are some studies in the empirical and theoretical literature, clinical cases, and material from other fields (e.g., anthropology, sociology) on sexual orientation among ethnic minorities and in different cultures and countries. Sexual orientation identity may be constructed differently in ethnic minority communities and internationally (Boykin, 1996; Carillo, 2002; Crawford et al., 2002; Harper et al., 2004; Mays, Cochran, & Zamudio, 2004; Miville & Ferguson, 2004; Walters, Evans-Campbell, Simoni, Ronquillo, & Bhuyan, 2006; B. D. Wilson & Miller, 2002; Zea, Diaz, & Reisen, 2003). There is some information that such populations experience distress or conflicts due to legal discrimination, cultural stigma, and other factors (McCormick, 2006), and in some other countries, homosexuality is still seen as a mental disorder or is illegal (Forstein, 2001; see also the publications of the International Gay & Lesbian Human Rights Commission: <http://www.iglhrc.org>). We did not identify empirical research on members of these populations who had sought or participated in SOCE other than as part of the research already cited.

Summary and Conclusion

The recent literature on those who participate in SOCE identifies a population of predominantly White men who are strongly religious and participate in conservative faiths. This contrasts with the early research that included primarily nonreligious individuals. There is a lack of research on non-Christian individuals and limited information on ethnic minority populations, women, and nonreligious populations.

The religious individuals in the recent literature report experiencing serious distress, including depression, identity confusion, and fear due to the strong prohibitions of their faith regarding same-sex sexual orientation, behaviors, and relationships.

⁴³ Internal motivation refers to a motivation that focuses on belief and values as ends in themselves, and quest sees religion as a process of exploration.

These individuals struggle to combine their faiths and their sexualities in meaningful personal and social identities. These struggles cause them significant distress, including frequent feelings of isolation from both religious organizations and sexual minority communities. The ensuing struggles with faith, sexuality, and identity lead many individuals to attempt sexual orientation change through professional interventions and faith-based efforts.

These individuals report a range of effects from their efforts to change their sexual orientation, including both benefits and harm. The benefits include social and

Mutual self-help groups (whether affirming or rejecting of sexual minorities) may provide a means to resolve the distress caused by conflicts between religious values and sexual orientation.

spiritual support, a lessening of isolation, an understanding of values and faith, and sexual orientation identity reconstruction. The perceived harms include negative

mental health effects (depression and suicidality), decreased self-esteem and authenticity to others, increased self-hatred and negative perceptions of homosexuality, a loss of faith, and a sense of having wasted time and resources.

Mutual self-help groups (whether affirming or rejecting of sexual minorities) may provide a means of resolving the distress caused by conflicts between religious values and sexual orientation (Erzen, 2006; Kerr, 1997; Ponticelli, 1999; Thumma, 1991; Wolkomir, 2001, 2006). Sexual orientation identity reconstruction found in such groups (Ponticelli, 1999; Thumma, 1991) and identity work in general may provide reduction in individual distress (Beckstead & Morrow, 2004). Individuals may seek out sexual-minority-affirming religious groups or SOCE in the form of ex-gay religious support groups due to (a) a lack of other sources of social support; (b) a desire for active coping, including both cognitive and emotional coping (Folkman & Lazarus, 1980); and (c) access to methods of sexual orientation identity exploration and reconstruction (Ponticelli, 1999; Wolkomir, 2001).

The limited information provided by the literature on individuals who experience distress with their sexual attractions and seek SOCE provides some direction to LMHP in formulating affirmative interventions for this population. The following appear to be helpful to clients:

- Finding social support and interacting with others in similar circumstances
- Experiencing understanding and recognition of the importance of religious beliefs and concerns
- Receiving empathy for their very difficult dilemmas and conflicts
- Being provided with affective and cognitive tools for identity exploration and development

Reports of clients' perceptions of harm also provide information about aspects of interventions to avoid:

- Overly directive treatment that insists on a particular outcome
- Inaccurate, stereotypic, or unscientific information or lack of positive information about sexual minorities and sexual orientation
- The use of unsound or unproven interventions
- Misinformation on treatment outcomes

It is important to note that the factors that are identified as benefits are not unique to SOCE. An affirmative and multiculturally competent framework can mitigate the harmful aspects of SOCE by addressing sexual stigma while understanding the importance of religion and social needs. An approach that integrates the information identified in this chapter as helpful is described in an affirmative model of psychotherapy in Chapter 6.

6. THE APPROPRIATE APPLICATION OF AFFIRMATIVE THERAPEUTIC INTERVENTIONS FOR ADULTS WHO SEEK SEXUAL ORIENTATION CHANGE EFFORTS

Our charge was to “generate a report that includes discussion of “the appropriate application of affirmative therapeutic interventions for children, adolescents, and adults who present [themselves for treatment expressing] a desire to change either their sexual orientation or their behavioral expression of their sexual orientation.” In this chapter, we report on affirmative interventions for adults. Affirmative interventions for children and adolescents are reported separately in Chapter 8.

The appropriate application of affirmative psychotherapy is based on the following scientific facts:

- Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality; in other words, they are not indicators of mental or developmental disorders.
- Homosexuality and bisexuality are stigmatized, and this stigma can have a variety of negative consequences (e.g., minority stress) throughout the life span (D’Augelli & Patterson, 1995; DiPlacido, 1998; Herek & Garnets, 2007; Meyer, 1995, 2003).
- Same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientations and sexual orientation identities (Diamond, 2006; Hoberg et al., 2004; Rust, 1996; Savin-Williams, 2005).
- Gay men, lesbians, and bisexual individuals can live satisfying lives as well as form stable, committed relationships and families that are equivalent to heterosexual relationships in essential respects

(APA, 2005c; Kurdek, 2001, 2003, 2004; Peplau & Fingerhut, 2007).

- There are no empirical studies or peer-reviewed research that support theories attributing same-sex sexual orientation to family dysfunction or trauma (Bell et al., 1981; Bene, 1965; Freund & Blanchard, 1983; Freund & Pinkava, 1961; Hooker, 1969; McCord et al., 1962; D. K. Peters & Cantrell, 1991; Siegelman, 1974, 1981; Townes et al., 1976).

A Framework for the Appropriate Application of Affirmative Therapeutic Interventions

The task force findings that are relevant to the appropriate application of affirmative therapeutic interventions for adults are the following:

1. Our systematic review of the research on sexual orientation change efforts (SOCE)⁴⁴ found that enduring change to an individual’s sexual orientation as a result of SOCE was unlikely. Further, some participants were harmed by the interventions.

⁴⁴ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person’s same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

2. What appears to shift and evolve in some individuals' lives is sexual orientation identity, not sexual orientation (Beckstead, 2003; Beckstead & Morrow, 2004; Buchanan, et al., 2001; Cass, 1983/1984; Diamond, 1998, 2006; McConaghy, 1999; Ponticelli, 1999; Rust, 2003; Tan, 2008; Throckmorton & Yarhouse, 2006; Troiden, 1988; Wolkomir, 2001, 2006; R. L. Worthington, 2003, 2004).
3. Some participants in SOCE reported benefits, but the benefits were not specific to SOCE. Rather, clients perceived a benefit when offered interventions that emphasized acceptance, social support, and recognition of important values and concerns.

On the basis of the above three findings and our comprehensive review of the research and clinical literature, we developed a framework for the appropriate application of affirmative therapeutic interventions for adults that has the following central elements: (a) acceptance and support, (b) a comprehensive assessment, (c) active coping, (d) social support, and (e) identity exploration and development.

Acceptance and Support

In our review of the research and clinical literature, we found that the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation has been grounded in a client-centered approach⁴⁵ (e.g., Astramovich, 2003; Bartoli & Gillem, 2008; Beckstead & Israel, 2007; Buchanan et al., 2001; Drescher, 1998b; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Lasser & Gottlieb, 2004; Mark, 2008; Ritter & O'Neill, 1989, 1995; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008; Yarhouse & Tan, 2005a). The client-centered approach (Rogers, 1957; cf. Brown, 2006) stresses (a) the LMHP's unconditional positive regard for and congruence and empathy with the client, (b) openness to the client's perspective as a means of understanding their concerns, and (c) encouragement of the client's positive self-concept. This approach incorporates aspects of the therapeutic relationship that have been shown in the research literature to have a positive benefit, such as empathy, positive regard, and honesty (APA, 2005a, 2005b; Lambert & Barley, 2001; Norcross, 2002; Norcross & Hill, 2004).

⁴⁵ We consider the client-centered approach not as the ultimate theoretical basis of our model but as a foundation that is consistent with a variety of theoretical approaches, as most psychotherapy focuses on acceptance and support as a foundation of interventions.

This approach consists of empathic attunement to concerns regarding sexual orientation identity that acknowledges the role of cultural context and diversity and allows the different aspects of the evolving self to be acknowledged, explored, respected, and potentially rewoven into a more coherent sense of self that feels authentic to the client (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; Brown, 2006; Buchanan et al., 2001; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Mark, 2008; Miville & Ferguson, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). The empathic therapeutic environment aspires to be a place of compassionate caring and respect that facilitates development (Bronfenbrenner, 1979; Winnicott, 1965) by exploring issues without criticism or condemnation (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; McMinn, 2005; Throckmorton & Welton, 2005) and by reducing distress caused by isolation, stigma, and shame (Drescher, 1998b; Glassgold, 2008; Haldeman, 2004; Isay, 2001).

This approach involves empathizing with the client's desire to change his or her sexual orientation while understanding that this outcome is unlikely (Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004). Haldeman (2004) cautioned that LMHP who turn down a client's request for SOCE at the onset of treatment without exploring and understanding the many reasons why the client may wish to change may instill hopelessness in the client, who already may feel at a loss about viable options. Haldeman emphasized that before coming to a conclusion regarding treatment goals, LMHP should seek to validate the client's wish to reduce suffering and normalize the conflicts at the root of distress, as well as create a therapeutic alliance that recognizes the issues important to the client (cf. Beckstead & Israel, 2007; Glassgold, 2008; Liddle, 1996; Yarhouse, 2008).

Affirmative client-centered approaches consider sexual orientation to be uniquely individual and inseparable from an individual's personality and sense of self (Glassgold, 1995, 2008). This includes (a) being aware of the client's unique personal, social, and historical context; (b) exploring and countering the harmful impact of stigma and stereotypes on the

client's self-concept (including the prejudice related to age, gender, gender identity, race, ethnicity,

LMHP who work with religious clients who are distressed by their sexual orientation may wish to consult the literature from the psychology of religion. This literature reminds us that religion is a complex way of making meaning that includes not only beliefs and values but also community, relationships, traditions, family ties, coping, and social identity.

culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status); and (c) maintaining a broad view of acceptable life choices. LMHP who work with religious clients who are distressed by their sexual orientation may wish to consult the literature from

the psychology of religion. This literature reminds us that religion is a complex way of making meaning that includes not only beliefs and values but also community, relationships, traditions, family ties, coping, and social identity (Mark, 2008; Pargament & Mahoney, 2002, 2005; Pargament et al., 2005; Park, 2005).

A Comprehensive Assessment

In our review of the research and clinical literature, we found that the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation included providing a comprehensive assessment in order to obtain a fuller understanding of the multiple issues that influence that client's presentation. Such an assessment allows the LMHP and client to see the client's sexual orientation as part of the whole person and to develop interventions based on all significant variables (Beckstead & Israel, 2007; Gonsiorek, 2004; Haldeman, 2004; Lasser & Gottlieb, 2004). This comprehensive assessment includes understanding how a client's distress may involve (a) psychological disequilibrium from trying to manage the stressors (e.g., anxiety, depression, substance abuse and dependence, sexual compulsivity, posttraumatic stress disorder) and (b) negative effects from developmental experiences and traumas and the impact of cultural and family norms. Assessing the influence of factors such as age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status on the experience and expression of sexual orientation and sexual orientation identity may aid the LMHP in understanding the complexity of the client's distress.

The literature indicated that most of the individuals who are extremely distressed about their same-sex sexual orientation and who are interested in SOCE have conservative religious beliefs. A first step to addressing the conflicts regarding faith and sexual orientation is a thorough assessment of clients' spiritual and religious beliefs, religious identity and motivations, and spiritual functioning (Exline, 2002; Hathaway, Scott, & Garver, 2004; Pargament et al., 2005). This helps the LMHP understand how the current dilemmas impact clients' spiritual functioning (and vice versa) and assess resources for growth and renewal.

This assessment could include (a) understanding the specific religious beliefs of the client; (b) assessing the religious and spiritual conflicts and distress experienced by the client (Hathaway et al., 2004); (c) assessing the client's religious goals (Emons & Paloutzian, 2003) and motivations (e.g., internal, external, quest, fundamentalism) and positive and negative ways of coping within his or her religion (Pargament, Koenig, Tasakeshwas, & Hahn, 2001; Pargament & Mahoney, 2005; Pargament et al., 1998); (d) seeking to understand the impact of religious beliefs and religious communities on the experience of the client's self-stigma, sexual prejudice, and sexual orientation identity (Beckstead & Morrow, 2004; Buchanan et al., 2001; Fulton et al., 1999; Herek, 1987; Hunsberger & Jackson, 2005; J. P. Schwartz & Lindley, 2005; Schulte & Battle, 2004); (e) developing an understanding of the client's faith identity development (Fowler, 1981, 1991; Oser, 1991; Reich, 1991; Streib, 2005) and its intersection with his or her sexual orientation identity development (Harris, Cook, & Kashubeck-West, 2008; Hoffman et al., 2007; Knight & Hoffman, 2007; Mahaffy, 1996; Yarhouse & Tan, 2005a; Yarhouse et al., 2005); and (f) enhancing with the client, when applicable, the search for meaning, significance, and a relationship with the definitions of the sacred in his or her life (Fowler, 2001; Goldstein, 2007; Pargament & Mahoney, 2005; Shafranske, 2000). Finally, an awareness of the varieties of religious faith, issues for religious minorities, and the unique role of religion in ethnic minority communities is important (Trujillo, 2000; Zea, Mason, & Muruia, 2000).

Some individuals who present with requests for SOCE may have clinical concerns that go beyond their sexual orientation conflicts. These may include mental health disorders, personality disorders, or trauma-related conditions that influence the presentation of sexual orientation conflicts and distress (cf. Brown, 2006; Drescher, 1998b; Glassgold, 2008; Haldeman,

2001; Iwasaki & Ristock, 2007; Lasser & Gottlieb, 2004; Mohr & Fassinger, 2003; S. L. Morrow, 2000; Pachankis et al., 2008; Schneider et al., 2002; Sherry, 2007; Szymanski & Kashubeck-West, 2008). Such conditions may require intervention separate from or in conjunction with the intervention directed at the sexual orientation distress. For instance, some clients who seek SOCE may have histories of trauma (Ponticelli, 1999), and in some individuals sexual abuse can cause sexual orientation identity confusion and other sexuality-related concerns (Gartner, 1999). Some heterosexual individuals may obsess over the fear of being gay and require a unique treatment model to help them accept their fear (M. Williams, 2008). Other individuals seeking SOCE may make homosexuality the explanation for all they feel is wrong with their lives (Beckstead & Morrow, 2004; Erzen, 2006; Ponticelli, 1999; Shidlo & Schroeder, 2002). This displacement of self-hatred onto homosexuality can be an attempt to resolve a sense of badness and shame (cf. Brandchaft, 2007; Drescher, 1998b), and clients may thus need effective interventions to deal with this self-hatred and shame (Brandchaft, 2007; Linehan, Dimeff, & Koerner, 2007; Zaslav, 1998).

Sexual stigma impacts a client's appraisal of sexuality, and since definitions and norms of healthy sexuality vary among individuals, LMHP, and religious and societal institutions, potential conflicts can arise for clients about what a person should do to be sexually acceptable and healthy. O'Sullivan, McCrudden, and Tolman (2006) emphasized that sexuality is an integral component of psychological health, involving mental and emotional health, physical health, and relational health.⁴⁶ Initiating sensitive but open and educated discussions with clients about their views of and experiences with sexuality may be helpful, especially for those who have never had the opportunity or the permission to talk about such issues (Schneider et al., 2002).

Active Coping

In our review of the research and clinical literature, we found that the appropriate application of affirmative

therapeutic interventions for adults presenting with a desire to change their sexual orientation seeks to

Active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it.

increase clients' capacity for active coping to mitigate distress. Coping strategies refer to the efforts that individuals use to resolve, endure, or diminish stressful

life experiences, and active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it (Folkman & Lazarus, 1980). Research has indicated that active coping is superior to other efforts, such as passive coping, and that individuals use both cognitive and emotional strategies to address stressful events (Folkman & Lazarus, 1980). These strategies are described in more depth in the following sections.

COGNITIVE STRATEGIES

Research on those individuals who resolve their sexual orientation conflicts indicate that cognitive strategies helped to reduce cognitive dissonance (Coyle & Rafalin, 2000; Mahaffy, 1996). One of the dilemmas for many clients who seek sexual orientation change is that they see their situation as a dichotomy. For instance, their same-sex sexual attractions make them unworthy or bad, and only if they are heterosexual can they be worthy (Beckstead & Morrow, 2004; Haldeman, 2001, 2004; Lasser & Gottlieb, 2004; D. F. Morrow, 2003; Wolkomir, 2001, 2006). Cognitive strategies can reduce the all-or-nothing thinking, mitigate self-stigma, and alter negative self-appraisals (Beckstead & Israel, 2007; Johnson, 2001, 2004; Lasser & Gottlieb, 2004; Martell et al., 2004). For example, Buchanan et al. (2001), using a narrative therapy approach, described a process of uncovering and deconstructing dominant worldviews and assumptions with conflicted clients that enabled them to redefine their attitudes toward their spirituality and sexuality (cf. Bright, 2004; Comstock, 1996; Graham, 1997; Yarhouse, 2008). Similarly, rejection of stereotypes about LGB individuals was found to be extremely important for increased psychological well-being in a mixed sample of LGB individuals (Luhtanen, 2003).

Recent developments in cognitive-behavior therapy, such as mindfulness-based cognitive therapy, dialectical

⁴⁶ The Pan American Health Organization and the World Health Organization (2000) defined sexual health in the following manner: "Sexual health is the ongoing process of physical, psychological, and sociocultural well-being in relationship to sexuality. Sexual health can be identified through the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching life within an ethical framework. It is not merely the absence of dysfunction, disease and/or infirmity. For sexual health to be attained and maintained it is necessary that sexual rights be recognized and exercised" (p. 9).

behavior therapy, and acceptance and commitment therapy techniques are relevant (e.g., Hayes, Strosahl,

Acceptance of same-sex sexual attractions and sexual orientation may not mean the formation of an LGB sexual orientation identity; alternate identities may develop instead. & Wilson, 2003; Linehan et al., 2007). Acceptance of the presence of same-sex sexual attractions and sexual orientation paired with

exploring narratives or reframing cognitions, meanings, or assumptions about sexual attractions have been reported to be helpful (cf. Beckstead & Morrow, 2004; Buchanan et al., 2001; Moran, 2007; Rodriguez, 2006; Tan, 2008; Yarhouse, 2005a, 2005c; Yarhouse & Beckstead, 2007). For instance, using these techniques, Beckstead and Morrow (2004) and Tan (2008) found that clients were able to cope with their sexual arousal experiences and live with them rather than negatively judge or fight against them. Male participants in Beckstead and Morrow's (2004) investigation, regardless of their ultimate sexual orientation identity, described their ability to accept, reframe, or "surrender" to their attractions as reducing their distress by decreasing their self-judgments and reducing their fear, anxiety, and shame. However, acceptance of same-sex sexual attractions and sexual orientation may not mean the formation of an LGB sexual orientation identity; alternate identities may develop instead (Beckstead & Morrow, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008; Yarhouse et al., 2005).

For clients with strong values (religious or secular), an LMHP may wish to incorporate techniques that promote positive meaning-making, an active process through which people revise or reappraise an event or series of events (Baumeister & Vohs, 2002; cf. Taylor, 1983) to resolve issues that arise out of crises, loss, and suffering (cf. Frankl, 1992; Nolen-Hoeksema & Davis, 2002; O'Neill & Ritter, 1992; Pargament et al., 2005; Ritter & O'Neill, 1989, 1995). Such new meanings involve creating a new purpose in life, rebuilding a sense of mastery, and increasing self-worth (Nolen-Hoeksema & Davis, 2002; Pargament & Mahoney, 2002).

EMOTION-FOCUSED STRATEGIES

For those who seek SOCE, the process of addressing one's sexual orientation can be very emotionally challenging, as the desired identity does not fit the individual's psychological, emotional, or sexual predispositions and needs. The experience of

irreconcilability of one's sexual orientation to one's deeply felt values, life situation, and life goals may disrupt one's core sense of meaning, purpose, efficacy, and self-worth (Beckstead & Morrow, 2004; Yarhouse, 2008; cf. Baumeister & Vohs, 2002; L. A. King & Smith, 2004) and result in emotional conflict, loss, and suffering (Glassgold, 2008; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995). Thus, emotion-focused strategies that facilitate mourning losses have reportedly been helpful to some (Beckstead & Israel, 2007; Glassgold, 2008; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Yarhouse, 2008; cf. Wolkomir, 2001, 2006).

Therapeutic outcomes that have been reported include (a) coming to terms with the disappointments and losses and with the dissonances between psychological and emotional needs and possible and impossible selves (Bartoli & Gillem, 2008; Drescher, 1998b; L.A. King & Hicks, 2007; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995); (b) clarifying and prioritizing values and needs (Glassgold, 2008; Yarhouse, 2008); and (c) learning to tolerate and adapt to the ambiguity, conflict, uncertainty, and multiplicity with a positive attitude (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; Buchanan et al., 2001; Corbett, 2001; Drescher, 1998b; Glassgold, 2008; Halbertal & Koren, 2006; Haldeman, 2002; Miville & Ferguson, 2004).

RELIGIOUS STRATEGIES

Although many individuals desire to live their lives consistently with their values, primarily their religious values, we concluded that telic congruence grounded

Connecting clients to core and overarching values and virtues such as charity, hope, forgiveness, gratitude, kindness, and compassion may shift the focus from their religion's rejection of homosexuality to the more accepting elements of their religion, which may provide more self-acceptance, direction, and peace. in self-stigma and shame was unlikely to result in psychological well-being (Beckstead & Morrow, 2004; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Mark, 2008; Shidlo & Schroeder, 2002). Psychotherapeutic interventions can focus the client on positive religious coping (e.g., Ano & Vasconcelles, 2005; Pargament et al., 2005; Park, 2005; Silberman, 2005; T. B. Smith, McCullough, & Poll,

2003) that may present the client with alternatives to the concreteness of the conflict between sexual orientation and religious values. For instance, several publications indicate that active engagement with religious texts can reduce identity conflicts by reducing the salience of negative messages about homosexuality and increasing self-authority or understanding (Brzezinski, 2000; Comstock, 1996; Coyle & Rafalin, 2000; Glassgold, 2008; Gross, 2008; Mahaffy, 1996; Ritter & O'Neill, 1989, 1995; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Schnoor, 2006; Schuck & Liddle, 2001; Thumma, 1991; Wilcox, 2001, 2002; Yip, 2002, 2003, 2005). Additionally, connecting clients to core and overarching values and virtues such as charity, hope, forgiveness, gratitude, kindness, and compassion may shift the focus from their religion's rejection of homosexuality to the more accepting elements of their religion, which may provide more self-acceptance, direction, and peace (Lease et al., 2005; McMinn, 2005). Exploration of how to integrate religious values and virtues into their sexuality may further development (cf. Helminiak, 2004).

Reframing the meaning of suffering and the burden of being conflicted as spiritual challenges rather than as divine condemnation (Glassgold, 2008; Hall & Johnson, 2001) and believing that God continues to love and accept them, because of or despite their sexual orientation, may be helpful in resolving distress (Graham, 1997; Ritter & O'Neill, 1989, 1995). For some, reframing spiritual struggles not only as a crisis of faith but also as an opportunity to increase faith or delve more deeply into it may be productive (Bartoli & Gillem, 2008; de la Huerta, 1999; Glassgold, 2008; Horne & Noffisnger-Frazier, 2003; Ritter & Terndrup, 2002).

Examining the intersection between mental health concerns and the presentation of religious beliefs can be helpful in understanding the client (Johnson, 2001, 2004; Nielsen, 2001; Pargament et al., 2005; Robb, 2001; Shrafranske, 2004). For instance, Johnson (2004) described a rational emotive behavior therapy case study that focused on reducing excessive self-criticism, which lessened the self-stigma surrounding same-sex sexual attractions. This approach seeks to understand the core depressive cognitive structures and other problematic schemata that can become associated with the clients' religious values or distort their religious values (Johnson, 2001, 2004; Nielsen, 2001; Robb, 2001).

Social Support

In our review of the research and clinical literature, we found that the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation seeks to increase clients' access to social support. As Coyle (1993) and others have noted (e.g., Wright & Perry, 2006), struggling with a devalued identity without adequate social support has the potential to erode psychological well-being. Increasing social support through psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) may relieve some distress. For instance, participants reported benefits from mutual support groups, both sexual-minority-affirming and ex-gay groups (Kerr, 1997; Ponticelli, 1999; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Rodriguez, 2006; Thumma, 1991; Wolkomir, 2001). These groups counteracted and buffered minority stress, marginalization, and isolation. Religious denominations that provide cognitive and affective strategies that aid in the resolution of cognitive dissonance and increase religious coping were helpful to religious individuals as well (Kerr, 1997; Maton, 2000; Ponticelli, 1999; Rodriguez & Ouellette, 2000; Wolkomir, 2001, 2006).

LMHP can provide clients with information about a wide range of diverse sexual minority communities and religious and faith organizations available locally, nationally, or internationally in person or over the Internet.⁴⁷ These settings can provide contexts in which clients may explore and integrate identities, find role models, and reduce self-stigma (Heinz, Gu, Inuzuka, & Zender, 2002; Johnson & Buhrke, 2006; Schneider et al., 2002). However, some groups may reinforce prejudice and stigma by providing inaccurate or stereotyped information about homosexuality, and LMHP may wish to weigh with clients alternative options in these circumstances (Schneider et al., 2002).

For those clients who cannot express all aspects of themselves in the community settings currently available to them, LMHP can help the client to consider more flexible and strategic ways of expressing the multiple aspects of self that include managing self-disclosure and multiple identities (Bing, 2004; Glassgold, 2008; Halbertal & Koran, 2006; LaFromboise, Coleman, & Gerton, 1993). Social support may be difficult to find

⁴⁷ There are growing numbers of communities available that address unique concerns and identities (see, e.g., www.safraproject.org/ for Muslim women or <http://www.al-fatiha.org/> for LGB Muslims; for Orthodox Jews, see <http://tirtzah.wordpress.com/>).

for clients whose communities stigmatize their sexual orientation identity and other identities (e.g., ethnic, racial, religious), and these clients may benefit from considering the alternate frame that the problem does not lie with the client but with the community that is not able to affirm their sexual orientation or particular identity or meet their developmental needs (Blechner, 2008; Buchanan et al., 2001; Lasser & Gottlieb, 2004; Mark, 2008; Tremble, 1989).

Individuals with same-sex attractions in other-sex marriages may struggle with the loss (or fear of the loss) of social support and important relationships. Several authors (e.g., Alessi, 2008; Auerback & Moser, 1987; Bridges & Croteau, 1994; Brownfain, 1985; Buxton, 1994, 2001, 2004, 2007; Carlsson, 2007; Coleman, 1989; Corley & Kort, 2006; Gochros, 1989; Hernandez & Wilson, 2007; Isay, 1998; Klein & Schwartz, 2001; Malcolm, 2000; Schneider et al. 2002; Treyger, Ehlers, Zajicek, & Trepper, 2008; Yarhouse et al., 2003) have laid out counseling strategies for individuals in marriages with the other sex who consider SOCE. These strategies for individual, couples, and group counseling do not focus solely on one outcome (e.g., divorce, marriage) but on exploring the underlying personal and contextual problems, motivations, realities, and hopes for being in, leaving, or restructuring the relationship.

Identity Exploration and Development

In our review of the research and clinical literature, we found that identity issues, particularly the ability to explore and integrate aspects of the self, are central to the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation. As described in earlier sections of this report, conflicts among disparate elements of identity appear to play a major role in the distress of those seeking SOCE, and identity exploration and development appear to be ways in which individuals resolve or avoid distress (e.g., Balsam & Mohr, 2007; Beckstead & Morrow, 2004; Coyle & Rafakin, 2000; Drescher, 1998b; Glassgold, 2008; Herek & Garnets, 2007; Mahaffy, 1996; Yarhouse et al., 2005; Yip, 2002, 2003, 2005).

Ideally, identity comprises a coherent sense of one's needs, beliefs, values, and roles, including those aspects of oneself that are the bases of social stigma, such as age, gender, race, ethnicity, disability, national origin, socioeconomic status, religion, spirituality, and sexuality (G. R. Adams & Marshall, 1996; Bartoli & Gillem, 2008; Baumeister & Vohs, 2002; LaFramboise

et al., 1993; Marcia, 1966; Meyers et al., 1991; R. L. Worthington et al., 2002). Marcia (1966) generated a model in which identity development is an active process of exploring and assessing one's identity and establishing a commitment to an integrated identity. R. L. Worthington et al. (2002) hypothesized that sexual orientation identity could be conceptualized along these same lines and advanced a model of heterosexual identity development based on the assumption that congruence among the dimensions of individual identity is the most adaptive status, which is achieved by active exploration. There is some empirical research supporting this model (R. L. Worthington, Navarro,

An affirmative approach is supportive of clients' identity development without an a priori treatment goal for how clients identify or live out their sexual orientation.

Savoy, & Hampton, 2008). Additionally, research has found that the formation of a collective identity has important mental health benefits for sexual minorities by buffering individuals from sexual stigma and increasing self-esteem (Balsam & Mohr, 2007; Crawford et al., 2002; Herek & Garnets, 2007).

An affirmative approach is supportive of clients' identity development without an a priori treatment goal for how clients identify or live out their sexual orientation. Sexual orientation identity exploration can be helpful for those who eventually accept or reject their same-sex sexual attractions; the treatment does not differ, although the outcome does. For instance, the existing research indicates that possible outcomes of sexual orientation identity exploration for those distressed by their sexual orientation may be:

- LGB identities (Glassgold, 2008; Haldeman, 2004; Mahaffy, 1996; Yarhouse, 2008)
- Heterosexual sexual orientation identity (Beckstead & Morrow, 2004)
- Disidentifying from LGB identities (e.g., ex-gay) (Yarhouse, 2008; Yarhouse & Tan, 2004; Yarhouse et al., 2005)
- Not specifying an identity (Beckstead & Morrow, 2004; Haldeman, 2004; Tan, 2008)

The research literature indicates that there are variations in how individuals express their sexual orientation and label their identities based on ethnicity,

culture, age and generation, gender, nationality, acculturation, and religion (Boykin, 1996; Carrillo, 2002; Chan, 1997; Crawford et al., 2002; Denizet-Lewis, 2003; Kimmel & Yi, 2004; Martinez & Hosek, 2005; Miville & Ferguson, 2004; Millett, Malebranche, Mason, & Spikes, 2005; Stokes, Miller, & Mundhenk, 1998; Toro-Alfonso, 2007; Weeks, 1995; Yarhouse, 2008; Yarhouse et al., 2005; Zea et al., 2003). Some authors have provided analyses of identity that take into account diversity in sexual identity development and ethnic identity formation (Helms, 1995; LaFramboise et al., 1993; Myers et al., 1991; Yi & Shorter-Gooden, 1999), religious identity (Fowler, 1981, 1991; Oser, 1991; Strieb, 2001), as well as combinations of religious and sexual orientation identities (Coyle & Rafalin, 2000; Hoffman et al., 2007; Kerr, 1997; Knight & Hoffman, 2007; Ritter & O'Neill, 1989, 1995; Thumma, 1991; Throckmorton & Yarhouse, 2006; Yarhouse & Tan 2004).

In some of the literature on SOCE, religious beliefs and identity are presented as fixed, whereas sexual orientation is considered changeable (cf. Rosik, 2003). Given that there is a likelihood that some individuals will change religious affiliations during their lifetime (Pew Forum on Religion and Public Life, 2008) and that many scholars have found that both religious identity and sexual orientation identity evolve (Beckstead & Morrow, 2004; Fowler, 1981; Glassgold, 2008; Haldeman, 2004; Mahaffy, 1996; Ritter & Terndrup, 2002; Yarhouse & Tan, 2005b), it is important for LMHP to explore the development of religious identity and sexual orientation identity (Bartoli & Gillem, 2008). Some authors hypothesize that developmental awareness or stage of religious or sexual orientation identity may play a role in identity outcomes (Knight & Hoffman, 2007; Mahaffy, 1996; cf. Yarhouse & Tan, 2005a). Other authors have described a developmental process that includes periods of crisis, mourning, reevaluation, identity deconstruction, and growth (Comstock, 1996; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995). Others have found that individuals disidentify or reject LGB identities (Ponticelli, 1999; Wolkomir, 2001, 2006; Yarhouse et al., 2005). Thus, LMHP seeking to take an affirmative attitude recognize that individuals will define sexual orientation identities in a variety of ways (Beckstead, as cited in Shidlo, Schroeder, & Drescher, 2002; Diamond, 2003; 2006; 2008; Savin-Williams, 2005; Yarhouse et al., 2005).

Some religious individuals may wish to resolve the tension between values and sexual orientation by choosing celibacy (sexual abstinence), which in some faiths, but not all, may be a virtuous path (Olson, 2007).

We found limited empirical research on the mental health consequences of that course of action.⁴⁸ Some clinical articles and surveys of individuals indicate that some may find such a life fulfilling (S. L. Jones & Yarhouse, 2007); however, there are others who cannot achieve such a goal and might struggle with depression and loneliness (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2001; Horlacher, 2006; Rodriguez, 2006; Shidlo & Schroeder, 2002). In a similar way, acting on same-sex sexual attractions may not be fulfilling solutions for others (Beckstead & Morrow, 2004; Yarhouse, 2008).

LMHP may approach such a situation by neither rejecting nor promoting celibacy but by attempting to understand how this outcome is part of the process of exploration, sexual self-awareness, and understanding of core values and goals. The therapeutic process could entail exploration of what drives this goal for clients (assessing cultural, family, personal context and issues, sexual self-stigma), the possible short- and long-term consequences/rewards, and impacts on mental health while providing education about sexual health and exploring how a client will cope with the losses and gains of this decision (cf. L. A. King & Hicks, 2007; Ritter & O'Neill, 1989, 1995).

On the basis of the aforementioned analyses, we adopted a perspective that recognizes the following:

- The important functional aspects of identity (G. R. Adams & Marshall, 1996).
- The multiplicity inherent in experience and identity, including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (Bartoli & Gillem, 2008; Miville & Ferguson, 2004; Myers et al., 1991).
- The influence of social context and the environment on identity (Baumeister & Muraven, 1996; Bronfenbrenner, 1979; Meeus, Iedema, Helsen, & Vollebergh, 1999; Myers et al., 1991; Steenbarger, 1991).
- That aspects of multiple identities are dynamic and can be in conflict (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008; D. F. Morrow, 2003; Tan, 2008; Yarhouse, 2008).

⁴⁸ However, Sipe (1990, 2003) has surveyed clergy and found difficulty in maintaining behavior consistent with aspirations. Other studies indicate that this goal is only achieved for a minority of participants who choose it (Brzezinski, 2000; S. L. Jones & Yarhouse, 2007).

- Identities can be explored, experienced, or integrated without privileging or surrendering one or another at any age (Bartoli & Gillem, 2008; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Myers et al., 1991; Phillips, 2004; Shallenberger, 1996).

Approaches based on models of biculturalism (LaFromboise et al., 1993) and pluralistic models of identity, including combining models of ethnic, sexual orientation, and religious identity that help individuals develop all aspects of self simultaneously or some sequentially, can encourage identity development and synthesis rather than identity conflict, foreclosure, or compartmentalization (Dworkin, 1997; Harris et al., 2008; Hoffman et al., 2007; Knight & Hoffman, 2007; Myers et al., 1991; Omer & Strenger, 1992; Ritter & O'Neill, 1989, 1995; Rosario, Schrimshaw, & Hunter, 2004; Rosario, Yali, Hunter, & Gwadz, 2006; Sophie, 1987; Troiden, 1988, 1993).

Sexual orientation identity exploration can help clients create a valued personal and social identity that provides self-esteem, belonging, meaning, direction, and future purpose, including the redefining of religious beliefs, identity, and motivations and the redefining of sexual values, norms, and behaviors (Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Mark, 2008; Tan, 2008; Yarhouse, 2008). We encourage LMHP to support clients in determining their own (a) goals for their identity process; (b) behavioral expression of sexual orientation; (c) public and private social roles; (d) gender role, identity, and expression; (e) sex and gender of partner; and (f) form of relationship(s).

Understanding gender roles and gender expression and developing a positive gender identity⁴⁹ continue to be concerns for many individuals who seek SOCE, especially as nonconformity with social expectations regarding gender can be a source of distress and stigma (APA, 2008e; Beckstead & Morrow, 2004; Corbett, 1996, 1998; Wolkomir, 2001). Some SOCE teach men how to adopt traditional masculine behaviors as a means of altering their sexual orientation (e.g., Nicolosi, 1991, 1993) despite the absence of evidence that such interventions affect sexual orientation. Such theoretical positions have been characterized as products of stigma and bias that are without an evidentiary basis

and may increase distress (American Psychoanalytic Association, 2000; Isay, 1987, 1999; Drescher, 1998b; Haldeman, 1994, 2001). For instance, Haldeman (2001) emphasized in his clinical work with men who had participated in SOCE that some men were taught that their homosexuality made them less masculine—a belief that was ultimately damaging to their self-esteem. Research on the impact of heterosexism and traditional gender roles indicates that an individual's adoption of traditional masculine norms increases sexual self-stigma and decreases self-esteem and emotional connection with others, thus negatively affecting mental health (Szymanski & Carr, 2008).

Advances in the psychology of men and masculinity provide more appropriate conceptual models for considering gender concerns—for instance, in such concepts as gender role strain or gender role stress (cf. Butler, 2004; Enns, 2008; Fischer & Good, 1997; Heppner & Heppner, 2008; Levant, 1992; Levant & Silverstein, 2006; O'Neil, 2008; Pleck, 1995; Wester, 2008). This literature suggests exploring with clients the role of traditional gender norms in distress and reconceptualizing gender in ways that feel more authentic to the client. Such approaches could also

Most literature in this area suggests that for clients who experience distress with their gender-role nonconformity, LMHP provide them with a more complex theory of gender that affirms a wider range of gender diversity and expands definitions and expressions of masculinity and femininity.

reduce the gender stereotypes associated with same-sex sexual orientation (Corbett, 1998; Haldeman, 2001; Schwartzberg & Rosenberg, 1998). Most literature in this area suggests that for clients who experience distress with their gender-role nonconformity, LMHP provide them with a more complex theory of gender that affirms a wider range of gender diversity and expands definitions and expressions of masculinity and femininity (Butler, 2004; Corbett, 1996, 1998, 2001; Haldeman, 2001; Levant & Silverstein, 2006).

Some women find current categories for conceptualizing their sexual orientation and sexual orientation identity limiting, as concepts in popular culture and professional literature do not mirror their experiences of fluidity and variation in sexuality and relationships (Chivers et al., 2007; Diamond, 2006, 2008; Peplau & Garnets, 2000). Some women, for example, may experience relationships with others as

⁴⁹ *Gender* refers to the roles, behaviors, activities, and attributes that a particular society considers appropriate for men and women. *Gender identity* is a person's own psychological sense of identification as male or female, another gender, or identifying with no gender. *Gender expression* is the activities and behaviors that purposely or inadvertently communicate our gender identity to others, such as clothing, hairstyles, mannerisms, way of speaking, and social roles.

important parts of sexuality and may place sexuality, sexual orientation, and sexual orientation identity in the context of interpersonal bonds and contexts (Diamond, 2003, 2006, 2008; Diamond & Savin-Williams, 2000; Garnets & Peplau, 2000; Kinnish, Strassberg, & Turner 2005; Kitzing, & Wilkinson, 1994; Miller, 1991; Morgan & Thompson, 2006; Peplau & Garnets, 2000; Surrey, 1991). Specific psychotherapy approaches that focus on an understanding of emotional and erotic interpersonal connections in sexuality rather than simply on sexual arousal can aide LMHP in providing a positive framework and goals for therapy with women (Garnets & Peplau, 2000; Glassgold, 2008; Miller, 1991; Surrey, 1991).

For many women, religious or cultural influences discourage exploration of sexuality and do not portray female sexuality as positive or self-directed (Brown, 2006; Espin, 2005; Fassinger & Arseneau, 2006; Mahoney & Espin, 2008; Moran, 2007; Stone, 2008). Treatment might involve deconstructing cultural scripts in order to explore possibilities for religion, sexuality, sexual orientation, identity, and relationships (Avishai, 2008; Biaggio, Coan, & Adams, 2002; Morgan & Thompson, 2006; Rose & Zand, 2000).

Conclusion

The appropriate application of affirmative therapeutic interventions to adults is built on three key findings in the research: (a) An enduring change to an individual's sexual orientation as a result of SOCE was unlikely, and some participants were harmed by the interventions; (b) sexual orientation identity—not sexual orientation—appears to change via psychotherapy, support groups, and life events; and (c) clients perceive a benefit when offered interventions that emphasize acceptance, support, and recognition of important values and concerns.

On the basis of these findings and the clinical literature on this population, we suggest client-centered approaches grounded on the following scientific facts:

- Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they are not indicators of mental or developmental disorders.
- Same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientations and sexual orientation identities.

- Gay men, lesbians, and bisexual individuals can live satisfying lives as well as form stable, committed relationships and families that are equivalent to heterosexual relationships in essential respects.
- No empirical studies or peer-reviewed research support theories attributing same-sex sexual orientation to family dysfunction or trauma.

Affirmative client-centered approaches consider sexual orientation uniquely individual and inseparable from an individual's personality and sense of self (Glassgold, 1995, 2008). This includes (a) being aware of the client's

Psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) provide social support that can mitigate distress caused by isolation, rejection, and lack of role models.

unique personal, social, and historical context; (b) exploring and countering the harmful impact of stigma and stereotypes on the client's self-concept (including the prejudice related to age, gender, gender identity, race,

ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status); and (c) maintaining a broad view of acceptable life choices.

We developed a framework for the appropriate application of affirmative therapeutic interventions for adults that has the following central elements: (a) acceptance and support, (b) comprehensive assessment, (c) active coping, (d) social support, and (e) identity exploration and development.

Acceptance and support include (a) unconditional positive regard for and empathy with the client, (b) an openness to the client's perspective as a means of understanding their concerns, and (c) encouragement of the client's positive self-concept.

Comprehensive assessment includes an awareness of the complete person, including mental health concerns that could impact distress about sexual orientation.

Active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it and includes both cognitive and emotional strategies.

Psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) provide social support that can

mitigate distress caused by isolation, rejection, and lack of role models.

Conflicts among disparate elements of identity play a major role in the conflicts and mental health concerns of those seeking SOCE. Identity exploration is an active process of exploring and assessing one's identity and establishing a commitment to an integrated identity that addresses the identity conflicts without an a priori treatment goal for how clients identify or live out their sexual orientation. The process may include a developmental process that includes periods of crisis, mourning, reevaluation, identity deconstruction, and growth.

LMHP address specific issues for religious clients by integrating aspects of the psychology of religion into their work, including obtaining a thorough assessment of clients' spiritual and religious beliefs, religious identity and motivations, and spiritual functioning; improving positive religious coping; and exploring the intersection of religious and sexual orientation identities. This framework is consistent with modern multiculturally competent approaches and evidence-based psychotherapy practices and can be integrated into a variety of theoretical systems.

7. ETHICAL CONCERNS AND DECISION MAKING IN PSYCHOTHERAPY WITH ADULTS⁵⁰

Ethical concerns relevant to sexual orientation change efforts (SOCE)⁵¹ have been a major theme in the literature and a central aspect of the debate around SOCE (e.g., Benoit, 2005; Cramer et al., 2008; Davison, 1976, 1978, 1991; Drescher, 1999, 2001, 2002; Gonsiorek, 2004; Haldeman, 1994, 2002, 2004; Herek, 2003; Lasser & Gottlieb, 2004; Rosik, 2003; Schreier, 1998; Schroeder & Shidlo, 2001; Sobocinski, 1990; Tozer & McClanahan, 1999; Wakefield, 2003; Yarhouse, 1998a; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002). The major concerns raised in these publications have been (a) the potential for harm, (b) the client's right to choose SOCE and other issues generally related to the ethical issue of client autonomy, and (c) questions of how to appropriately balance respect for two aspects of diversity—religion and sexual orientation. SOCE presents an ethical dilemma to practitioners because these publications have urged LMHP to pursue multiple and incompatible courses of action (cf. Kitchener, 1984).

In 1997 APA adopted the Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998). This resolution highlighted the provisions of the then-current *Ethical Principles for Psychologists*

and *Code of Conduct* (APA, 1992) that APA believed to be relevant to situations in which clients request treatments to alter sexual orientation and psychologists provide such treatments, including the provisions regarding bias and discrimination, false or deceptive information, competence, and informed consent to treatment. For a discussion of the resolution's application to clinical situations, readers are referred to Schneider et al. (2002). In the resolution, APA also reaffirmed (a) its position that homosexuality is not a mental disorder; (b) its opposition to stigma, prejudice, and discrimination based on sexual orientation; and (c) its concern about the contribution of the promotion of SOCE to the continuation of sexual stigma in U.S. culture.

The APA's charge to the task force included "to review and update the APA Resolution on Appropriate Therapeutic Responses to Sexual Orientation." In the process of fulfilling this aspect of our charge, we considered the possibility of recommending revisions to the 1997 resolution to update it with the specific principles and standards of the 2002 APA Ethics Code. Ultimately, we decided against a revision,⁵² because the relevant concepts in the two versions of the principles and code are similar. Instead, this chapter examines the relevant sections of the 2002 APA *Ethical Principles for Psychologists and Code of Conduct* [hereafter referred to as the Ethics Code] in light of current debates regarding

⁵⁰ Ethical concerns for children and adolescents are considered in Chapter 8.

⁵¹ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

⁵² We developed a new resolution that APA adopted in August 2009 (see Appendix A)..

ethical decision making in this area.⁵³ We build our discussion on the concepts outlined in the 1997 resolution and discuss some of the ethical controversies in light of the newer APA Ethics Code (2002b) and of the systematic research review presented in Chapters 3 and 4 of this report. Although many of the principles and standards in the Ethics Code are potentially pertinent,⁵⁴ the principles and standards most relevant to this discussion are (in alphabetical order):

1. Bases for Scientific and Professional Judgments (Standard 2.04) and Competence (e.g., 2.01a, 2.01b)⁵⁵
2. Principle A: Beneficence and Nonmaleficence
3. Principle D: Justice
4. Principle E: Respect for People's Rights and Dignity

Bases for Scientific and Professional Judgments and Competence

Many of the standards of the Ethics Code are derived from the ethical and valuative foundations found in the principles (Knapp & VandeCreek, 2004). Two of the more important standards are competence and the bases for scientific and professional judgments. These standards are linked, as competence is based on knowledge of the scientific evidence relevant to a case (Glassgold & Knapp, 2008). When practicing with those who seek sexual orientation change for themselves or for others, commentators on ethical practice have

recommended that the practitioner understand the scientific research on sexual orientation and SOCE (Glassgold & Knapp, 2008; Schneider et al., 2002). It is obviously beyond the task force's scope to provide a systematic review of the whole body of research on sexual orientation, but we have tried to provide a systematic review of the research on SOCE in Chapters 3 and 4. From this review, we have drawn two key conclusions.

The first finding from our review is that there is insufficient evidence that SOCE are efficacious for changing sexual orientation. Furthermore, there is some evidence that such efforts cause harm. On the

On the basis of this evidence, we consider it inappropriate for psychologists and other LMHP to foster or support in clients the expectation that they will change their sexual orientation if they participate in SOCE.

basis of this evidence, we consider it inappropriate for psychologists and other LMHP to foster or support in clients the expectation that they will change their sexual orientation if they participate

in SOCE. We believe that among the various types of SOCE, the greatest level of ethical concern is raised by SOCE that presuppose that same-sex sexual orientation is a disorder or a symptom of a disorder.⁵⁶ Treatments based on such assumptions raise the greatest level of ethical scrutiny by LMHP because they are inconsistent with the scientific and professional consensus that homosexuality per se is not a mental disorder. Instead, we counsel LMHP to consider other treatment options when clients present with requests for sexual orientation change.

The second key finding from our review is that those who participate in SOCE, regardless of the intentions of these treatments, and those who resolve their distress through other means, may evolve during the course of their treatment in such areas as self-awareness, self-concept, and identity. These changes may include (a) sexual orientation identity, including changes in private and public identification, behavior, group membership, and affiliation; (b) emotional adjustment, including reducing self-stigma and shame; and (c) personal beliefs, values, and norms, including changes in religious and moral beliefs and behaviors and motivations (Buchanon et al., 2001; Diamond, 1998, 2006; Rust, 2003; Savin-Williams, 2004; R. L.

⁵³ This section is for descriptive and educational purposes. It is not designed to interpret the APA (2002b) Ethics Code. The APA Ethics Committee alone has the authority to interpret the APA (2002b) Ethics Code and render decisions about whether a course of treatment is ethical. Furthermore, this section is not intended to provide guidelines or standards for practice. Guidelines and standards for practice are created through a specific process that is outside the purview of the task force.

⁵⁴ The following are some of the pertinent standards: 2. Competence, 2.01 Boundaries of Competence, 2.03 Maintaining Competence, 2.04 Bases for Scientific and Professional Judgments; 3. Human Relations, 3.01 Unfair Discrimination, 3.03 Other Harassment, 3.04 Avoiding Harm, 3.10 Informed Consent; 5.01 Avoidance of False or Deceptive Statements, 5.04 Media Presentations; 7.01 Design of Education and Training Programs; 8.02 Informed Consent to Research; 10.01 Informed Consent to Therapy, 10.02 Therapy Involving Couples or Families.

⁵⁵ Knapp and VandeCreek (2004) proposed that Ethical Standard 2 (Competence) is derived from Principle A: Beneficence & Nonmaleficence, as it is more likely that an LMHP can provide benefit if he or she is competent; however, for our purposes, this chapter will discuss these issues sequentially.

⁵⁶ See, e.g., Socarides (1968), Hallman (2008), and Nicolosi (1991); these theories assume homosexuality is always a sign of developmental defect or mental disorder.

Worthington, 2002, 2004, 2005; Yarhouse, 2008). These areas become targets of LMHP interventions in order to reduce identity conflicts and distress and to explore and enhance the client's identity integration.

Because a large number of individuals who seek SOCE are from conservative faiths and indicate that religion is very important to them, integrating research on the psychology of religion into treatment may be helpful. For instance, individual religious motivations can be examined, positive religious coping increased, and religious identity and sexual orientation identity explored and integrated (Beckstead & Israel, 2007; Fowler, 1981; Glassgold, 2008; Haldeman, 2004; Knight & Hoffman, 2007; O'Neill & Ritter, 1992; Yarhouse & Tan, 2005a, 2005b). This is consistent with advances in the understanding of human diversity that place LGB-affirmative approaches within current multicultural perspectives that include age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (e.g., Bartoli & Gillem, 2008; Brown, 2006; Fowers & Davidov, 2006), consistent with Principle D (Justice) and Principle E (Respect for People's Rights and Dignity).

However, in some of the debates on these issues, there are tensions between conservative religious perspectives and affirmative and scientific perspectives (Haldeman, 2002; Rosik, 2003; Throckmorton & Welton, 2005; Yarhouse, 1998a; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002). Although there are tensions

APA (2008a) delineates a perspective that affirms the importance of science in exploring and understanding human behavior while respecting religion as an important aspect of human diversity.

between religious and scientific perspectives, the task force and other scholars do not view these perspectives as mutually exclusive (Bartoli & Gillem, 2008; Haldeman, 2004; S. L. Morrow & Beckstead, 2004; Yarhouse, 2005b).

As we noted in the introduction, in its Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice, APA (2008a) delineates a perspective that affirms the importance of science in exploring and understanding human behavior while respecting religion as an important aspect of human diversity. Scientific findings from the psychology of religion can be incorporated into treatment, thus respecting all aspects of diversity while providing therapy that is consistent with scientific research.

Most important, respecting religious values does not require using techniques that are unlikely to have an effect. We proposed an approach that respects religious values and welcomes all of the client's actual and potential identities by exploring conflicts and identities without preconceived outcomes. This approach does not prioritize one identity over another and may aide a client in creating a sexual orientation identity consistent with religious values (see Chapter 6) (Bartoli & Gillem, 2008; Beckstead & Israel, 2007; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Tan, 2008; Yarhouse, 2008).

Benefit and Harm

Principle A of the APA Ethics Code, Beneficence and Nonmaleficence, establishes that psychologists aspire to provide services that maximize benefit and minimize harm (APA, 2002b). Many ethicists and scholars consider the avoidance of harm to be the priority of modern health care and medical ethics (Beauchamp & Childress, 2008; Herek, 2003; S. L. Morrow, 2000). The literature on effective treatments and interventions stresses that to be considered effective, interventions must not have serious negative side effects (Beutler, 2000; Flay et al., 2005). When applying this principle in the context of providing interventions, LMHP assess the risk of harm, weigh that risk with the potential benefits, and communicate this to clients through informed consent procedures that aspire to provide the client with an understanding of potential risks and benefits that are accurate and unbiased. Some of the published considerations of ethical issues related to SOCE have focused on the limited evidence for its efficacy, the potential for client harm, and the potential for misrepresentation of these issues by proponents of SOCE (Cramer et al., 2008; Haldeman, 1994, 2002, 2004; Herek, 2003; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002). Other discussions focus on other harms of SOCE, such as reinforcing bias, discrimination, and stigma against LGB individuals (Davison, 1976, 1978, 1991; Drescher, 1999, 2001, 2002; Gonsiorek, 2004).

In weighing the harm and benefit of SOCE, LMHP can review with clients the evidence presented in this report. Research on harm from SOCE is limited, and some of the research that exists suffers from methodological limitations that make broad and definitive conclusions difficult. Early well-designed experiments that used aversive and behavioral

interventions did cause inadvertent and harmful mental health effects such as increased anxiety, depression, suicidality, and loss of sexual functioning in some participants. Additionally, client dropout rate is sometimes an indication of harmful effects (Lilienfeld, 2007). Early studies with aversive procedures are characterized by very high dropout rates, perhaps indicating harmful effects, and substantial numbers of clients unwilling to participate further. Other perceptions of harm mentioned by recipients of SOCE include increased guilt and hopelessness due to the failure of the intervention, loss of spiritual faith, and a sense of personal failure and unworthiness (Beckstead & Morrow, 2004; Haldeman, 2001, 2004; Shidlo & Schroeder, 2002). Other indirect harms from SOCE include the time, energy, and cost of interventions that were not beneficial (Beckstead & Morrow, 2004; Lilienfeld, 2007; G. Smith et al., 2004).

We found limited research evidence of benefits from SOCE. There is qualitative research that describes clients' positive perceptions of such efforts, such as

... the benefits reported by participants in SOCE may be achieved through treatment approaches that do not attempt to change sexual orientation.

experiencing empathy and a supportive environment to discuss problems and share similar values, which seemed to reduce their stress about their same-sex sexual attractions

(Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkowicz, 2001). The literature on SOCE support groups, for instance, illustrates results similar to those found for LGB-affirming groups and mutual help groups in general (e.g., Kerr, 1997; Levine et al., 2004; Thumma, 1991). The positive experiences clients report in SOCE are not unique. Rather, they are benefits that have been found in studies of therapeutic relationships and support groups in a number of different contexts (Levine et al., 2004; Norcross, 2002; Norcross & Hill, 2004). Thus, the benefits reported by participants in SOCE may be achieved through treatment approaches that do not attempt to change sexual orientation.

Perceptions of risks and rewards of certain courses of action influence the individual's decisions, distress, and process of exploration in psychotherapy. The client and LMHP may define these risks and rewards differently, leading to different perceptions of benefit and harm. Recognizing, understanding, and clarifying these different perceptions of risks and rewards are crucial for a thorough ethical analysis of each client's unique situation and are aspects of client-centered

approaches. For instance, an LMHP may attempt to provide information to the client to reduce sexual stigma and increase life options by informing the client about the research literature on same-sex couples. Such relationships may be threatening to the client when such a life course is perceived as being inconsistent with existing religious beliefs and motivations and potentially having negative repercussions on existing relationships with religious communities. Thus, the client and LMHP may perceive the benefits and harms of the same course of action differently. Yet, discussing positive coping resources with clients regarding how to manage such inconsistencies, stigma, and negative repercussions may provide the client with more informed and empowered solutions from which to choose, thus increasing benefit and autonomy and reducing harm.

Justice and Respect for Rights and Dignity

In this section, we focus on two concepts, Justice (Principle D) and Self-Determination (Principle E, Respect for People's Rights and Dignity). The first considers justice, both distributive and procedural justice (Knapp & VandeCreek, 2004), and the second focuses on recognizing diversity and maximizing a client's ability to choose. The APA Ethics Code uses the term *self-determination* to encompass the meanings for which many ethicists have used the term autonomy; we define self-determination as the process by which a person controls or determines the course of her or his own life (*Oxford American Dictionary*, 2007). Client self-determination encompasses the ability to seek treatment, consent to treatment, and refuse treatment. The informed consent process is one of the ways by which self-determination is maximized in psychotherapy.

Informed consent and self-determination cannot be considered without an understanding of the individual, community, and social contexts that shape the lives of sexual minorities. By understanding self-determination as context-specific and by working to increase clients' awareness of the influences of context on their decision making, the LMHP can increase clients' self-determination and thereby increase their ability to make informed life choices (Beckstead & Israel, 2007; Glassgold, 1995; 2008; Haldeman, 2004). For instance, some have suggested that social stigma and prejudice are fundamental reasons for sexual minorities' desire

to change their sexual orientation (Davison, 1976, 1978, 1982, 1991; Haldeman, 1994; Silverstein, 1991; G. Smith et al., 2004; Tozer & Hayes, 2004). As stigma, prejudice, and discrimination continue to be prevalent,⁵⁷ we recommend that LMHP strive to understand their clients' request for SOCE in the context of sexual stigma and minority stress (e.g., DiPlacido, 1998; Meyer, 2001). We further recommend that providers explore with their clients the impact of these factors on their clients' decision making in order to assess the extent to which self-determination is compromised (cf. G. Smith et al., 2004).

For instance, repressive, coercive, or invalidating cultural, social, political, and religious influences can limit autonomous expression of sexual orientation, including the awareness and exploration of options for expression of sexual orientation within an individual life (e.g., Glassgold, 2008; Mark, 2008; McCormick, 2006; G. Smith et al., 2004; Wax, 2008). We recommend that LMHP consider the impact of discrimination and stigma on the client and themselves (e.g., Beckstead & Israel, 2007; Haldeman, 2001, 2002). This consideration can become quite complex when the client or the community of the client or the LMHP believes that homosexuality is sinful and immoral (see Beckstead & Israel, 2007). Further exploration of religious beliefs and the cognitive assumptions underlying those beliefs may be helpful in understanding the client's beliefs and perception of choices (Buchanan et al., 2001; Fischer & DeBord, 2007; Johnson, 2004; Yarhouse, 2008; Yip, 2000, 2002, 2005).

The issue of self-determination has become controversial, and some have suggested that SOCE be offered in the spirit of maximizing client autonomy so that clients have access to a treatment they request (e.g., Rosik, 2003; Yarhouse & Throckmorton, 2002). Others have cautioned against providing interventions that have very limited evidence of effectiveness, run counter to current scientific knowledge, and have the potential for harm, despite client requests (Drescher,

1999, 2002; Forstein, 2001; Gonsiorek, 2004; Haldeman, 2002; Herek, 2003). With regard to claims that client autonomy is the defining concern in treatment decision making, elevating one aspect of ethical reasoning, such as autonomy, above all others is not consistent with the current framework of the APA Ethics Code or medical ethics that focus on the interrelatedness of ethical principles (Beauchamp & Childress, 2008; Knapp & VandeCreek, 2004).

For instance, current ethics guidance focuses on the interrelatedness of ethical principles and understanding a clinical situation fully so as to appropriately balance the various pertinent principles (e.g., Knapp & VandeCreek, 2004). Self-determination and autonomy can vary in degree due to interpersonal and intrapersonal concerns and can be considered in relation to other ethical principles, such as providing services that (a) are likely to provide benefit, (b) are not effective, or (c) have the potential for harm.

We believe that simply providing SOCE to clients who request it does not necessarily increase self-

We also believe that LMHP are more likely to maximize their clients' self-determination by providing effective psychotherapy that increases a client's abilities to cope, understand, acknowledge, explore, and integrate sexual orientation concerns into a self-chosen life in which the client determines the ultimate manner in which he or she does or does not express sexual orientation.

determination but rather abdicates the responsibility of LMHP to provide competent assessment and interventions that have the potential for benefit with a limited risk of harm. We also believe that LMHP are more likely to maximize their clients' self-determination by providing effective psychotherapy that increases a client's abilities to cope, understand,

acknowledge, explore, and integrate sexual orientation concerns into a self-chosen life in which the client determines the ultimate manner in which he or she does or does not express sexual orientation (Bartoli & Gillem, 2008; Beckstead & Israel, 2007; S. L. Morrow & Beckstead, 2004; Haldeman, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008).

Relational Issues in Treatment

Ideal or desired outcomes may not always be possible, and at times the client may face difficult decisions that

⁵⁷ For instance, the criminalization of certain forms of same-sex sexual behavior between consenting adults in private was constitutional in the United States until 2003 (see *Lawrence v. Texas*, 2003). The federal government and most U.S. states do not provide civil rights protections to LGB individuals and their families (National Gay and Lesbian Task Force: <http://www.thetaskforce.org>). In some other countries, homosexual behavior is still illegal and subject to extreme consequences, even death (e.g., Human Rights Watch, 2008; Wax, 2008; see also International Gay & Lesbian Human Rights Commission (IGLHRC): <http://www.iglhrc.org>). In extremely repressive environments, sexual orientation conversion efforts are provided in a coercive manner and have been the subject of human rights complaints (e.g., IGLHRC, 2001).

require different types and degrees of disappointment, distress, and sacrifice, as well as benefits, fulfillment, and rewards (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Yarhouse, 2008). LMHP may face strong emotions regarding the limits of their ability to provide relief from such difficult decisions or their consequences. Such emotions are understandable in this complex area, yet acting on such emotions within treatment has the potential to be harmful to the client (Knapp & VandeCreek, 2004; Pope & Vasquez, 2007). In these situations, in order to aid the client, the LMHP may have to address his or her own emotional reactions to the client's dilemmas. As the client must address regrets, losses (such as impossible and possible selves; see L. A. King & Hicks, 2007), and definitions of what is a fulfilling and worthwhile life, the LMHP must address his or her own values and beliefs about such issues. The LMHP's self-awareness, self-care, and judicious use of consultation can be helpful in these circumstances (Pope & Vasquez, 2007; Porter, 1995).

Moreover, LMHP may have their own internalized assumptions about sexual orientation, sexual orientation identity, sexuality, religion, race, ethnicity, and cultural issues (APA, 2000, 2002b; Garnets et al., 1991; McIntosh, 1990; Pharr, 1988; Richards & Bergin, 2005). The ethical principles of justice and respect for people's rights and dignity encourage LMHP to be aware of discrimination and prejudice so as to avoid condoning or colluding with the prejudices of others, including societal prejudices. As a way to increase awareness of their assumptions and promote the resolution of their own conflicts, R. L. Worthington, Dillon, and Becker-Schutte (2005) advised LMHP to develop their own competence surrounding sexual orientation, sexual minorities, and heterosexual privilege. Such competence requires self-reflection, contact with diverse sexual minority communities, and self-management of biases and sexual prejudice (cf. Israel, Ketz, Detrie, Burke, & Shulman, 2003).

Several authors (e.g., Faiver & Ingersoll, 2005; Lomax, Karff, & McKenny, 2002; Richards & Bergin, 2005; Yarhouse & Tan, 2005a; Yarhouse & VanOrman, 1999) have described potential ethical concerns related to working with religious clients. LMHP can strive to be aware of how their own religious values affect treatment and can aspire to focus on the client's perspective and aspire to become informed about the importance and content of specific religious beliefs and the psychology of religion (Bartoli, 2007; Yarhouse & Fisher, 2002; Yarhouse & VanOrman, 1999). Yet, for LMHP, the goal of treatment is determined by mental health concerns

Although LMHP strive to respect religious diversity and to be aware of the importance of religion to clients' worldviews, LMHP focus on scientific evidence and professional judgment in determining mental health interventions.

rather than directed by religious values (Gonsiorek, 2004). Although LMHP strive to respect religious diversity and to be aware of the importance of religion to clients' worldviews, LMHP

focus on scientific evidence and professional judgment in determining mental health interventions (APA, 2008a; Beckstead, 2001; Glassgold, 2008; Haldeman, 2004; Yarhouse & Burkett, 2002).

Summary

The principles and standards of the 2002 *Ethical Principles for Psychologists and Code of Conduct* most relevant to working with sexual minorities who seek to alter their sexual orientation are (a) Bases for Scientific and Professional Judgments (Standard 2.04) and Competence (2.01); (b) Beneficence and Nonmaleficence (Principle A); (c) Justice (Principle D); and (d) Respect for People's Rights and Dignity (Principle E). The key scientific findings relevant to the ethical concerns that are important in the area of SOCE are the limited evidence of efficacy or benefit and the potential for harm. LMHP are cautioned against promising sexual orientation change to clients. LMHP are encouraged to consider affirmative treatment options when clients present with requests for sexual orientation change. Such options include the therapeutic approaches included in Chapter 6. Self-determination is increased by approaches that support a client's exploration and development of sexual orientation identity. These approaches balance an understanding of the role of sexual stigma and respect other aspects of diversity in a client's exploration and maximize client self-determination.

8. ISSUES FOR CHILDREN, ADOLESCENTS, AND THEIR FAMILIES

Task Force Charge and Its Social Context

The task force was asked to report on three issues for children and adolescents:

- The appropriate application of affirmative therapeutic interventions for children and adolescents⁵⁸ who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.
- The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.⁵⁹
- Recommendations regarding treatment protocols that promote stereotyped gender-

normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

These issues reflected recent events in the current social context. Advocacy groups (Sanchez, 2007), law journals (Goishi, 1997; Morey, 2006; Weithorn, 1987), and the news media (A. Williams, 2005) have reported on involuntary⁶⁰ sexual orientation change efforts (SOCE)⁶¹ among adolescents. Publications by LMHP directed at parents and outreach from religious organizations advocate SOCE for children and youth as interventions to prevent adult same-sex sexual orientation (e.g., Nicolosi & Nicolosi, 2002; Rekers, 1982; see also Cianciotto & Cahill, 2006; Kennedy & Cianciotto, 2006; Sanchez, 2007).

Reports by LGB advocacy groups (e.g., Cianciotto & Cahill, 2006; Kennedy & Cianciotto, 2006) have claimed that there has been an increase in attention to youths by religious organizations that believe homosexuality is a mental illness or an adverse developmental outcome. These reports further suggested that there has

⁵⁸ In this report, we define *adolescents* as individuals between the ages of 12 and 18 and children as individuals under age 12. The age of 18 was chosen because many jurisdictions in the United States use this age as the legal age of majority, which determines issues such as consent to treatment and other relevant issues.

⁵⁹ We define *coercive treatments* as practices that compel or manipulate a child or adolescent to submit to treatment through the use of threats, intimidation, trickery, or some other form of pressure or force. The threat of future harm leads to the cooperation or obedience. Threats of negative consequences can be physical or emotional, such as threats of rejection or abandonment from or disapproval by family, community, or peer-group; engendering feelings of guilt/obligation or loss of love; exploiting physical, emotional, or spiritual dependence.

⁶⁰ We define *involuntary treatment* as that which is performed without the individual's consent or assent and which may be contrary to his or her expressed wishes. Unlike coercive treatment, no threats or intimidation are involved.

⁶¹ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals,

been an increase in outreach to youths that portrays homosexuality in an extremely negative light and uses fear and shame to fuel this message. These reports expressed concern that such efforts have a negative impact on adolescents' and their parents' perceptions of their sexual orientation or potential sexual orientation, increase the perception that homosexuality and religion are incompatible, and increase the likelihood that some adolescents will be exposed to SOCE without information about evidence-based treatments.

One aspect of these concerns expressed by LGB advocacy groups has been the presence of residential programs in which adolescents have been placed by their parents, in some cases with reported lack of assent from the adolescent (e.g., Cianciotto & Cahill, 2006; Kennedy & Cianciotto, 2006). In addition, a longstanding concern raised by advocacy groups for both LGB people and transgender people has been the alleged use of residential psychiatric commitment and gender-normative behavioral treatments for children and adolescents whose expression of gender or sexuality violates gender norms (Goishi, 1997; Morey, 2006; Weithorn, 1988).

To fulfill our charge, we reviewed the literature on SOCE in children and adolescents and affirmative psychotherapy for children, adolescents, and their families. We considered the literature on best practices in child and adolescent treatment, inpatient treatment, and legal issues regarding involuntary or coercive treatments and consent to and refusal of treatment. We also reviewed the literature on the development of sexual orientation in children and adolescents.

Literature Review

Literature on Children

There is a lack of published research on SOCE among children. Research on sexuality in childhood is limited and seldom includes sexual orientation or sexual orientation identity (Perrin, 2002). Although LGB adults and others with same-sex sexual attractions often report emotional and sexual feelings and attractions from their childhood or early adolescence and recall a sense of being different even earlier in childhood (Beckstead & Morrow, 2004; Bell et al., 1981; D'Augelli & Hershberger, 1993; Diamond & Savin-Williams, 2000; Troiden, 1989), such concerns have not been studied directly in young children (cf. Bailey & Zucker, 1995; Cohen & Savin-Williams, 2004).

There is no published research suggesting that children are distressed about their sexual orientation per se. Parental concern or distress about a child's behavior, mental health, and possible sexual orientation plays a central role in referrals for psychotherapy (Perrin, 2002; C. Ryan & Futterman, 1997). Parents may be concerned about behaviors in the child that are stereotypically associated with a same-sex sexual orientation (e.g., affection directed at another child of the same sex, lack of interest in the other sex, or behaviors that do not conform to traditional gender norms) (American Academy of Pediatrics [AAP], 1999; Haldeman, 2000). This situation contrasts with the condition of gender dysphoria in childhood and adolescence, for which there is clear evidence that some children and adolescents experience distress regarding their assigned sex, and some experience distress with the consequences of their gender and biological sex (i.e., youth struggling with social discrimination and stigma surrounding gender nonconformity) (APA, 2008e; R. Green, 1986, 1987; J. D. Menville, 1998; E. J. Menville & Tuerk, 2002; Zucker & Bradley, 1995).

Childhood interventions to prevent homosexuality have been presented in non-peer-reviewed literature (see Nicolosi & Nicolosi, 2002; Rekers, 1982).⁶² These interventions are based on theories of gender and sexual orientation that conflate stereotypic gender roles or interests with heterosexuality and homosexuality or that assume that certain patterns of family relationships cause same-sex sexual orientation. These treatments focus on proxy symptoms (such as nonconforming gender behaviors), since sexual orientation as it is usually conceptualized does not emerge until puberty, with the onset of sexual desires and drives (see APA, 2002a; Perrin, 2002). These interventions assume a same-sex sexual orientation is caused by certain family relationships that form gender identity and assume that encouraging gender stereotypic behaviors and certain family relationships will alter sexual orientation (Burack & Josephson, 2005; see, e.g., Nicolosi & Nicolosi, 2002; Rekers, 1979, 1982).

⁶² The only peer-reviewed literature did not focus on sexual orientation but rather on children with gender identity disorder or who exhibited nonconformity with gender roles (e.g., Rekers, 1979, 1981; Rekers, Bentler, Rosen, & Lovaas, 1977; Rekers, Kilgus, & Rosen, 1990; Rekers & Lovaas, 1974). However, the relevance of such work to this topic is limited, as none of these children reported experiencing same-sex sexual attractions or were followed into adulthood. Gender nonconformity differs from gender identity disorder, and children with gender identity disorder are not necessarily representative of the larger population of those children who will experience same-sex sexual attractions in adulthood (Bailey & Zucker, 1995; Bradley & Zucker, 1998; Zucker, 2008).

The theories on which these interventions are based have not been confirmed by empirical study (Perrin, 2002; Zucker, 2008; Zucker & Bradley, 1995). Although retrospective research indicates that some gay men and lesbians recall gender nonconformity in childhood (Bailey & Zucker, 1995; Bem, 1996; Mathy & Drescher, 2008), there is no research evidence that childhood gender nonconformity and adult homosexuality are identical or are necessarily sequential developmental phenomena (Bradley & Zucker, 1998; Zucker, 2008). Theories that certain patterns of family relationships cause same-sex sexual orientation have been discredited (Bell et al., 1981; Freund & Blanchard, 1983; R. R. Green, 1987; D. K. Peters & Cantrell, 1991).

The research that has been attempted to determine whether interventions in childhood affect adult sexual orientation exists only within the specific population of children with gender identity disorder (GID). R. Green (1986, 1987) and Zucker and Bradley (1995) (to a limited degree) examined prospectively whether psychotherapy in children with GID influenced adult or adolescent sexual orientation and concluded that it did not (for a review of the issues for children with GID, see APA, 2009, *Report of the Task Force on Gender Identity and Gender Variance*). Thus, we concluded that there is no existing research to support the hypothesis that psychotherapy in children alters adult sexual orientation.

Literature on Adolescents

We found no empirical research on adolescents who request SOCE, but there were a few clinical articles reporting cases of psychotherapy with religious

The general body of research on adolescents who identify themselves as same-sex oriented does not suggest that the normal development of a same-sex sexual orientation in adolescence is typically characterized by distress that results in requests for sexual orientation change.

of these cases, the adolescents or their families sought SOCE or considered SOCE (Cates, 2007; Yarhouse & Tan, 2005a; Yarhouse et al., 2005). The general body of research on adolescents who identify themselves as same-sex oriented does not suggest that the normal

adolescents who expressed confusion regarding their sexual orientation and conflicts between religious values and sexual orientation (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a; Yarhouse et al., 2005). In some

development of a same-sex sexual orientation in adolescence is typically characterized by distress that results in requests for sexual orientation change (e.g., D'Augelli, 2002; Garofalo & Harper, 2003; Savin-Williams & Cohen, 2004).

The absence of evidence for adolescent sexual orientation distress that results in requests for SOCE and the few studies in the literature on religious adolescents seeking psychotherapy related to sexual orientation suggest that sexual orientation distress is most likely to occur among adolescents in families for whom religious views that homosexuality is sinful and undesirable are important. Yarhouse and colleagues (Yarhouse, 1998b; Yarhouse, Brooke, Pisano, & Tan, 2005; Yarhouse & Tan, 2005a) discussed clinical examples of distress caused by conflicts between faith and sexual orientation identity. For instance, a female adolescent client struggled with guilt and shame and fears that God would not love her, and a male adolescent experienced a conflict between believing God created him with same-sex feelings and believing that God prohibited their expression (Yarhouse & Tan, 2005a). Cates (2007) described three cases of Caucasian males who were referred by schools, courts, or parents for concerns that included their sexual orientation. All three youths perceived that within their faith community and family, an LGB identity was unacceptable and would probably result in exclusion and rejection (Cates, 2007). Because of the primacy of religious beliefs, the adolescents or their families requested religiously based therapy or SOCE. For instance, Cates described the treatment of an adolescent who belonged to the Old Amish Community and who requested SOCE. The young man perceived that there was no place for him in his faith community as a gay man and did not want to leave that community.

Research on Parents' Concerns About Their Children's Sexual Orientation

We did not find specific research on the characteristics of parents who bring their children to SOCE. Thus, we do not know whether this population is similar to or different from the more general population of parents who may have concerns or questions regarding their children's sexual orientation or future sexual orientation. We cannot conclude that parents who present to LMHP with a request for SOCE are motivated by factors that cause distress in other parents of adolescents with emerging LGB identities.

As reported in case studies and clinical papers, parents' religious beliefs appear to be factors in their request for SOCE for their children. These articles identified a population of parents who have strong conservative religious beliefs that reject LGB identities and perceive homosexuality as sinful (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a; Yarhouse et al., 2005).

Other reports suggest that parents of adolescents with emerging same-sex sexual orientation and conservative religious beliefs that perceive homosexuality negatively appear to be influenced by religious authorities and LMHP who promote SOCE. For instance, Burack and Josephson (2005) and Cianciotto and Cahill (2006) reported that fear and stereotypes appeared to be contributing factors in parents who resort to residential SOCE or other related coercive treatment on youth. Cianciotto and Cahill found that some advocacy groups do outreach to parents that encourages commitment to SOCE residential programs even if the children do not assent. These programs also appear to provide information to parents that stresses that sexual orientation can be changed (Burack & Josephson, 2005; Cianciotto & Cahill, 2006), despite the very limited empirical evidence for that assertion.

Residential and Inpatient Services

We were asked to report on "the presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation." We performed a thorough review of the literature on these programs. Upon completion of this review, we decided that the best way to address this task was to evaluate issues of the appropriateness of these programs for adolescents in light of issues of harm and benefit based on the literature on adolescent development, standards for inpatient and residential treatment, and ethical issues such as informed consent.

There are several accounts of inpatient and residential treatment, sometimes involuntary or coerced, for adolescents who were LGB-identified, confused or questioning their sexual orientation, gender nonconforming, or transgender (Arriola, 1998; Burack & Josephson, 2005; Goishi, 1997; Molnar, 1997; Weithorn, 1988). These incidents mostly occurred because the parent or guardian was distressed regarding the child's actual sexual orientation or potential and perceived sexual orientation. An account of an adolescent boy who was placed in a program sponsored by Love in Action,

a religious-based program, was reported widely in the press (A. Williams, 2005). This program was reported to focus on religious approaches to SOCE as well as approaches that stress conformity to traditional gender roles and behaviors.

Concerns have arisen over the conduct of some private psychiatric hospitals that use alternative diagnoses—such as GID, conduct disorders, oppositional defiant disorders, or behaviors identified as self-defeating or self-destructive—to justify hospitalization of LGB and questioning youth and expose adolescents to SOCE (Arriola, 1998; Morey, 2006). Data on these issues are incomplete, as each state has different reporting requirements for public and private hospitals, and laws regarding confidentiality understandably protect client information.

ADOLESCENTS' RIGHTS TO CONSENT TO TREATMENT

In researching involuntary treatment, we reviewed the recent literature on the growing movement to increase adolescents' rights to consent to outpatient and inpatient mental health treatment so as to reduce involuntary hospitalization (Mutcherson, 2006;

It is now recognized that adolescents are cognitively able to participate in some health care treatment decisions, and such participation is helpful.

Redding, 1993). It is now recognized that adolescents are cognitively able to participate in some health care treatment decisions, and such participation is helpful

(Hartman, 2000, 2002; Mutcherson, 2006; Redding, 1993). The APA *Guidelines for Psychotherapy for Lesbian, Gay, and Bisexual Clients* (2000) and the APA Ethics Code (2002b) encourage professionals to seek the assent of minor clients for treatment. Within the field of adolescent mental health and psychiatry, there are developmental assessment models to determine an adolescent's competence to assent or consent to and potentially refuse treatment (Forehand & Ciccone, 2004; Redding, 1993; Rosner, 2004a, 2004b). Some states now permit adolescents some rights regarding choosing or refusing inpatient treatment, participating in certain interventions, and control over disclosure of records (Koocher, 2003).

INPATIENT TREATMENT

The use of inpatient and residential treatments for SOCE is inconsistent with the recommendations of the

field. For instance, the American Academy of Child and Adolescent Psychiatry (1989) recommended that inpatient treatment, when it does occur, be of the shortest possible duration and reserved for the most serious psychiatric illnesses, such as those of a psychotic nature or where there is an acute danger to self or others. For less serious mental health conditions, the Academy recommended that inpatient hospitalization occur only after less restrictive alternatives (i.e., outpatient and community resources) are shown to be ineffective. In *Best Practice Guidelines: Serving LGBT Youth in Out-of-Home Care* (Wilber, Ryan, & Marksamer, 2006), the Child Welfare League of America recommended that, if necessary, hospitalization or residential substance abuse treatment for adolescents be in a setting that provides mental health treatments that are affirmative of LGB people and for which the staff is competent to provide such services. Further, in a review of the psychiatric literature, Weithorn (1988) concluded that the deprivation of normal social contacts and prevention of attendance at school and other normal social settings can be harmful as well as punitive.

PROGRAMS WITH RELIGIOUS AFFILIATIONS

Programs such as Love in Action's Refuge⁶³ provided religiously based interventions that claimed to change sexual orientation, control sexual behavior, or prevent the development of same-sex sexual orientation (Burack & Josephson, 2005; Sanchez, 2007; A. Williams, 2005). Because such programs are religious in nature and are not explicitly mental health facilities,⁶⁴ they are not licensed or regulated by state authorities. Burack and Josephson reported that there was effort by religious organizations and sponsors of these programs to communicate to parents that homosexuality is abnormal and sinful and could be changed.⁶⁵ Such religious organizations, according to the authors of the report, encouraged parents to seek treatment for their children. Based on anecdotal accounts of current and past residents, these programs, to influence adolescents' life decisions, allegedly used fear and even threats about negative spiritual, health, and life consequences and

thus are viewed as coercive (Burack & Josephson, 2005; Sanchez, 2007).

To provide an overview of the issues with residential programs for youth, we reviewed information gathered by the APA (2002a) Committee on Children, Youth, and Families in collaboration with the APA State Advocacy Office and the testimony and subsequent published report by members of the U.S. General Accounting Office before the Committee on Education and Labor of the U.S. House of Representatives (Kutz & O'Connell, 2007). These reports and testimony evaluated some current problems in adolescent residential mental health care. There are a large number of unlicensed and unregulated programs marketed to parents struggling to find behavioral or mental health programs for their

Although religious doctrines themselves are not the purview of psychologists, how religious doctrine is inculcated through educational and socialization practices is a psychological issue and an appropriate subject of psychological examination, especially if there are concerns regarding substantiation of benefit or harm, unlicensed and unregulated facilities, and coercive and involuntary treatment.

adolescent children.

Although many of these programs avoid regulation by not identifying themselves as mental health programs, they do advertise mental health, behavioral, and/or educational goals, especially for those youth perceived as troubled by their parents. Many of these programs

are involuntary and coercive and use seclusion or isolation and escort services to transport unwilling youth to program locations (Kutz & O'Connell, 2007). The testimony and report described the negative mental health impacts of these programs and expressed grave concerns about them, including questions about quality of care and harm caused by coercive or involuntary measures (Kutz & O'Connell, 2007).

Thus, residential and outpatient programs that are involuntary and coercive and provide inaccurate scientific information about sexual orientation or are excessively fear-based pose both clinical and ethical concerns, whether or not they are based on religious doctrine. Although religious doctrines themselves are not the purview of psychologists, how religious doctrine is inculcated through educational and socialization practices is a psychological issue and an appropriate subject of psychological examination, especially if there are concerns regarding substantiation of benefit

⁶³ The program "Refuge," directed at adolescents, was closed in 2007 and is no longer advertised. However, Love in Action still sponsors residential programs for adults.

⁶⁴ These programs advertise helping with addiction, "negative self-talk and irrational belief systems," and behavior change (see www.loveinaction.org).

⁶⁵ See www.loveinaction.org.

or harm, unlicensed and unregulated facilities, and coercive and involuntary treatment.

As noted earlier, we define coercive treatments as practices that compel or manipulate an individual to submit to treatment through the use of threats, intimidation, manipulation, trickery, or some other form of pressure, including threats of future harm. Harm can be physical or psychological. Harmful psychological consequences include disapproval; loss of love; rejection or abandonment by family, community, or peer group; feelings of guilt/obligation; and exploitation of physical, emotional, or spiritual dependence. Working with a variety of client populations presents ethical dilemmas for providers (APA, 2002b; Beauchamp & Childress, 2008; Davis, 2002); however, with children and adolescents, such concerns are heightened (Molnar, 1997; Weithorn, 1988). Children and adolescents are more vulnerable to such treatments because of the lack of legal rights and cognitive and emotional maturity and emotional and physical dependence on parents, guardians, and LMHP (Molnar, 1997; Weithorn, 1988). The involuntary nature of particular programs raises issues similar to those of other involuntary mental health settings; however, because they are religious programs, not mental health programs, they pose complex issues for licensure and regulation (A. Williams, 2005). On the basis of ethical principles (APA, 2002b; Beauchamp & Childress, 2008), LMHP should strive to maximize autonomous decision making and self-determination and avoid coercive and involuntary treatments.

Appropriate Application of Affirmative Interventions With Children and Adolescents

Multicultural and Client-Centered Approaches for Adolescents

A number of researchers and practitioners have advised LMHP that when working with children or adolescents and their families, they should address concerns regarding sexual orientation and base their interventions on the current developmental literature on children and adolescents and the scholarly literature on parents' responses to their child's sexual orientation (e.g., Ben-Ari, 1995; Bernstein, 1990; Holtzen & Agriesti, 1990; Mattison & McWhirter, 1995; Perrin, 2002; C. Ryan, Huebner, Diaz, & Sanchez, 2009;

Salzburg, 2004, 2007; Yarhouse & Tan, 2005a).⁶⁶ This literature recommends that LMHP learn about the law and scholarship on developmental factors in informed consent and take steps to ensure that minor clients have a developmentally appropriate understanding of treatment, are afforded complete information about their rights, and are provided treatment in the least restrictive environment. LMHP can review the recommendations for assent to treatment recommended in the *Guidelines for Psychotherapy for Lesbian, Gay, and Bisexual Clients* (APA, 2000) and can seek an adolescent's consent consistent with evolving considerations of developmental factors (Forehand & Ciccone, 2004; Redding, 1993; Rosner, 2004a, 2004b).

APA policies (APA, 1993, 2000) and the vast majority of current publications on therapy for LGB and questioning adolescents who are concerned about their sexual orientation recommend that LMHP support adolescents' exploration of identity by

- accepting homosexuality and bisexuality as normal and positive variants of human sexual orientation,
- accepting and supporting youths as they address the stigma and isolation of being a sexual minority,
- using person-centered approaches as youths explore their identities and experience important developmental milestones (e.g., exploring sexual values, dating, and socializing openly),
- reducing family and peer rejection and increasing family and peer support (e.g., APA, 2000, 2002a; D'Augelli & Patterson, 2001; Floyd & Stein, 2002; Fontaine & Hammond, 1996; Hart & Heimberg, 2001; Hetrick & Martin, 1987; Lemoire & Chen, 2005; Mallon, 2001; A. D. Martin, 1982; Perrin, 2002; Radkowsky & Siegel, 1997; C. Ryan, 2001; C. Ryan et al., 2009; C. Ryan & Diaz, 2005; C. Ryan & Futterman, 1997; Schneider, 1991; Slater, 1988; Wilber, Ryan & Marksamer, 2006; Savin-Williams & Cohen, 2004; Yarhouse & Tan, 2005a).

When sexual minority and questioning youth require residential or inpatient treatment for mental health, behavioral, or family issues, it has been recommended that such treatment be safe from discrimination and

⁶⁶ Due to the limited research on children, adolescents, and families who seek SOCE, our recommendations for affirmative therapy for children, youth, and their families distressed about sexual orientation are based on general research and clinical articles addressing these and other issues, not on research specific to those who specifically request SOCE. We acknowledge that limitation in our recommendations.

prejudice and affirming of sexual orientation diversity by staff who are knowledgeable about LGB identities and life choices (Mallon, 2001; Wilber et al., 2006).

Other aspects of human diversity, such as age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status, may be relevant to an adolescent's identity development, and these differences may intersect with sexual orientation identity (Diamond & Savin-Williams, 2000; Rosario, Rotheram-Borus, & Reid, 1996; Rosario, Schrimshaw, & Hunter, 2004; Rosario, Schrimshaw, Hunter, & Braun, 2006). Some adolescents are more comfortable with fluid or flexible identities due to gender differences and generational or developmental concerns, and their sexual orientation identities may not be exclusive or dichotomous (Diamond, 2006; Morgan & Thompson, 2006; Savin-Williams, 2005).

Only a few articles addressed the specific conflicts between religious identities and sexual orientation identities among youth (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a). For instance, Yarhouse and Tan proposed solutions that respect religious beliefs and emphasized nondirective exploration of religious and sexual orientation identity that does not advocate a particular sexual orientation identity outcome. As adolescents may experience a crisis of faith and distress linked to religious and spiritual beliefs, the authors explored interventions that integrate the psychology of religion into interventions that stress improving the client's positive religious coping and relationship with the sacred (e.g., Exline, 2002; Pargament & Mahoney, 2005; Pargament et al., 1998, 2005). Cates (2007), from a more secular frame, emphasized a client-centered approach that stresses the LMHP's unconditional acceptance of the client and client choices even if the client cannot accept his or her own sexual orientation.

The ethical issues outlined in Chapter 7 are also relevant to children and adolescents; however, working with adolescents presents unique ethical dilemmas to LMHP (Koocher, 2003). Children and adolescents are often unable to anticipate the future consequences of a course of action and are emotionally and financially dependent on adults. Further, they are in the midst of developmental processes in which the ultimate outcome is unknown. Efforts to alter that developmental path may have unanticipated consequences (Perrin, 2002). LMHP should strive to be mindful of these issues, particularly as these concerns affect assent and consent to treatment and goals of treatment (Koocher, 2003; Rosner, 2004a, 2004b; Sobocinski, 1990). Possible

approaches include open-ended and scientifically based age-appropriate exploration with children, adolescents, and parents regarding these issues.

Multicultural and Client-Centered Approaches for Parents and Families

Parental attitudes and behaviors play a significant role in children's and adolescents' adjustment (Radkowski & Siegel, 1997; C. Ryan & Diaz, 2005; C. Ryan et al., 2009; Savin-Williams, 1989b, 1998; Wilber et al., 2006; Yarhouse, 1998b). One retrospective research study of adults indicated that LGB children are more likely to be abused by their families than by nonrelated individuals (Corliss, Cochran, & Mays, 2002). Another

<i>Reducing parental rejection, hostility, and violence (verbal or physical) may contribute to the mental health and safety of the adolescent.</i>	found that family rejection is a key predictor of negative health outcomes in White and Latino LGB young adults (C. Ryan et al., 2009).

Reducing parental rejection, hostility, and violence (verbal or physical) may contribute to the mental health and safety of the adolescent (Remafedi et al., 1991; C. Ryan et al., 2009; Savin-Williams, 1994; Wilber et al., 2006). Further, to improve parents' responses, LMHP can find ways to ameliorate parents' distress about their children's sexual orientation. Exploring parental attributions and values regarding same-sex sexual orientation is especially important in order to facilitate engagement in treatment, resolution of ethical dilemmas, and more beneficial psychotherapy (Morrissey-Kane & Prinz, 1999; Sobocinski, 1990).

Family therapy for families who are distressed by their child's sexual orientation may be helpful in facilitating dialogues, increasing acceptance and support, reducing rejection, and improving management of conflicts or misinformation that may exacerbate an adolescent's distress (Mattison & McWhirter, 1995; C. Ryan et al., 2009; Salzburg, 2004, 2007). Such therapy can include family psychoeducation to provide accurate information and teach coping skills and problem-solving strategies for dealing more effectively with the challenges sexual minority youth may face and the concerns the families and caretakers may have (Ben-Ari, 1995; Perrin, 2002; C. Ryan & Diaz, 2005; Ryan & Futterman, 1997; C. Ryan et al., 2009; Salzburg, 2004, 2007; Yarhouse, 1998b). C. Ryan and Futterman (1997) termed this *anticipatory*

guidance: LMHP provide family members with accurate information regarding same-sex sexual orientation and dispel myths regarding the lives, health, and psychological well-being of LGB individuals.

Perrin (2002) recommended that providers, when working with families of preadolescent children, counsel parents who are concerned that their young children may grow up to be lesbian or gay to tolerate the ambiguity inherent in the limited knowledge of development. In addition, Perrin suggested a two-pronged approach: (a) provide information to reduce heterosexism within the family and increase the family's capacity to provide support and (b) introduce information about LGB issues into family discussions to aid the child's own self-awareness and self-acceptance and to counter stigma. For adolescents, C. Ryan et al. (2009) recommended that LMHP assess family reactions to LGB youth, specifically the presence of family rejection. Further, the authors advocated explaining to families the link between family rejection and negative health problems in children and adolescents, providing anticipatory guidance to families that includes recommendations for support on the part of the family, and helping families to modify highly rejecting behaviors.

Families with strong religious beliefs that condemn homosexuality may struggle with a child's same-sex sexual orientation (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a). Yarhouse and Tan (2005a) suggested that family therapy reframe the religious beliefs to focus on aspects of faith that encourage love and acceptance of their child rather than on a religion's prohibitions. The authors stressed that these positive elements of faith can lay a constructive foundation for communication and problem solving and reduce family discord and rejection.

Providing anticipatory guidance to parents to address their unique personal concerns can be helpful (C. Ryan & Futterman, 1997). The LMHP can help the parents plan in an affirmative way for the unique life challenges that they may face as parents of a sexual minority child. Parents must deal with their own unique choices and process of "coming out" and resolve fears of enacted stigma if they risk disclosure within their communities, at work, and to other family members (Bernstein, 1990). Further, the LMHP can address other stresses, such as managing life celebrations and transitions and coping with feelings of loss, and aid parents in advocating for their children in school situations—for example, when they face bullying or harassment. Multiple family groups led by LMHP might be helpful to counter the

isolation that many parents experience (J. D. Menveille & Tuerk, 2002).

Community Approaches for Children, Adolescents, and Families

Research has illuminated the potential that school-based and community interventions have for increasing safety and tolerance of sexual minorities, preventing distress and negative mental health consequences, and increasing the psychological well-being and health of sexual minority youth (APA, 1993; D'Augelli & Patterson, 2001; Goodenow, Szalacha, & Westheimer, 2006; Harper, Jamil, & Wilson, 2007; Kosciw & Diaz, 2006; A. J. Peters, 2003; Roffman, 2000; Safren & Heimberg, 1999; Schneider, 1991; Treadway & Yoakum, 1992). For instance, sexual minority adolescents in schools with support groups for LGB students reported lower rates of suicide attempts and victimization than those without such groups (Goodenow et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003). Kosciw and Diaz (2006) found that such support groups were related to improved academic performance and college attendance. The support groups that were examined in the research provided accurate affirmative information and social support, and the groups' presence was also related to increased school tolerance and safety for LGB youth (Goodenow et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003). School policies that increased staff support and positive school climate have been found to moderate suicidality and to positively affect sexual minority youth school achievement and mental health (Goodenow et al., 2006).

School and community interventions have the potential for introducing other sources of peer and adult support that may buffer children and adolescents from rejection that may occur in certain family, community, and religious contexts. These school and community interventions may provide alternative sources of information regarding LGB identities and lives. However, such school and community interventions are unlikely to directly affect the core attitudes and beliefs of the religious institutions and communities in which sexual orientation distress and family rejection might occur. These programs may have an indirect effect on communities and religious institutions because of their potential to change the general social context in which families deal with conflicts between their children's emerging sexual orientations and identities. We hope that such change will reduce the level of psychological

distress that such conflicts between religion and sexuality create and reduce the level of hostility and punitiveness to which some children and adolescents are exposed as a result of their sexual orientation.

For families, groups such as Parents, Families, and Friends of Lesbians and Gays (PFLAG) and the Straight Spouse Network may also provide a safe, nonjudgmental space in which to discuss their concerns, receive accurate information, reduce isolation, and reduce feelings of perceived stigma (Goldfried & Goldfried, 2001). PFLAG offers extensive literature for parents based on affirmative approaches to same-sex sexual attractions as well as a nationwide network of support groups. Such groups, by providing affirmative sources of information, could reduce the distress for parents that is and increase family support of their sexual minority children, thus positively affecting sexual minority youth and children whose families are concerned about their future sexual orientation.

Parents who are religious may benefit from finding support through religious organizations and groups. One concern is that some groups may provide parents with information that presents same-sex sexual orientation in a negative light (e.g., defective, “broken”), which could increase stigma and rejection of children and adolescents; thus, such groups should rarely be considered. Alternatively, some groups provide resources that are both LGB affirming and religious.⁶⁷

Conclusion

We were asked to report on three issues for children and adolescents. First, we were asked to provide recommendations regarding treatment protocols that attempt to prevent homosexuality in adulthood by promoting stereotyped gender-normative behavior in children to mitigate behaviors that are perceived to be

Some advocates of these treatments see homosexuality as a mental disorder, a concept that has been rejected by the mental health professions for more than 35 years.

indicators that a child will develop a homosexual orientation in adolescence and adulthood. We found no empirical evidence that

providing any type of therapy in childhood can alter adult same-sex sexual orientation. Some advocates

⁶⁷ See, e.g., “Family Fellowship” (www.ldsfamilyfellowship.org/) for parents who belong to the Church of Jesus Christ of Latter-Day Saints. The Institute of for Sexual Orientation and Judaism also lists resources: www.huc.edu/ijso/.

of these treatments see homosexuality as a mental disorder, a concept that has been rejected by the mental health professions for more than 35 years. Further, the theories that such efforts are based on have not been corroborated by scientific evidence or evaluated for harm. Thus, we recommend that LMHP avoid such efforts and provide instead multicultural, client-centered, and affirmative treatments that are developmentally appropriate (Perrin, 2002).

Second, we were asked to comment on the presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation. We found that serious questions are raised by involuntary and coercive interventions and residential centers for adolescents due to their advocacy of treatments that have no scientific basis and potential for harm due to coercion, stigmatization, inappropriateness of treatment level and type, and restriction of liberty. Although the prevalence of these treatment centers is unknown, we recommend that some form of oversight be established for such youth facilities, such as licensure and monitoring, especially as a means of reporting abuse or neglect.

States have different requirements and standards for obtaining informed consent to treatment for adolescents; however, it is recognized that adolescents are cognitively able to participate in some health care treatment decisions and that such participation is helpful. We recommend that when it comes to treatment that purports to have an impact on sexual orientation, LMHP assess the adolescent’s ability to understand treatment options, provide developmentally appropriate informed consent to treatment, and, at a minimum, obtain the youth’s assent to treatment. SOCE that focus on negative representations of homosexuality and lack a theoretical or evidence base provide no documented benefits and can pose harm through increasing sexual stigma and providing inaccurate information. We further concluded that involuntary or coercive residential or inpatient programs that provide SOCE to children and adolescents may pose serious risk of harm, are potentially in conflict with ethical imperatives to maximize autonomous decision making and client self-determination, and have no documented benefits. Thus, we recommend that parents, guardians, or youth not consider such treatments.

Finally, we were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change their sexual orientation or their behavioral

expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.

We recommend that LMHP provide multiculturally competent and client-centered therapies to children, adolescents, and their families rather than SOCE.

We recommend that LMHP provide multiculturally competent and client-centered therapies to children,

adolescents, and their families rather than SOCE.

Such approaches include an awareness of the interrelatedness of multiple identities in individual development as well an understanding of cultural, ethnic, and religious variation in families. Specific approaches can include (a) supporting children and youth in their developmental processes and milestones, (b) reducing internalized stigma in children and sexual stigma in parents, and (c) providing affirmative information and education on LGB identities and lives.

These approaches would support children and youth in identity exploration and development without seeking predetermined outcomes. Interventions that incorporate knowledge from the psychology of religion and that increase acceptance, love, and understanding among individuals, families, and communities are recommended for populations for whom religion is important. Family therapy that provides anticipatory guidance to parents to increase their support and reduce rejection of children and youth addressing these issues is essential. School and community interventions are also recommended to reduce societal-level stigma and provide information and social support to children and youth.

9. SUMMARY AND CONCLUSIONS

APA's charge to the task force included three major tasks that this report has addressed:

1. Review and update the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998).
2. Generate a report that includes discussion of the following:
 - The appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.
 - The appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both.
 - The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.
 - Education, training, and research issues as they pertain to such therapeutic interventions.
 - Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived

to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

3. Inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.

The substance of the second task has been achieved in the preceding chapters of this report. In Chapters 3 and 4, we reviewed the body of research on the efficacy and safety of sexual orientation change efforts (SOCE).⁶⁸ In Chapter 5 we synthesized the literature on the nature of distress and identified conflicts in adults, which provided the basis for our recommendations for affirmative approaches to psychotherapy practice that are described in Chapter 6. Chapter 7 discussed ethical issues in SOCE for adults. In Chapter 8 we considered the more limited body of research on children and adolescents, including a review of SOCE with children and adolescents and affirmative approaches for psychotherapy.

In this final chapter, we summarize the report and focus on those two tasks—one and three—that have not been addressed in the report. With regard to the policy, we recommended that the 1997 policy be retained and

⁶⁸ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

that a new policy be adopted to complement it. The new policy that we proposed (see Appendix A) was adopted by APA's Council of Representatives in August 2009. With regard to APA's response to groups that advocate for SOCE, we provide those recommendations at the end of this chapter in the section on policy.

To achieve the charge given by APA, we decided to conduct a systematic review of the empirical literature on SOCE. This review covered the peer-reviewed journal articles in English from 1960 to 2007.⁶⁹ The review is reported in Chapters 3 and 4: Chapter 3 addresses methodological issues in the research; and Chapter 4, the outcomes, such as safety, efficacy, benefit, and harm of SOCE.

We also reviewed the recent literature on the psychology of sexual orientation. There is a growing body of literature that concludes that social stigma, known specifically as sexual stigma, manifested as prejudice and discrimination directed at same-sex sexual orientations and identities, is a major source of stress for sexual minorities. This stress, known as minority stress, is a major cause of the mental health disparities of sexual minorities. On the basis of this literature, we recommend that all interventions and policy for these populations include efforts to mitigate minority stress and reduce stigma.

Further, we found that religious individuals with beliefs that homosexuality is sinful and morally unacceptable are prominent in the population that currently undergoes SOCE. These individuals seek SOCE because the disapproving stance of their faiths toward homosexuality produces conflicts between, on the one hand, their beliefs and values and, on the other, their sexual orientation. These conflicts result in significant distress due to clients' perceptions that they are unable to integrate their faith and sexual orientation. To respond as well as possible to this population, we included in our review some of the empirical and theoretical literature from the psychology of religion, recently adopted APA policies on religion and science, and specific interventions that have been proposed in the literature for religious populations.

SOCE has been quite controversial, and the controversy has at times become polemical because of clashes between differing political viewpoints about LGB individuals and communities and the differing

values between some faith-based organizations and scientific and professional organizations (Drescher, 2003; Zucker, 2008). Psychology, as a science, and various faith traditions, as theological systems, can

APA has affirmed that proven methods of scientific inquiry are the best methods to explore and understand human behavior and are the basis for the association's policies.

acknowledge and respect their profoundly different methodological and philosophical viewpoints. The APA has affirmed that proven

methods of scientific inquiry are the best methods to explore and understand human behavior and are the basis for the association's policies (APA, 2007a, 2008a). The APA affirms that discrimination directed at religions and their adherents or derived from religious beliefs is unacceptable and that religious faith should be respected as an aspect of human diversity (APA, 2008c).

Summary of the Systematic Review of the Literature

To fulfill the charge given by APA, we undertook a systematic review to address the key questions: What are the outcomes of SOCE and their potential benefits and harms? Is SOCE effective or safe? The first step was to evaluate the research to determine if such conclusions could be drawn from the research—in other words, was the research performed with the appropriate degree of methodological rigor to provide such answers? The next question was to determine, if such research existed, what answers it provided.

Efficacy and Safety

We found few scientifically rigorous studies that could be used to answer the questions regarding safety, efficacy, benefit, and harm (e.g., Birk et al., 1971; S. James, 1978; McConaghy, 1969, 1976; McConaghy et al., 1972; Tanner, 1974, 1975). Few studies could be considered true experiments or quasi-experiments that would isolate and control the factors that might effect change (see the list of studies in Appendix B). These studies were all conducted in the period from 1969 to 1978 and used aversive or other behavioral methods.

Recent SOCE differ from those interventions explored in the early research studies. The recent nonreligious interventions are based on the assumption that homosexuality and bisexuality are mental

⁶⁹ The articles in English include material on populations outside the United States, including Canada, Mexico, Western Europe, and some material on Middle Eastern, South Asian, and East Asian populations. No articles based on new research have been published since 2007. One article published in 2008 is a restatement of Schaeffer et al. (2000).

disorders or deficits and are based on older discredited psychoanalytic theories (e.g., Socarides, 1968; see American Psychoanalytic Association, 1991, 1992, 2000; Drescher, 1998b; Mitchell, 1978, 1981). Some focus on increasing behavioral consistency with gender norms and stereotypes (e.g., Nicolosi, 1991). None of these approaches is based on a credible scientific theory, as these ideas have been directly discredited through evidence or rendered obsolete. There is longstanding scientific evidence that homosexuality per se is not a mental disorder (American Psychiatric Association, 1973; Bell & Weinberg, 1978; Bell et al., 1981; Conger, 1975; Gonsiorek, 1991; Hooker, 1957), and there are a number of alternate theories of sexual orientation and gender consistent with this evidence (Bem, 1996; Butler, 2004; Chivers et al., 2007; Corbett, 1996, 1998, 2001; Diamond, 1998, 2006; Drescher, 1998b; Enns, 2008; Heppner & Heppner, 2008; Levant & Silverstein, 2006; Mustanski et al., 2002; O'Neil, 2008; Peplau & Garnets, 2000; Pleck, 1995; Rahman & Wilson, 2005; Wester, 2008).

Other forms of recent SOCE are religious, are not based on theories that can be scientifically evaluated, and have not been subjected to rigorous examination of efficacy and safety. These approaches are based on religious beliefs that homosexuality is sinful and immoral and, consequently, that identities and life paths based on same-sex sexual orientation are not religiously acceptable. The few high-quality studies of SOCE conducted from 1999 to 2004 are qualitative (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkowicz, 2001) and these, due to the research questions explored, aid in understanding the population that seeks sexual orientation change but do not provide the kind of information needed for definitive answers to questions of the safety and efficacy of SOCE.

Thus, we concluded that the early evidence, though extremely limited, is the best basis for predicting what would be the outcome of psychological interventions. Scientifically rigorous older work in this area (e.g., Birk et al., 1971; S. James, 1978; McConaghy, 1969, 1976; McConaghy et al., 1972; Tanner, 1974, 1975) shows that enduring change to an individual's sexual orientation is uncommon and that only a very small number of people in these studies show any credible evidence of reduced same-sex sexual attraction, though some show lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and increased sexual attraction to and engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence

that any changes produced in laboratory conditions translated to daily life. Many individuals continued to experience same-sex sexual attractions following SOCE and seldom reported significant change to other-sex sexual attractions. Thus, we concluded the following about SOCE: *The results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex sexual attractions or increase other-sex attractions through SOCE.*

The few early research investigations that were conducted with scientific rigor raise concerns about the safety of SOCE, as some participants suffered unintended harmful side effects from the interventions. These negative side effects included loss of sexual feeling, depression, suicidality, and anxiety. The high dropout rate in these studies may indicate that some research participants may have experienced these treatments as harmful and discontinued treatment (Lilienfeld, 2007). There are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom.

Individuals Who Undergo SOCE and Their Experiences

Although scientific evidence shows that SOCE is not likely to produce its intended outcomes and can produce harm for some of its participants, there is a population of consumers who participate in SOCE. To address the questions of appropriate application of affirmative interventions for this population, which was a major aspect of APA's charge to the task force, we returned to the research literature on SOCE, expanding beyond the scope of the systematic review to include other literature in order to develop an understanding of the current population that participates in SOCE. The research does reveal something about those individuals who undergo SOCE, how they evaluate their experiences, and why they may seek SOCE, even if the research does not indicate whether SOCE has anything to do with the changes some clients perceive themselves have experienced. We sought this information to be as comprehensive as possible and to develop an information base that would serve as a basis for considering affirmative interventions.

SOCE research identifies a population of individuals who experience conflicts and distress related to same-sex sexual attractions. The population of adults included in recent SOCE research is highly religious, participating

in faiths that many would consider traditional or conservative (e.g., the Church of Jesus Christ of Latter-Day Saints [Mormon], evangelical Christian, or Orthodox Jewish). Most of the participants in recent studies are White men who report that their religion is extremely important to them (Nicolosi et al., 2000; Schaeffer et al., 2000; Shidlo & Schroeder, 2002; Spitzer, 2003). These recent studies include a small number of participants who identify as members of ethnic minority groups. Recent studies include more women than in early studies, and one qualitative study focused exclusively on women (Ponticelli, 1999). Most of the individuals studied tried a variety of methods to change their sexual orientation, including psychotherapy, support groups, and religious efforts. Many of the individuals studied were recruited from groups endorsing SOCE. The body of literature overall is based on convenience samples; thus, the relationship between the characteristics of these individuals compared to the entire population of people who seek SOCE is unknown.

Comparisons of the early and recent research indicate changes in the demographics of those who seek SOCE. The individuals who participated in early research on SOCE were also predominantly White males, but those studies included men who were court-referred to treatment, men who were referred to treatment for a range of psychiatric and sexual concerns, and men who were fearful of criminal or legal sanctions, in addition to men who were distressed by their sexual attractions. There are no data on the religious beliefs of those in the early studies. As noted previously, the individuals in recent studies indicated that religion is very important to them.

We concluded that some of the controversy surrounding SOCE can be explained by different understandings of the nature of sexual orientation and sexual orientation identity. Recent research in the field of sexual orientation indicates a range of sexual attractions and desires, sexual orientations, and multiple ways of self-labeling and self-identifying (e.g., Carrillo, 2002; Diamond, 1998, 2006, 2008; Fox, 1995; Hoberg et al., 2004; Savin-Williams, 2005). Some researchers have found that distinguishing the constructs of sexual orientation and sexual orientation identity adds clarity to an understanding of the variability in reports of these two variables (R. L. Worthington & Reynolds, 2009). *Sexual orientation* refers to an individual's patterns of sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics. Sexual orientation is tied to physiological drives and

biological systems that are beyond conscious choice and involve profound emotional feelings such as "falling in love" and emotional attachment. Other dimensions commonly attributed to sexual orientation (e.g., sexual behavior with men and/or women; sexual values, norms, and motivations; social affiliations with LGB or heterosexual individuals and communities; emotional attachment preferences for men or women; gender role and identity; lifestyle choices) are potential correlates of sexual orientation rather than principal dimensions of the construct. *Sexual orientation identity* refers to recognition and internalization of sexual orientation and reflects self-awareness, self-recognition, self-labeling, group membership and affiliation, culture, and self-stigma. Sexual orientation identity is a key element in determining relational and interpersonal decisions, as it creates a foundation for the formation of community, social support, role models, friendship, and partnering (APA, 2003; Jordan & Deluty, 1998; McCarn & Fassinger, 1996; Morris, 1997).

Recent studies of SOCE participants frequently do not distinguish between sexual orientation and sexual orientation identity. We concluded that the failure to distinguish these aspects of human sexuality in this recent SOCE research has obscured an understanding of what aspects of human sexuality might and might not change through intervention. The available evidence, from both early and recent studies, suggests that

The available evidence, from both early and recent studies, suggests that although sexual orientation is unlikely to change, some individuals modified their sexual orientation identity (i.e., individual or group membership and affiliation, self-labeling) and other aspects of sexuality (i.e., values and behavior).

although sexual orientation is unlikely to change, some individuals modified their sexual orientation identity (i.e., individual or group membership and affiliation, self-labeling) and other aspects of sexuality (i.e.,

values and behavior). They did so in a variety of ways and with varied and unpredictable outcomes, some of which were temporary (Beckstead, 2003; Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). For instance, in recent research, many individuals claim that through participating in SOCE, they became skilled in ignoring or tolerating their attractions or limiting the impact of their attractions on their sexual behavior (Beckstead & Morrow, 2004; McConaghy, 1976; Shidlo & Schroeder, 2002). Early nonexperimental case studies described

individuals who reported that they went on to lead outwardly heterosexual lives, including, for some, developing a sexual relationship with an other-sex partner and adopting a heterosexual identity (Birk, 1974; Larson, 1970). Some of these individuals reported heterosexual experience prior to treatment. People whose sexual attractions were initially limited to people of the same sex report much lower increases (if any) in other-sex attractions compared to those who report initial attractions to both men and women (Barlow et al., 1975). However, the low degree of scientific rigor in these studies makes any conclusion tentative.

Recent research indicates that former participants in SOCE report diverse evaluations of their experiences. Some individuals perceive that they have benefited from SOCE, while other individuals perceive that they have been harmed by SOCE (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002). Across studies, it is unclear what specific individual characteristics and diagnostic criteria would prospectively distinguish those individuals who will later perceive that they have succeeded and benefited from SOCE from those who will later perceive that they have failed or been harmed.

Some individuals who participated in the early research reported negative side effects such as loss of sexual arousal, impotence, depression, anxiety, and relationship dysfunction. Individuals who participated in recent research and who failed to change sexual orientation, while believing they should have changed with such efforts, described their experiences as a significant cause of emotional distress and negative self-image (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Overall, those in this recent research who indicated that they were harmed reported feelings of distress, anxiety, depression, suicidal ideation, self-blame, guilt, and loss of hope among other negative feelings. Some who experienced religious interventions and perceived them negatively said that they felt disillusioned with religion; others felt they had failed their religion by having same-sex attraction (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Indirect harm from the associated costs (time, effort, money, disillusionment with psychotherapy) spent in ineffective treatment is significant. Both the early and recent research provide little clarity on the associations between claims to modify sexual orientation from same-sex to other-sex and subsequent improvements or harm to mental health.

Other individuals reported that they perceived SOCE to be helpful by providing a place to discuss

their conflicts, reduce isolation, and receive support (Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Shidlo & Schroeder, 2002; Spitzer, 2003; Wolkomir, 2001, 2006). Some reported that SOCE helped them view their sexual orientation in a different light that permitted them to live in a manner consistent with their faith, which they perceived as positive (Nicolosi et al., 2000). Some individuals described finding a sense of support and community through SOCE and valued having others with whom they could identify (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001). These effects mirror those provided by mutual support groups for a range of problems. And the positive benefits reported by participants in SOCE, such as reduction of isolation, change of meaning, and stress reduction, are consistent with the findings of social support literature (Levine et al., 2004). Given the findings of limited efficacy of change of sexual orientation, it is unlikely that SOCE provides any unique benefits other than those documented for the social support mechanisms of mutual help groups. For those who had received psychotherapy, the positive perceptions of SOCE seem inconsistent with the documented effects of the supportive function of psychotherapy relationships (e.g., Norcross, 2002).

Literature on Children and Adolescents

The task force was asked to report on the following: (a) the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change; (b) the presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation; and (c) recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

We reviewed the limited research on child and adolescent issues and drew the following conclusions: There is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation. The few studies of children with gender identity disorder found no evidence that psychotherapy provided to those children had an impact on adult sexual orientation (R. Green, 1986,

1987; Zucker, 2008; Zucker & Bradley, 1995). There is currently no evidence that teaching or reinforcing stereotyped gender-normative behavior in childhood or adolescence can alter sexual orientation (Mathy & Drescher, 2008). We are concerned that such interventions may increase the self-stigma, minority stress, and ultimately the distress of children and adolescents. We have serious concerns that the coercive or involuntary treatment of children or adolescents has the potential to be harmful and may potentially violate current clinical and practice guidelines, standards for ethical practice, and human rights.

Recommendations and Future Directions

Affirmative Psychotherapy With Adults

The appropriate application of affirmative therapeutic interventions with adults is built on three key findings in the research: (a) an enduring change to an individual's sexual orientation as a result of SOCE was unlikely, and some participants were harmed by the interventions; (b) for some individuals, sexual orientation identity, not sexual orientation, shifted and evolved via psychotherapy, support groups, or life events; and (c) clients benefit from psychotherapeutic approaches that emphasize acceptance, support, and recognition of important values and concerns.

On the basis of these findings and the clinical literature on this population, we suggest client-centered, multiculturally competent approaches grounded in the following scientific facts: (a) same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they are not indicators of mental or developmental disorders; (b) same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientations and sexual orientation identities; (c) gay men, lesbians, and bisexual individuals can live satisfying lives and form stable, committed relationships and families that are equivalent to those of heterosexual individuals in essential respects; and (d) no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma.

Based on these findings summarized above and our comprehensive review of the research and clinical literature, we developed a framework for the appropriate application of affirmative therapeutic

interventions for adults that has the following central elements:

- Acceptance and support
- A comprehensive assessment
- Active coping
- Social support
- Identity exploration and development

Acceptance and support include (a) unconditional positive regard for and empathy with the client, (b) openness to the client's perspective as a means of understanding his or her concerns, and (c) encouragement of the client's positive self-concept.

A comprehensive assessment considers sexual orientation uniquely individual and inseparable from an individual's personality and sense of self. This includes (a) being aware of the client's unique personal, social, and historical context and (b) exploring and countering the harmful impact of stigma and stereotypes on the client's self-concept (including the prejudice related to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status).

Active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it and include both cognitive and emotional strategies. These may include cognitive strategies to reframe conflicts and emotional strategies to manage potential losses.

Psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) provide social support that can mitigate distress caused by isolation, rejection, and lack of role models. Conflicts among disparate elements of identity play a major role in the conflicts and mental health concerns of those seeking SOCE (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004).

Identity exploration is an active process of exploring and assessing one's identity and establishing a commitment to an integrated identity. LMHP facilitate this exploration by not having an a priori treatment goal for how clients identify or live out their sexual orientation. The process may include a developmental process that includes periods of crisis, mourning, reevaluation, identity deconstruction and reconstruction, and growth.

Treatments that are based on the assumption that homosexuality or same-sex sexual attractions are a mental disorder or based on inaccurate stereotypes regarding LGB people are to be avoided because they run counter to empirical data and because reports of harm suggest that such treatments can reinforce restricting stereotypes, increase internalized stigma, and limit a client's development (Beckstead & Morrow, 2004; Haldeman, 2001; Shidlo & Schroeder, 2002; G. Smith et al., 2004; see Lilienfeld, 2007, for information on psychotherapy harms).

Psychotherapy With Children and Adolescents

We were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or the behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change. Consistent with the current scientific evidence, those working with children and adolescents strive to have a developmentally appropriate perspective that includes a client-centered multicultural perspective to reduce self-stigma and mitigate minority stress. This includes interventions that (a) reduce stigma and isolation, (b) support the exploration and development of identity, (c) facilitate achievement of developmental milestones, and (d) respect age-appropriate issues regarding self-determination. Such services are ideally provided in the least restrictive setting and with, at a minimum, the assent of the youth. However, LMHP are encouraged to acquire developmentally appropriate informed consent to treatment.

Affirmative approaches encourage families to reduce rejection and increase acceptance of their child and adolescent (Perrin, 2002; Ryan et al., 2009). Parents who are concerned or distressed by their children's sexual orientation can be provided accurate information about sexual orientation and sexual orientation identity and offered anticipatory guidance and psychotherapy that supports family reconciliation (e.g., communication, understanding, and empathy) and maintenance of their child's total health and well-being. Interventions that increase family, school, and community acceptance and safety of sexual minority children and youth appear particularly helpful. Such interventions are offered in ways that are consistent with aspects of diversity such as age, gender, gender identity, race, ethnicity, culture,

national origin, religion, sexual orientation, disability, language, and socioeconomic status.

Special Concerns of Religious Individuals and Families

Many religious sexual minorities experience significant psychological distress and conflict due to the divergence between their sexual orientation and religious beliefs. To support clients who have these concerns, LMHP can provide psychological acceptance, support, and recognition of the importance of faith to individuals and communities while recognizing the science of sexual orientation. LMHP working with religious individuals and families can incorporate research from

The goal of treatment is for the client to explore possible life paths that address the reality of his or her sexual orientation while considering the possibilities for a religiously and spiritually meaningful and rewarding life.

the psychology of religion into the client-centered multicultural framework summarized previously. The goal of treatment is for the client

to explore possible life paths that address the reality of his or her sexual orientation while considering the possibilities for a religiously and spiritually meaningful and rewarding life. Such psychotherapy can enhance clients' search for meaning, significance, and a relationship with the sacred in their lives (e.g., Pargament & Maloney, 2005). Such an approach would focus on increasing positive religious coping, understanding religious motivations, integrating religious and sexual orientation identities, and reframing sexual orientation identities to reduce or eliminate self-stigma.

Ethical Considerations

LMHP strive to provide interventions that benefit clients and avoid harm, consistent with current professional ethics. Psychologists aspire to provide treatment that is consistent with the APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002b) and relevant APA guidelines and resolutions (e.g., APA, 2000, 2002c, 2004, 2005a, 2007b) with a special focus on ethical principles such as Beneficence and Nonmaleficence; Justice; and Respect for People's Rights and Dignity (including self-determination). LMHP reduce potential harms and increase potential benefits by basing their professional judgments

and actions on the most current and valid scientific evidence, such as that provided in this report (see APA, 2002b, Standard 2.04, Bases for Scientific and Professional Judgments).

LMHP enhance principles of social justice when they strive to understand and mitigate the effects of sexual stigma, prejudice, and discrimination on the lives of individuals, families, and communities. Further, LMHP aspire to respect diversity in all aspects of their work, including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, and socioeconomic status.

Self-determination is the process by which a person controls or determines the course of her or his own life (*Oxford American Dictionary*, 2007). LMHP maximize self-determination by (a) providing effective psychotherapy that explores the client's assumptions and goals, without preconditions on the outcome; (b) providing resources to manage and reduce distress; and (c) permitting the client herself or himself to decide the ultimate goal of how to self-identify and live out her or his sexual orientation. We were not persuaded by some accounts that suggest that providing SOCE increases self-determination, because these suggestions encourage LMHP to offer treatment that (a) has not

... therapy that increases the client's ability to cope, understand, acknowledge, and integrate sexual orientation concerns into a self-chosen life is the measured approach.

provided evidence of efficacy; (b) has the potential to be harmful; and (c) delegates important professional decisions that should be based on qualified expertise and training—such as diagnosis and the type of intervention. Rather, therapy that increases the client's ability to cope, understand, acknowledge, and integrate sexual orientation concerns into a self-chosen life is the measured approach.

Education, Training, and Research

We were asked to provide recommendations for education, training, and research as they pertain to such affirmative interventions. We examine these areas separately.

EDUCATION AND TRAINING

Professional education and training

Training of LMHP to provide affirmative, evidence-based, and multicultural interventions with individuals

distressed by their same-sex sexual attractions is critical. Research on LMHP behaviors indicates a range of interventions, some of which are based on attitudes and beliefs rather than evidence, especially as some LMHP may have been educated during the period when homosexuality was pathologized (cf. Bartlett et al., 2001; Beutler, 2000; M. King et al., 2004; Liszcz & Yarhouse, 2005). We recommend that LMHP increase their awareness of their own assumptions and attitudes toward sexual minorities (APA, 2000; R. L. Worthington et al., 2005). This occurs by increasing knowledge about the diversity of sexual minorities (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status), as well as the management of the LMHP's own biases in order to avoid colluding with clients' internalized stigma and with the negating environments in which clients and LMHP live (APA, 2000; Dillon et al., 2004; Israel & Hackett, 2004; R. L. Worthington et al., 2005). We recommend that training in affirmative, evidence-based, and multiculturally informed interventions for sexual minorities be offered at all graduate schools and postgraduate training programs.

An important resource for LMHP is the APA (2000) *Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients*,⁷⁰ which advises LMHP to be competent in a variety of domains, including knowledge of the impact of stigma on mental health, the unique issues facing same-sex relationships and families, and the range of diversity concerns for sexual minority individuals. We recommend that several areas in which LMHP working with clients seeking SOCE obtain additional knowledge and skills include: (a) sexuality, sexual orientation, and sexual identity development; (b) the psychology of religion and spirituality, including models of faith development, religious coping, and the positive psychology of religion; (c) identity development models, including those that integrate multiple identities and facilitate identity conflict resolution; and (d) adaptive ways to manage stigma, minority stress, and multiple aspects of identity. We also recommend that practitioners review publications that explicate the above-mentioned topics and evidence-based, LGB-affirmative, and multicultural approaches to psychological interventions (APA, 2000, 2002a, 2002c, 2004, 2005b, 2006, 2007b, 2008a; Bartoli & Gillem, 2008; Brown, 2006; Fowers & Davidov, 2006; Schneider et al., 2002).

⁷⁰ These guidelines are being revised, and a new version will be available in 2010.

Those less familiar with religious perspectives can broaden their views on religion and religious individuals and reduce their potential biases by seeking relevant information on religious faith and the psychology of religion (e.g., Ano & Vasconcelles, 2005; Exline, 2002; Emmons, 1999; Emmons & Paloutzian, 2003; Fowler, 2001; Goldstein, 2007; Pargament & Mahoney, 2005; Pargament et al., 1998, 2005). Training programs for practitioners can increase competencies in these areas by including comprehensive material on religion and spirituality (Bartoli, 2007; Hage, 2006; Hathaway et al., 2004; Yarhouse & Fisher, 2002; Yarhouse & VanOrman, 1999) and on ways to incorporate religious approaches into psychotherapy (see, e.g., Richards & Bergin, 2000, 2004; Sperry & Shafranske, 2004). Additionally, publications that illustrate affirmative integration and resolution of religious and sexual minority identity are helpful (Astramovich, 2003; Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Ritter & O'Neil, 1989, 1995).

Conservative religious practitioners can increase their compassionate and understanding responses to sexual minorities. Some focus on increasing compassionate responses toward sexual minorities by conservative religious students or individuals (Bassett et al., 2005; Benoit, 2005; Fischer & DeBord, 2007; McMinn, 2005; Yarhouse, Burkett, & Kreeft, 2001; Zahniser & Boyd, 2008; Zahniser & Cagle, 2007). One study found an evolution of positive attitudes toward sexual minorities among LMHP who hold conservative religious values (E. Adams, Longoria, Hitter, & Savage, 2009). These perspectives are based on established social psychology research, such as the contact hypothesis, where increasing personal contact with members of minority groups of equal status reduces bias, including attitudes toward sexual minorities (e.g., Herek & Capitanio, 1996; Herek & Glunt, 1993; Pew Forum on Religion and Public Life, 2003).

Finally, although this report has limited information regarding sexual minorities in other countries, the research review and practice recommendations may be helpful to professionals. We recommend dissemination of this report to international mental health organizations and LGBT advocacy groups.

We recommend the following steps be taken by the APA to educate LMHP and support training programs in providing education:

1. Disseminate this report to accredited doctoral programs, internships, and other postdoctoral

programs in psychology both in the United States and other countries to encourage the incorporation of this report and other relevant material on LGBT issues into graduate school training programs and internship sites.

2. Disseminate information to faculty in psychology departments in community colleges, colleges, and university programs as information and for use in curriculum development.
3. Maintain the currently high standards for APA approval of continuing professional education providers and programs.
4. Offer symposia and continuing professional education workshops at APA's annual convention that focus on treatment of individuals distressed by their same-sex sexual attractions, especially those who struggle to integrate religious and spiritual beliefs with sexual orientation identity.
5. Pursue the publication of a version of this report in an appropriate journal or other publication.

Public education

The information available to the public about SOCE and sexual orientation is highly variable and can be confusing. In those information sources that encourage SOCE, the portrayals of homosexuality and sexual minorities tend to be negative and at times to emphasize inaccurate and misleading stereotypes (Kennedy & Cianciotto, 2006; SPLC, 2005). Sexual minorities, individuals aware of same-sex sexual attractions, families, parents, caregivers, policymakers, religious leaders, and society at large can benefit from accurate scientific information about sexual orientation and about appropriate interventions for individuals distressed by their same-sex sexual attractions both in the United States and internationally. We recommend that APA:

1. Create informational materials for sexual minority individuals, families, parents, and other stakeholders on appropriate multiculturally competent and client-centered interventions for those distressed by their sexual orientation who may seek SOCE.
2. Create informational materials on sexual orientation, sexual orientation identity, and religion for all stakeholders, including the public and institutions of faith.
3. Create informational materials focused on the integration of ethnic, racial, national origin and

cultural issues, and sexual orientation and sexual orientation identity.

4. Integrate the conclusions of this report into existing APA public information resources, including print, media, and the Internet.
5. Collaborate with other relevant organizations, especially religious organizations, to disseminate this information.

RESEARCH

Our systematic review of research has highlighted the methodological problems pervasive in recent research on SOCE. This raises two issues: (a) the publication of poorly designed research and (b) whether more research on SOCE should be conducted to pursue questions of benefit, harm, and safety. These two issues are addressed separately.

Much of the recent research on SOCE has had serious methodological problems. Although this research area presents serious challenges (e.g., obtaining a representative sample, finding appropriate measures, and using evidence-based constructs), many of the problems were avoidable. Problems included (a) inappropriate use of statistical tests, (b) poor measurement, and (c) designs that did not permit valid causal conclusions to be drawn.

Hunt and Carlson (2007) have argued that studies with immediate social relevance that have an impact on social policy or social issues should be held to a higher standard because this literature has the potential to influence policymakers and the public, and incomplete or misleading information has serious costs. Research published on SOCE needs to meet current best-practice research standards. Many of the problems in published SOCE research indicate the need for improvement in the journal review process. It is recommended that professional and scientific journals retain reviewers and editors with expertise in this area to maintain the standards of published research.

We concluded that research on SOCE (psychotherapy, mutual self-help groups, religious techniques) has not answered basic questions of whether it is safe or effective and for whom. Any future research should conform to best-practice standards for the design of efficacy research. Additionally, research into harm and safety is essential. Certain key issues are worth highlighting. Future research must use methods that are prospective and longitudinal, allow for conclusions about

cause and effect to be confidently drawn, and employ sampling methods that allow proper generalization.⁷¹

Future research should also include appropriate measures in terms of specificity of measurement of sexual orientation, sexual orientation identity and outcomes, and psychometric adequacy. Mixed-method research, in which methods and measures with offsetting weaknesses are simultaneously employed, may be especially advantageous. Alternative physiological means of measuring sexual orientation objectively may also be helpful. Recent research has used alternatives to genital gauges for the assessment of sexual orientation in men and women, such as functional magnetic resonance imaging (Ponseti et al., 2006). Physiological measures often use visual portrayals of nude individuals that some religious individuals may find morally unacceptable. Jlang, Costello, Fang, Huang, and He (2006) have explored the use of invisible images and have measured selective inattention/attention as an alternative to assess sexual arousal. Such methods or the development of methods that are less intrusive and are more consistent with religious values would be helpful to develop for this population.

Additionally, preexisting and co-occurring conditions, mental health problems, participants' need for monitoring self-impression, other interventions, and life histories would have to be given appropriate consideration so that research can better account for and test competing explanations for any changes observed in study participants over time. Specific conceptual and methodological challenges exist in research related to sexual minority populations, such as the conceptualization of sexual orientation and sexual orientation identity and obtaining representative samples. Researchers would be advised to consider and compensate for the unique conceptual and

⁷¹ A published study that appeared in the grey literature in 2007 (S. L. Jones & Yarhouse, 2007) has been described by SOCE advocates and its authors as having successfully addressed many of the methodological problems that affect other recent studies, specifically the lack of prospective research. The study is a convenience sample of self-referred populations from religious self-help groups. The authors claim to have found a positive effect for some study respondents in different goals such as decreasing same-sex sexual attractions, increasing other-sex attractions, and maintaining celibacy. However, upon close examination, the methodological problems described in Chapter 3 (our critique of recent studies) are characteristic of this work, most notably the absence of a control or comparison group and the threats to internal, external, construct, and statistical validity. Best-practice analytical techniques were not performed in the study, and there are significant deficiencies in the analysis of longitudinal data, use of statistical measures, and choice of assessment measures. The authors' claim of finding change in sexual orientation is unpersuasive due to their study's methodological problems.

methodological challenges in this area (Meyer & Wilson, 2009; Moradi, Mohr, Worthington, Fassinger, 2009).

Safety issues continue to be important areas of study. As noted previously, early research indicates that aversive techniques have been found to have very limited benefits as well as potentially harmful effects. These documented harms were serious. An additional finding is that these treatments had extremely high dropout rates, which has been linked to adverse effects. Some individuals report harm from recent nonaversive techniques, and some individuals report benefits.

Some authors have stated that SOCE should not be investigated or practiced until safety issues have been resolved (Davison, 1976, 1991; Herek, 2003), as it is still unclear which techniques or methods may or may not be harmful. Assessing the safety of recent practices is a high priority given that this research is the least rigorous. Given that types of harm can be multiple, outcome studies with measures capable of assessing deterioration in mental health, appearance of new symptoms, heightened concern regarding existing symptoms, excessive dependency on the LMHP, and reluctance to seek out new treatment are important to include in future research (Lilienfeld, 2007). Other areas to assess are types of harm to others (e.g., some individuals have noted that advocating other-sex marriage or promising sexual orientation change may negatively affect spouses, potential spouses, and children) (Buxton, 1994, 2007; Wolkomir, 2006).

Finally, LMHP must be mindful of the indirect harms of SOCE, such as the “opportunity costs” (Lilienfeld, 2007) and the time, energy, effort, and expense of interventions that offer limited benefit and have the potential to cause disillusionment in psychotherapy. However, as concerns regarding harm have been raised, addressing risks to research participants and concerns regarding voluntary participation (see Standard 8.02 in APA, 2002b) must be carefully considered in any future research.

Research that meets these scientific standards and addresses efficacy and safety might help to clarify the issues. Even so, scientific research may not help to resolve the issues unless it can better account for the complexity of the concerns of the current population. The results of current research are complicated by the belief system of many of the participants whose religious faith and beliefs may be intricately tied to the possibility of change. Future research will have to better account for the motivations and beliefs of participants in SOCE.

Emerging research reveals that affirmative interventions show promise for alleviating the distress

of children, adolescents, and families around sexual orientation and identity concerns (D’Augelli, 2002, 2003; Goodenow et al., 2006; Perrin, 2002; C. Ryan et al., 2009). However, sexual minority adolescents are underrepresented in research on evidence-based approaches, and sexual orientation issues in children are virtually unexamined (APA, 2008d). Specific research on sexual minority adolescents and children has identified that stigma can be reduced through community interventions, supportive client-centered approaches, and family reconciliation techniques that focus on strengthening the emotional ties of family members to each other, reducing rejection, and increasing acceptance (D’Augelli, 2003; Goodenow et al., 2006; C. Ryan et al., 2009). This line of research should be continued and expanded to include conservatively religious youth and their families.

Finally, we presented a framework for therapy with this population. Although this model is based on accepted principles of psychotherapy and is consistent with evidence-based approaches to psychotherapy, it has not been evaluated for safety and efficacy. Such studies would have to be conducted in the same manner as research on SOCE and in ways that are consistent with current standards (see, e.g., Flay et al., 2005).

Recommendations for basic research

To advance knowledge in the field and improve the lives of individuals distressed by same-sex sexual attractions who seek SOCE, it is recommended that researchers, research-funding organizations, and other stakeholders, including those who establish funding priorities, work together to improve our knowledge of sexuality, sexual orientation, and sexual orientation identity in the following areas:

1. The nature and development of sexuality, sexual orientation, sexual orientation identity across the life span and the correlates to these variables, incorporating differences across age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status.
2. Religious identity and faith development (inclusive of all world religions) and their intersection with other aspects of human life and identity, such as sexual orientation, sexual orientation identity, and the multiple social identity statuses related to privilege and stigma.

3. Identity integration, reduction in distress, and positive mental health for populations of religious sexual minorities and ethnic minority populations.
4. Culture, gender, religion, and race/ethnicity in the experience and construction of sexual orientation and sexual orientation identity.
5. Mental health outcomes of those who choose not to act on their sexual orientation by living celibately or in relationships with other-sex partners.

Recommendations for research in psychotherapy

We recommend that researchers and practitioners rigorously investigate multiculturally competent and affirmative evidence-based treatments for sexual minorities and those distressed by their sexual orientation that do not aim to alter sexual orientation but rather focus on sexual orientation identity exploration, development, and integration without prioritizing one outcome over another, for the following populations:

1. Sexual minorities who have traditional religious beliefs
2. Sexual minorities who are members of ethnic minority and culturally diverse communities both in the United States and internationally
3. Children and adolescents who are sexual minorities or questioning their sexual orientation
4. Parents who are distressed by their children's perceived future sexual orientation
5. Populations with any combination of the above demographics

Policy

We were asked to make recommendations to APA to inform the association's response to groups that promote treatments to change sexual orientation or its behavioral expression and to support public policy that furthers affirmative therapeutic interventions.

The debate surrounding SOCE has become mired in ideological disputes and competing political agendas (Drescher, 2003; Drescher & Zucker, 2006). Some organizations opposing civil rights for LGBT individuals advocate SOCE (SPLC, 2005). Other policy concerns involve religious or socially conservative agendas where issues of religious morality conflict with scientific-based conceptions of positive and healthy

development. We encourage APA to continue its advocacy for lesbian, gay, bisexual, and transgender individuals and families and to oppose prejudice against sexual minorities (APA, 2003, 2005, 2006, 2008b). We encourage collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles. These collaborative relationships can be designed to integrate humanitarian perspectives and professional expertise (Tyler, Pargament, & Gatz, 1983).

Thus, the task force urges APA to:

1. Actively oppose the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion and take a leadership role in responding to such distortions.
2. Support the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based on lack of scientific knowledge about sexual orientation.
3. Encourage advocacy groups, elected officials, policymakers, religious leaders, and other organizations to seek accurate information and avoid promulgating inaccurate information about sexual minorities.
4. Seek areas where collaboration with religious leaders, institutions, and organizations can promote the well-being of sexual minorities through the use of accurate scientific data regarding sexual orientation and sexual orientation identity.
5. Encourage the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns to prioritize initiatives that address religious and spiritual concerns and the concerns of sexual minorities from conservative faiths.
6. Adopt a new resolution: the Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts (see Appendix A).⁷²

⁷² The resolution was adopted by the APA Council of Representatives in August 2009.

REFERENCES

- Ackerman, S., & Hilsenroth, M. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*, 1-33.
- Adams, E., Longoria, V., Hitter, T. L., & Savage, T. A. (2009, January). *Experiences of religiously conservative therapists who are gay-affirmative*. Poster session presented at the National Multicultural Summit, New Orleans, LA.
- Adams, G. R., & Marshall, S. K. (1996). A developmental social psychology of identity: Understanding the person-in-context. *Journal of Adolescence, 19*, 429-442.
- Adams, H. E., & Sturgis, E. T. (1977). Status of behavioral reorientation techniques in the modification of homosexuality: A review. *Psychological Bulletin, 84*, 1171-1188.
- Alessi, E. J. (2008). Staying put in the closet: Examining clinical practice and counter transference issues in work with gay men married to heterosexual women. *Clinical Social Work Journal, 36*, 195-201.
- Allen, D. J. (2001). The role of personality and defense mechanisms in the adjustment to a homosexual identity. *Journal of Homosexuality, 42*, 45-62.
- American Academy of Child & Adolescent Psychiatry. (1989). Inpatient treatment of children and adolescents [Policy statement]. *American Academy of Child and Adolescent Psychiatry*. Retrieved from www.aacap.org/cs/root/policy_statements/inpatient_hospital_treatment_of_children_and_adolescents
- American Academy of Pediatrics. (1999). *Caring for your school age child: Ages 5-12* (E. I. Schor, Ed.). New York: Bantam.
- American Counseling Association Governing Council. (1998). *Affirmative resolution on lesbian, gay, and bisexual people*. Alexandria, VA: Author.
- American Educational Research Association (AERA), American Psychological Association and National Council on Measurement in Education (NCME). (1999). *The standards for educational and psychological testing*. Washington, DC: Author.
- American Psychiatric Association. (1952). *Mental disorders: Diagnostic and statistical manual* (1st ed.). Washington, DC: Author.
- American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.
- American Psychiatric Association. (1973). *Homosexuality and civil rights: Position statement*. Retrieved January 5, 2008, from www.psych.org/edu/other_res/lib_archives/archives/197310.pdf.
- American Psychiatric Association. (2000). *Therapies focused on attempts to change sexual orientation (reparative or conversion therapies)*. Retrieved July 5, 2008, from www.psych.org/Departments/EDU/Library/APAOfficial-DocumentsandRelated/PositionStatements/200001.aspx
- American Psychoanalytic Association. (1991). *Position statement: Homosexuality*. Retrieved July 7, 2008, from www.apsa.org/ABOUTAPSAA/POSITION-STATEMENTS/HOMOSEXUALITY/tabid/473/Default.aspx
- American Psychoanalytic Association. (1992). *Position statement: Homosexuality* (Rev.). Retrieved July 7, 2008, from www.apsa.org/ABOUTAPSAA/POSITIONSTATEMENTS/HOMOSEXUALITY/tabid/473/Default.aspx
- American Psychoanalytic Association. (2000). *Position statement on reparative therapy*. Retrieved November 30, 2007, from www.apsa.org/ABOUTAPSAA/POSITIONSTATEMENTS/REPARATIVETHERAPY/tabid/472/Default.aspx

- American Psychological Association. (1975). Resolution on discrimination against homosexuals. *American Psychologists*, 30, 633.
- American Psychological Association. (1992). *Ethical principles of psychologists and code of conduct*. Washington, DC: Author.
- American Psychological Association. (1993). Resolution on lesbian, gay, and bisexual youths in the schools. *American Psychologist*, 48, 782-783.
- American Psychological Association. (1998). Resolution on appropriate therapeutic responses to sexual orientation. *American Psychologist*, 43, 934-935.
- American Psychological Association. (2000). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist*, 55, 1440-1451.
- American Psychological Association. (2002a). *Developing adolescents: A reference guide for professionals*. Retrieved from www.apa.org/pi/pii/develop.pdf
- American Psychological Association. (2002b). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073. Retrieved from www.apa.org/ethics/code2002.html
- American Psychological Association. (2002c). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists*. Retrieved January 5, 2008, from www.apa.org/pi/multiculturalguidelines/formats.html
- American Psychological Association. (2003). *Lawrence v. Texas: Brief for amicus curiae, Supreme Court of the United States*. Washington, DC. Retrieved February 25, 2008, from <http://www.apa.org/pi/lgbcpolicy/amicusbriefs.html#lawrence>
- American Psychological Association. (2004). Guidelines for psychological practice with older adults. *American Psychologist*, 59, 236-260.
- American Psychological Association. (2005a). *Policy statements on lesbian, gay, and bisexual concerns*. Retrieved July 4, 2008, from www.apa.org/pi/lgbcpolicy/pshome.html
- American Psychological Association. (2005b). *Report of the 2005 Presidential Task Force on Evidence-Based Practice*. Retrieved January 4, 2008, from www.apa.org/practice/ebpreport.pdf
- American Psychological Association. (2005c). Resolution on sexual orientation and marriage and resolution on sexual orientation, parents, and children. *American Psychologist*, 60, 494-496.
- American Psychological Association. (2006a). Policy statement on evidence-based practice in psychology. *American Psychologist*, 61, 475-476
- American Psychological Association. (2006b). Resolution on prejudice, stereotypes, and discrimination. *American Psychologist*, 62, 475-481.
- American Psychological Association. (2007a, March 1). *APA adopts policy statement opposing the teaching of intelligent design as scientific theory* [Press release]. Retrieved from www.apa.org/releases/design.html
- American Psychological Association. (2007b). Guidelines for psychological practice with girls and women. *American Psychologist*, 62, 949-979.
- American Psychological Association. (2008a). Resolution rejecting intelligent design as scientific and reaffirming support for evolutionary theory. *American Psychologist*, 63, 426-427.
- American Psychological Association. (2008b). Resolution on opposing discriminatory legislation and initiatives aimed at lesbian, gay, and bisexual persons. *American Psychologist*, 63, 428-430.
- American Psychological Association. (2008c). Resolution on religious, religion-related, and/or religion-derived prejudice. *American Psychologist*, 63, 431-434.
- American Psychological Association. (2008d). Resolution rejecting intelligent design as scientific and reaffirming support for evolutionary theory. *American Psychologist*, 63, 426-427.
- American Psychological Association. (2008e). *Disseminating evidence-based practice for children & adolescents: A systems approach to enhancing care*. Retrieved February 17, 2009, from <http://www.apa.org/pi/cyf/evidence.html>
- American Psychological Association. (2009). *Report of the APA Task Force on Gender Identity and Gender Variance*. Retrieved February 17, 2009, from www.apa.org/pi/lgbcp/transgender/2008TaskForceReport.pdf
- Ano, G. G., & Vasconcelles, E. B. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology*, 61, 461-480.
- Antze, P. (1976). The role of ideologies in peer psychotherapy organizations: Some theoretical considerations of three case studies. *Journal of Applied Behavioral Science*, 12, 323-346.
- Armon, V. (1960). Some personality variables in overt female homosexuality. *Journal of Projective Techniques*, 24, 293-309.
- Aronson, E., & Mills, J. (1959). The effect of severity of liking for a group. *Journal of Abnormal and Social Psychology*, 59, 177-181.
- Arriola, E. R. (1998). The penalties for puppy love: Institutionalized violence against lesbian, gay, bisexual, and transgender youth. *Journal of Gender, Race, and Justice*, 429, 1-43.
- Astramovich, R. L. (2003). Facilitating spiritual wellness with gays, lesbians, and bisexuals: Composing a spiritual autobiography. In J. S. Whitman & C. J. Boyd (Eds.), *The therapist's notebook for lesbian, gay, and bisexual clients: Homework, handouts and activities for use in psychotherapy* (pp. 210-214). Binghamton, NY: Haworth Clinical Press.
- Auerback, S., & Moser, C. (1987). Groups for the wives of gay and bisexual men. *Social Work*, 32, 321-325.

- Avishai, O. (2008). Doing religion in a secular world: Women in conservative religions and the question of agency. *Gender & Society, 22*, 409-433.
- Bailey, J. M., & Zucker, K. J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology, 31*, 43-55.
- Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: A comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology, 54*, 306-319.
- Bancroft, J. (1969). Aversion therapy of homosexuality: A pilot study of 10 cases. *British Journal of Psychiatry, 115*, 1417-1431.
- Bancroft, J. (2003). Can sexual orientation change? A long-running saga. *Archives of Sexual Behavior, 32*, 419-468.
- Barlow, D., & Agras, W. (1973). Fading to increase heterosexual responsiveness in homosexuals. *Journal of Applied Behavior Analysis, 6*, 355-366.
- Barlow, D. H., Agras, W. S., Abel, G. G., Blanchard, E. B., & Young, L. D. (1975). Biofeedback and reinforcement to increase heterosexual arousal in homosexuals. *Behaviour Research & Therapy, 13*, 45-50.
- Bartlett, A., King, M., & Phillips, P. (2001). Straight talking: An investigation of the attitudes and practice of psychoanalysts and psychotherapists in relation to gays and lesbians. *British Journal of Psychiatry, 179*, 545-549.
- Bartoli, E. (2007). Religious and spiritual issues in psychotherapy practice: Training the trainer. *Psychotherapy: Theory, Research, Practice, Training, 44*, 54-65.
- Bartoli, E., & Gillem, A. R. (2008). Continuing to depolarize the debate on sexual orientation and religious identity and the therapeutic process. *Professional Psychology: Research and Practice, 39*, 202-209.
- Bassett, R. L., Van Niekelen-Kuyper, M., Johnson, D., Miller, A., Carter, A., & Grimm, J. P. (2005). Being a good neighbor: Can students come to value homosexual persons? *Journal of Psychology and Theology, 33*, 17-26.
- Batson, C. D., Flink, C. H., Schoenrade, P. A., Fultz, J., & Pych, V. (1986). Religious orientation and overt and covert racial prejudice. *Journal of Personality and Social Psychology, 50*, 175-181.
- Batson, C. D., Naifeh, S. J., & Pate, S. (1978). Social desirability, religiosity, and prejudice. *Journal for the Scientific Study of Religion, 50*, 31-41.
- Baumeister, R. F., & Exline, J. J. (2000). Self-control, morality, and human strength. *Journal of Social and Clinical Psychology, 19*, 29-43.
- Baumeister, R. F., & Muraven, M. (1996). Identity as adaptation to social, cultural, and historical context. *Journal of Adolescence, 19*, 405-416.
- Baumeister, R. F., & Vohs, K. D. (2002). The pursuit of meaningfulness in life. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 608-618). New York: Oxford University Press.
- Bayer, R. (1981). *Homosexuality and American psychiatry: The politics of diagnosis*. New York: Basic Books.
- Beauchamp, T. L., & Childress, J. (2008). *Principles of biomedical ethics* (6th ed.). New York: Oxford University Press.
- Beauvois, J. L. O., & Joule, R. V. (1996). *A radical dissonance theory*. Philadelphia: Taylor & Francis.
- Beckstead, A. L. (2003). Understanding the self-reports of reparative therapy "successes." *Archives of Sexual Behavior, 32*, 421-423.
- Beckstead, A. L., & Morrow, S. L. (2004). Mormon clients' experiences of conversion therapy: The need for a new treatment approach. *The Counseling Psychologist, 32*, 651-690.
- Beckstead, L., & Israel, T. (2007). Affirmative counseling and psychotherapy focused on issues related to sexual orientation conflicts. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 221-244). Washington, DC: American Psychological Association.
- Bell, A. P., & Weinberg, M. S. (1978). *Homosexuality: A study of diversity among men and women*. New York: Simon & Schuster.
- Bell, A. P., Weinberg, M., & Hammersmith, S. K. (1981). *Sexual preference: Its development in men and women*. Bloomington: Indiana University Press.
- Bem, D. (1996). Exotic becomes erotic: A developmental theory of sexual orientation. *Psychological Review, 103*, 320-355.
- Ben-Ari, A. (1995). The discovery that an offspring is gay: Parents', gay men's, and lesbians' perspectives. *Journal of Homosexuality, 30*, 89-112.
- Bene, E. (1965). On the genesis of male homosexuality: An attempt at classifying the role of the parents. *British Journal of Psychiatry, 3*, 803.
- Benoit, M. (2005). Conflict between religious commitment and same-sex attraction: Possibilities for a virtuous response. *Ethics & Behavior, 15*, 309-325.
- Bernstein, B. E. (1990). Attitudes and issues of parents of gay men and lesbians and implications for therapy. *Journal of Gay & Lesbian Psychotherapy, 1*, 37-53.
- Beutler, L. E. (2000). David and Goliath: When empirical and clinical standards of practice meet. *American Psychologist, 55*, 997-1007.
- Biaggio, M., Coan, S., & Adams, W. (2002). Couples therapy for lesbians: Understanding merger and the impact of homophobia. *Journal of Lesbian Studies, 6*, 129-138.
- Bieber, I., Dain, H. J., Dince, P. R., Drellich, M. G., Grand, H. G., Gundlach, R. H., et al. (1962). *Homosexuality: A psychoanalytic study*. New York: Basic Books.
- Bieschke, K. J. (2008). We've come a long way, baby. *The Counseling Psychologist, 36*, 631-638.

- Bieschke, K. J., Perez, R. M., & DeBord, K. A. (Eds.). (2007). *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed.). Washington, DC: American Psychological Association.
- Binder, C. V. (1977). Affection training: An alternative to sexual reorientation. *Journal of Homosexuality*, 2, 251-259.
- Bing, V. M. (2004). Out of the closet but still in hiding: Conflicts and identity issues for a Black-White biracial lesbian. *Women and Therapy*, 27, 185-201.
- Birk, L. (1974). Group psychotherapy for men who are homosexual. *Journal of Sex & Marital Therapy*, 1, 29-52.
- Birk, L., Huddleston, W., Miller, E., & Cohler, B. (1971). Avoidance conditioning for homosexuality. *Archives of General Psychiatry*, 25, 314-323.
- Blanchard, R. (2008). Review and theory of handedness, birth order, and homosexuality in men. *Laterality: Asymmetries of Body, Brain and Cognition*, 13, 51-70.
- Blechner, M. J. (2008). Selective inattention and bigotry: A discussion of the film *Trembling Before G-d*. *Journal of Gay and Lesbian Mental Health*, 12, 195-204.
- Blitch, J. W., & Haynes, S. N. (1972). Multiple behavioral techniques in a case of female homosexuality. *Journal of Behavior Therapy & Experimental Psychiatry*, 3, 319-322.
- Blumenfeld, W. J. (Ed.). (1992). *How we all pay the price* [Introduction.]. New York: Beacon Press.
- Borowich, A. (2008). Failed reparative therapy of Orthodox Jewish homosexuals. *Journal of Gay and Lesbian Mental Health*, 12, 167-177.
- Boykin, K. (1996). *One more river to cross: Black and gay in America*. New York: Anchor.
- Bozett, F. W. (1982). Heterogeneous couples in heterosexual marriages: Gay men and straight women. *Journal of Marital & Family Therapy*, 8, 81-89.
- Bradley, S., & Zucker, K. (1998). Drs. Bradley and Zucker reply. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 244-245.
- Brandchaft, B. (2007). Systems of pathological accommodation and change in analysis. *Psychoanalytic Psychology* 24, 667-687.
- Bridges, K. L., & Croteau, J. M. (1994). Once-married lesbians: Facilitating life patterns. *Journal of Counseling & Development*, 73, 134-140.
- Bright, C. (2004). Deconstructing reparative therapy: An examination of the processes involved when attempting to change sexual orientation. *Clinical Social Work Journal*, 32, 471-481.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard.
- Brooke, H. L. (2005). "Gays, ex-gays, ex-ex-gays: Examining key religious, ethical, and diversity Issues": A follow-up interview with Douglas Haldeman, Ariel Shidlo, Warren Throckmorton, and Mark Yarhouse. *Journal of Psychology and Christianity*, 24, 343-351.
- Brown, L. S. (1996). Ethical concerns with sexual minority patients. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 887-916). Washington, DC: American Psychiatric Press.
- Brown, L. S. (2006). The neglect of lesbian, gay, bisexual and transgendered clients. In J. Norcross, L. Beutler, & R. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on fundamental questions* (pp. 346-352). Washington, DC: American Psychological Association.
- Brownfain, J. J. (1985). A study of the married bisexual male: Paradox and resolution. *Journal of Homosexuality*, 11(1/2), 173-188.
- Browning, C., Reynolds, A. L., & Dworkin, S. H. (1991). Affirmative psychotherapy for lesbian women. *The Counseling Psychologist*, 19, 177-196.
- Brzezinski, L. G. (2000). *Dealing with disparity: Identity development of same-sex attracted/gay men raised in the Church of Jesus Christ of Latter-Day Saints*. Unpublished doctoral dissertation, University of Utah, Salt Lake City.
- Buchanan, M., Dzelme, K., Harris, D., & Hecker, L. (2001). Challenges of being simultaneously gay or lesbian and spiritual and/or religious: A narrative perspective. *The American Journal of Family Therapy*, 29, 435-449.
- Bullough, V. L. (1976). *Sexual variance in society and history*. Chicago: University of Chicago Press.
- Burack, C., & Josephson, J. J. (2005). *A report from "Love Won Out: Addressing, Understanding, and Preventing Homosexuality."* New York: National Gay and Lesbian Task Force Policy Institute. Retrieved from www.thetaskforce.org/downloads/reports/reports/LoveWonOut.pdf
- Butler, J. (2004). *Undoing gender*. New York: Routledge.
- Buxton, A. P. (1994). *The other side of the closet: The coming-out crisis for straight spouses and families*. New York: Wiley.
- Buxton, A. P. (2001). Writing our own script: How bisexual men and their heterosexual wives maintain their marriages after disclosure. *Journal of Bisexuality*, 1(2-3), 155-189.
- Buxton, A. P. (2004). Works in progress: How mixed-orientation couples maintain their marriages after their wives come out. *Journal of Bisexuality*, 1/2, 57-82.
- Buxton, A. P. (2007). Counseling heterosexual spouses of bisexual or transgender partners. In B. Firestein (Ed.), *Becoming visible: counseling bisexuals across the lifespan* (pp. 395-416). New York: Columbia University Press.
- Byrd, A. D., & Nicolosi, J. (2002). A meta-analytic review of treatment of homosexuality. *Psychological Reports*, 90, 139-152.
- Byrd, A. D., Nicolosi, J., & Potts, R. W. (2008). Clients' perceptions of how reorientation therapy and self-help can promote changes in sexual orientation. *Psychological Reports*, 102, 3-28.
- Callahan, E. J., & Leitenberg, H. (1973). Aversion therapy for sexual deviation: Contingent shock and covert sensitization. *Journal of Abnormal Psychology*, 81, 60-73.

- Campos, P. E., & Goldfried, M. E. (2001). Introduction: Perspectives on gay, lesbian, and bisexual clients. *Journal of Clinical Psychology, 57*, 609-613.
- Carlsson, G. (2007). Counseling the bisexual married man. In B.A. Firestein (Ed.), *Becoming visible: Counseling bisexuals across the lifespan* (pp. 108-126). New York: Columbia University Press.
- Carrillo, H. (2002). *The night is young: Sexuality in Mexico in the time of AIDS*. Chicago: University of Chicago Press.
- Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist, 35*, 13-105.
- Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4*, 219-235.
- Cass, V. C. (1983/1984). Homosexual identity: A concept in need of definition. *Journal of Homosexuality, 9*(2-3), 105-126.
- Castonguay, L. G., Proulx, J., Aubut, J., McKibben, A., & Campbell, M. (1993). Sexual preference assessment of sexual aggressors: Predictors of penile response magnitude. *Archives of Sexual Behavior, 22*, 325-334.
- Cates, J. A. (2007). Identity in crisis: Spirituality and homosexuality in adolescence. *Child and Adolescent Social Work Journal, 24*, 369-383.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*, 7-18.
- Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*, 685-716.
- Chan, C. S. (1997). Don't ask, don't tell, don't know: The formation of a homosexual identity and sexual expression among Asian American lesbians. In B. Greene (Ed.), *Ethnic and cultural diversity among lesbians and gay men* (pp. 240-248). Thousand Oaks, CA: Sage.
- Chang, Y. B., & Katayama, M. (1996). Assessment of sexual orientation in lesbian/gay/bisexual studies. *Journal of Homosexuality, 30*(4), 49-62.
- Chivers, M. L., Seto, M. C., & Blanchard, R. (2007). Gender and sexual orientation differences in sexual response to sexual activities versus gender of actors in sexual films. *Journal of Personality and Social Psychology, 93*, 1108-1121.
- Cianciotto, J., & Cahill, S. (2006). *Youth in the crosshairs: The third wave of ex-gay activism*. New York: National Gay and Lesbian Task Force.
- Cochran, S. D., & Mays, V. M. (2006). Estimating prevalence of mental and substance using disorders among lesbians and gay men from existing national health data. In A. Omoto & H. Kurtzman (Eds.), *Sexual orientation and mental health: Examining identity and development in lesbian, gay, and bisexual people* (pp. 143-165). Washington DC: American Psychological Association.
- Cohen, K. M., & Savin-Williams, R. C. (2004). Growing up with same-sex attractions. *Current Problems in Pediatric and Adolescent Health Care, 34*, 361-369.
- Coleman, E. (1981/1982). Developmental stages of the coming out process. *Journal of Homosexuality, 7*(2/3), 31-43.
- Coleman, E. (1989). The married lesbian. *Marriage & Family Review, 14*(3/4), 119-135.
- Colson, C. E. (1972). Olfactory aversion therapy for homosexual behavior. *Journal of Behavior Therapy & Experimental Psychiatry, 3*, 185-187.
- Comstock, G. D. (1996). *Unrepentant, self-affirming, practicing: Lesbian/bisexual/gay people within organized religion*. London: Continuum International Publishing Group.
- Conger, J. J. (1975). Proceedings of the American Psychological Association, Incorporated, for the year 1974: Minutes of the annual meeting of the Council of Representatives. *American Psychologist, 30*, 620-651.
- Conover, W. (1980). *Practical non-parametric statistics*. New York: Wiley.
- Conrad, S. R., & Wincze, J. P. (1976). Orgasmic reconditioning: A controlled study of its effects upon the sexual arousal and behavior of adult male homosexuals. *Behavior Therapy, 7*, 155-166.
- Cook, D. A., & Wiley, C. Y. (2000). Psychotherapy with members of African-American churches and spiritual traditions. In P. S. Richards & A. E. Bergin, (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 369-398). Washington, DC: American Psychological Association.
- Cook, D. J., Mulrow, C. D., & Haynes, R. B. (1998). Synthesis of best evidence for clinical decisions. In C. D. Mulrow & D. J. Cook (Eds.), *Systematic reviews: Synthesis of best evidence for health care decisions*. Philadelphia: American College of Physicians.
- Corbett, K. (1996). Homosexual boyhood: Notes on girlyboys. *Gender & Psychoanalysis, 1*, 429-461.
- Corbett, K. (1998). Cross-gendered identifications and homosexual boyhood: Toward a more complex theory of gender. *American Journal of Orthopsychiatry, 68*, 352-360.
- Corbett, K. (2001). More life: Centrality and marginality in human development. *Psychoanalytic Dialogues, 11*, 313-335.
- Corley, M. D., & Kort, J. (2006). The sex addicted mixed-orientation marriage: Examining attachment styles, internalized homophobia and viability of marriage after disclosure. *Sexual Addiction & Compulsivity, 13*(2-3), 167-193.
- Corliss, H. L., Cochran, S. D., & Mays, V. (2002). Reports of parental maltreatment during childhood in a United States population-based survey of homosexual, bisexual, and heterosexual adults. *Child Abuse & Neglect, 26*, 1165-1178.
- Coyle, A. (1993). A study of psychological well-being among gay men using the GHQ-30. *British Journal of Clinical Psychology, 32*, 218-220.

- Coyle, A., & Rafalin, D. (2000). Jewish gay men's accounts of negotiating cultural, religious, and sexual identity: A qualitative study. *Journal of Psychology & Human Sexuality, 12*, 21-48.
- Cramer, R. J., Golom, F. D., LoPresto, C. T., & Kirkley, S. M. (2008). Weighing the evidence: Empirical assessment and ethical implications of conversion therapy. *Ethics & Behavior, 18*, 93-114.
- Crawford, I., Allison, K., Zamboni, B., & Soto, T. (2002). The influence of dual identity development on the psychosocial functioning of African-American gay and bisexual men. *Journal of Sex Research, 39*, 179-189.
- Curtis, R. H., & Presly, A. S. (1972). The extinction of homosexual behavior by covert sensitization: A case study. *Behaviour Research & Therapy, 10*, 81-83.
- D'Augelli, A. R. (1994). Lesbian and gay male development: Steps toward an analysis of lesbians' and gay men's lives. In B. Greene & G. M. Herek (Eds.), *Lesbian and gay psychology: Theory, research, and clinical application* (pp. 118-132). Newbury Park, CA: Sage.
- D'Augelli, A. R. (2002). Mental health problems among lesbian, gay, and bisexual youths ages 14 to 21. *Clinical Child Psychology and Psychiatry, 7*, 439-462.
- D'Augelli, A. R. (2003). Lesbian and bisexual female youths aged 14 to 21: Developmental challenges and victimization experiences. *Journal of Lesbian Studies, 7*, 9-29.
- D'Augelli, A. R., & Hershberger, S. L. (1993). Lesbian, gay, and bisexual youth in community settings: Personal challenges and mental health problems. *American Journal of Community Psychology, 21*, 421-448.
- D'Augelli, A. R., Hershberger, S. L., & Pilkington, N. W. (1998). Lesbian, gay, and bisexual youth and their families: Disclosure of sexual orientation and its consequences. *American Journal of Orthopsychiatry, 68*, 361-371.
- D'Augelli, A. R., & Patterson, C. J. (Eds.). (1995). *Lesbian, gay, and bisexual identities over the lifespan*. New York: Oxford University Press.
- D'Augelli, A. R., & Patterson, C. J. (Eds.). (2001). *Lesbian, gay, and bisexual identities and youths: Psychological perspectives*. New York: Oxford University Press.
- David, S., & Knight, B. G. (2008). Stress and coping among gay men: Age and ethnic differences. *Psychology and Aging, 23*, 62-69.
- Davis, S. (2002). Autonomy versus coercion: Reconciling competing perspectives in community mental health. *Community Mental Health Journal, 38*, 239-250.
- Davison, G. C. (1976). Homosexuality: The ethical challenge. *Journal of Consulting and Clinical Psychology, 44*, 157-162.
- Davison, G. C. (1978). Not can but ought: The treatment of homosexuality. *Journal of Consulting and Clinical Psychology, 46*, 170-172.
- Davison, G. C. (1982). Conceptual and ethical issues in therapy for the psychological problems of gay men, lesbians, and bisexuals. *JCLP/In Session: Psychotherapy in Practice, 57*, 695-704.
- Davison, G. C. (1991). Constructionism and morality in therapy for homosexuality. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 137-148). Newbury Park, CA: Sage.
- Davison, G. C., & Wilson, G. T. (1973). Attitudes of behavior therapists toward homosexuality. *Behavior Therapy, 4*, 686-696.
- D'Emilio, J. (1983). *Sexual politics, sexual communities: The making of a homosexual minority in the United States 1940-1970*. Chicago: University of Chicago Press.
- de Jong, A., & Jivraj, S. (2002, September/October). The journey to self-acceptance: Working with and for lesbian and gay refugees from Muslim countries. *InExile*. Retrieved February 10, 2009, from <http://www.safraproject.org/Reports/Inexile.pdf>
- de la Huerta, C. (1999). *Coming out spiritually: The next step*. New York: Penguin Putnam.
- Denizet-Lewis, B. (2003, August). Double lives on the down low. *The New York Times*. August 3, 2003. Retrieved February 10, 2009, from <http://query.nytimes.com/gst/fullpage.html?sec=health&res=9F0CE0D61E3FF930A3575BC0A9659C8B63>
- Diamond, L. M. (1998). Development of sexual orientation among adolescent and young adult women. *Developmental Psychology, 34*, 1085-1095.
- Diamond, L. M. (2003). Was it a phase? Young women's relinquishment of lesbian/bisexual identities over a 5-year period. *Journal of Personality and Social Psychology, 84*, 352-364.
- Diamond, L. M. (2006). What we got wrong about sexual identity development: Unexpected findings from a longitudinal study of young women. In A. M. Omoto & H. S. Kurtzman (Eds.), *Sexual orientation and mental health: Examining identity and development in lesbian, gay, and bisexual people* (pp. 73-94). Washington, DC: American Psychological Association.
- Diamond, L. M. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology, 44*, 5-14.
- Diamond, L. M., & Savin-Williams, R. C. (2000). Explaining diversity in the development of same-sex sexuality among young women. *Journal of Social Issues, 56*, 297-313.
- Diaz, R. M., Ayala, G., & Bein, E. (2004). Sexual risk as an outcome of social oppression: Data from a probability sample of Latino gay men in three U.S. cities. *Cultural Diversity and Ethnic Minority Psychology, 10*, 255-267.
- Diener, E. (2000). Subjective well-being: The science of happiness and a proposal for a national index. *American Psychologist, 55*, 34-43.

- Dillon, F. R., Worthington, R. L., Bielstein Savoy, H. B., Rooney, S. C., Becker-Schutte, A., & Guerra, R. M. (2004). On becoming allies: A qualitative study of LGB-affirmative counselor training. *Counselor Education & Supervision, 43*, 162-178.
- DiPlacido, J. (1998). Minority stress among lesbians, gay men, and bisexuals: A consequence of heterosexism, homophobia, and stigmatization. In G. M. Herek (Ed.), *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals* (pp. 138-159). Thousand Oaks, CA: Sage.
- Dorff, E., Nevins, D., & Reisner, A. (2006) *Homosexuality, human dignity and halakhah*. Retrieved December 31, 2008, from http://rabbinicalassembly.org/law/teshuvot_public.html
- Drescher, J. (1998a). I'm your handyman: A history of reparative therapies. *Journal of Homosexuality, 36*, 19-42.
- Drescher, J. (1998b). *Psychoanalytic therapy and the gay man*. Hillsdale, NJ: Analytic Press.
- Drescher, J. (1999). The therapist's authority and the patient's sexuality. *Journal of Gay & Lesbian Psychotherapy, 3*, 61-80.
- Drescher, J. (2001). Ethical concerns raised when patients seek to change same-sex attractions. *Journal of Gay & Lesbian Psychotherapy, 5*(3/4), 181-210.
- Drescher, J. (2002). Causes and becauses: On etiological theories of homosexuality. *The Annual of Psychoanalysis, 30*, 57-68.
- Drescher, J. (2003). The Spitzer study and the culture wars. *Archives of Sexual Behavior, 32*, 431-432.
- Drescher, J., & Merlino, J. P. (Eds.). (2007). *American psychiatry and homosexuality: An oral history*. New York: Harrington Park Press.
- Drescher, J., Stein, T. S., & Byne, W. (2005). Homosexuality, gay, and lesbian identities, and homosexual behavior. In B. Sadock & V. Sadock (Eds.), *Kaplan and Sadock's comprehensive textbook of psychiatry* (8th ed., pp. 1936-1965). Baltimore: Lippincott Williams & Wilkins/Wolters Kluwer.
- Drescher, J., & Zucker, K. J. (Eds.). (2006). *Ex-gay research: Analyzing the Spitzer study and its relation to science, religion, politics, and culture*. New York: Harrington Park Press.
- Dunne, M. P., Bailey, J., Kirk, K. M., & Martin, N. G. (2000). The subtlety of sex-atypicality. *Archives of Sexual Behavior, 29*, 549-565.
- Durlak, J. A., Meerson, I., & Ewell Foster, C. J. (2003). Meta-analysis. In J. C. Thomas, & M. Hersen (Eds.), *Understanding research in clinical and counseling psychology* (pp. 243-267). Mahwah, NJ: Erlbaum.
- Dworkin, S. (1997). Female, lesbian, and Jewish: complex and invisible. In B. Greene (Ed.), *Ethnic and cultural diversity among lesbians and gay men* (pp. 63-87). Thousand Oaks, CA: Sage.
- Dworkin, S. H. (2001). Treating the bisexual client. *Journal of Clinical Psychology, 57*, 671-680.
- Ellis, A. (1956). The effectiveness of psychotherapy with individuals who have severe homosexual problems. *Journal of Consulting Psychology, 20*, 191-195.
- Ellis, A. (1959). A homosexual treated with rational psychotherapy. *Journal of Clinical Psychology, 15*, 338-343.
- Ellis, A. (1965). *Homosexuality: Its causes and cure*. New York: Lyle Stuart.
- Emmons, R. A. (1999). *The psychology of ultimate concerns: Motivation and spirituality in personality*. New York: Guilford Press.
- Emmons, R. A., & Paloutzian, R. E. (2003). The psychology of religion. *Annual Review of Psychology, 54*, 377-402.
- Enns, C. Z. (2008). Toward a complexity paradigm for understanding gender role conflict. *The Counseling Psychologist, 36*, 446-454.
- Erzen, T. (2006). *Straight to Jesus: Sexual and Christian conversions in the ex-gay movement*. Los Angeles: University of California Press.
- Espin, O. M. (2005, January). *The age of the cookie cutter has passed: Contradictions in identity at the core of therapeutic intervention*. Paper presented at the National Multicultural Conference and Summit IV, Los Angeles, CA.
- Eubanks-Carter, C., Burckell, L. A., & Goldfried, M. R. (2005). Enhancing therapeutic effectiveness with lesbian, gay, and bisexual clients. *Clinical Psychology: Science & Practice, 12*, 1-18.
- Exline, J. J. (2002). Stumbling blocks on the religious road: Fractured relationships, nagging vices, and inner struggle to believe. *Psychological Inquiry, 13*, 182-189.
- Faiver, C., & Ingersoll, R. E. (2005). Knowing one's limits. In C. S. Cashwell & J. S. Young (Eds.), *Integrating spirituality and religion into counseling: A guide to competent practice* (pp. 169-184). Alexandria, VA: American Counseling Association.
- Farber, B. A., & Lane, J. S. (2002). Positive regard. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 175-194). New York: Oxford University Press.
- Fassinger, R. E., & Arseneau, J. R. (2006). "I'd rather get wet than be under that umbrella": Differentiating the experiences and identities of lesbian, gay, bisexual, and transgender people. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 19-49). Washington, DC: American Psychological Association.
- Feldman, M. P., & MacCulloch, M. J. (1965). The application of anticipatory avoidance learning to the treatment of homosexuality: I. Theory, technique, and preliminary results. *Behaviour Research & Therapy, 3*, 165-183.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Palo Alto, CA: Stanford University Press.

- Firestein, B. A. (Ed.). (2007). *Becoming visible: Counseling bisexuals across the lifespan*. New York: Columbia University Press.
- Fischer, A. R., & DeBord, K. A. (2007). Perceived conflicts between sexual and religious diversity affirmation: "That's perceived." In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 317-339). Washington, DC: American Psychological Association.
- Fischer, A. R., & Good, G. E. (1997). Men and psychotherapy: An investigation of alexithymia, intimacy, and masculine gender roles. *Psychotherapy: Theory, Research, Practice, Training*, 43, 160-170.
- Fisher, R. J., & Katz, J. E. (2000). Social-desirability bias and the validity of self-reported values. *Psychology and Marketing*, 17, 105-120.
- Flay, B. R., Biglan, A., Boruch, R. F., Castro, F. G., Gottfredson, D., Kellam, S., et al. (2005). Standards of evidence: Criteria for efficacy, effectiveness, and dissemination. *Prevention Science*, 6, 151-175.
- Floyd, F. J., & Stein, T. S. (2002). Sexual orientation identity formation among gay, lesbian and bisexual youths: Multiple patterns of milestone. *Journal of Research on Adolescence*, 12, 167-191.
- Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior*, 21, 219-239.
- Fontaine, J. H., & Hammond, N. L. (1996). Counseling issues with gay and lesbian adolescents. *Adolescence*, 31, 817-830.
- Fookes, B. H. (1960). Some experiences in the use of aversion therapy in male homosexuality, exhibitionism, and fetishism-transvestism. *British Journal of Psychiatry*, 115, 339-341.
- Ford, C. S., & Beach, F. A. (1951). *Patterns of sexual behavior*. New York: Harper & Row.
- Ford, J. G. (2001). Healing homosexuals: A psychologist's journey through the ex-gay movement and the pseudo-science of reparative therapy. *Journal of Gay and Lesbian Psychotherapy*, 5, 69-86.
- Forehand, H., & Ciccone, J. R. (2004). The competence of adolescents to consent to treatment. *Adolescent Psychiatry*, 28, 5-27.
- Forstein, M. (2001). Overview of ethical and research issues in sexual orientation therapy. *Journal of Gay & Lesbian Psychotherapy*, 5(3/4), 167-179.
- Fowers, B. J., & Davidov, B. J. (2006). The virtue of multiculturalism: Personal transformation, character, and openness to the other. *American Psychologist*, 61, 581-594.
- Fowler, J. (1981). *Stages of faith: The psychology of human development and the quest for meaning*. New York: Harper & Row.
- Fowler, J. (1991). Stages in faith consciousness. *New Directions for Child Development*, 52, 27-45.
- Fowler, J. W. (2001). Faith development theory and the postmodern challenges. *International Journal for the Psychology of Religion*, 11, 159-172.
- Fox, R. C. (1995). Bisexual identities. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian, gay and bisexual identities across the lifespan* (pp. 48-86). New York: Oxford University Press.
- Fox, R. C. (Ed.). (2004). *Current research on bisexuality*. Ithaca, NY: Harrington Park Press. [Published simultaneously as *Journal of Bisexuality*, 4(1/2).]
- Frankl, V. (1992). *Man's search for meaning* (4th ed.). New York: Simon & Schuster.
- Freeman, W., & Meyer, R. G. (1975). A behavioral alteration of sexual preferences in the human male. *Behavior Therapy*, 6, 206-212.
- Freud, S. (1960). Three essays on the theory of sexuality. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, 123-143). London: Hogarth. (Original work published 1905)
- Freud, S. (1960). The psychogenesis of a case of homosexuality in a woman. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 18, 147-172). London: Hogarth. (Original work published 1920)
- Freud, S. (1960). Anonymous (Letter to an American mother). In E. Freud (Ed.), *The letters of Sigmund Freud* (pp. 423-424). New York: Basic Books. (Original work published 1935)
- Freund, K. (1971). A note on the use of the phallometric method of measuring mild sexual arousal in the male. *Behavior Therapy*, 2, 223-228.
- Freund, K. (1976). Psycho-physiological assessment of change in erotic preferences. *Behavioral Research and Therapy*, 15, 297-301.
- Freund, K., & Blanchard, R. (1983). Is the distant relationship of fathers and homosexual sons related to the sons' erotic preference for male partners, or to the sons' atypical gender identity, or to both? *Journal of Homosexuality*, 9, 7-25.
- Freund, K., & Pinkava, V. (1961). Homosexuality in man and its association with parental relationships. *Review of Czechoslovak Medicine*, 7, 32-40.
- Freund, K., Watson, R., & Rienzo, D. (1988). Signs of feigning in the phallometric test. *Behaviour Research & Therapy*, 26, 105-112.
- Frost, D. M., & Meyer, I. H. (2009). Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. *Journal of Counseling Psychology*, 56, 97-109.
- Fulton, A. S., Gorsuch, R. L., & Maynard, E. A. (1999). Religious orientation, antihomosexual sentiment and fundamentalism among Christians. *Journal for the Scientific Study of Religion*, 38, 14-22.

- Garnets, L. D., Hancock, K., Cochran, S., Goodchilds, J., & Peplau, L. (1991). Issues in psychotherapy with lesbians and gay men: A survey of psychologists. *American Psychologist*, 46, 964-972.
- Garnets, L. D., & Peplau, L. A. (2000). Understanding women's sexualities and sexual orientations: An introduction. *Journal of Social Issues*, 56, 181-192.
- Garofalo, R., & Harper, G. W. (2003). Not all adolescents are the same: Addressing the unique needs of gay and bisexual male youth. *Adolescent Medicine*, 14, 595-612.
- Gartner, R. (1999). *Betrayed as boys*. New York: Guilford Press.
- George, L., Larson, D., Koenig, H., & McCullough, M. (2000). Spirituality and health: What we know and what we need to know. *Journal of Social and Clinical Psychology*, 19, 102-116.
- Glassgold, J. M. (1995). Psychoanalysis with lesbians: Self-reflection and agency. In J. M. Glassgold & S. Iasenza (Eds.), *Lesbians & psychoanalysis: Revolutions in theory and practice*. New York: The Free Press.
- Glassgold, J. M. (2007). "In dreams begin responsibilities": Psychology, agency & activism. *Journal of Gay and Lesbian Mental Health*, 11(3/4), 37-57.
- Glassgold, J. M. (2008). Bridging the divide: Integrating lesbian identity and orthodox Judaism. *Women and Therapy*, 31, 59-73.
- Glassgold, J. M., & Iasenza, S. (1995). *Lesbians & psychoanalysis: Revolutions in theory and practice* [Introduction]. New York: The Free Press
- Glassgold, J. M., & Iasenza, S. (2004). Lesbians, feminism and psychoanalysis: The second wave [Introduction]. *Journal of Lesbian Studies*, 8(1/2), 1-10.
- Glassgold, J. M., & Knapp, S. (2008). Ethical issues in screening clergy or candidates for religious professions for denominations that exclude homosexual clergy. *Professional Psychology: Research and Practice*, 39, 346-352.
- Gochros, J. S. (1989). *When husbands come out of the closet*. Binghamton, NY: Harrington.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.
- Goishi, M. A. (1997). Legal and social responses to the problems of queer youth: Unlocking the closet door: Protecting children from involuntary civil commitment because of their sexual orientation. *Hastings Law Journal*, 48.
- Goldfried, M. R., & Goldfried, A. P. (2001). The importance of parental support in the lives of lesbian, gay, and bisexual individuals. *Journal of Clinical Psychology*, 57, 681-693.
- Goldstein, E. D. (2007). Sacred moments: Implications on well-being and stress. *Journal of Clinical Psychology*, 63, 1001-1019.
- Gonsiorek, J. C. (1991). The empirical basis for the demise of the illness model of homosexuality. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 115-136). Newbury Park, CA: Sage.
- Gonsiorek, J. C. (2004). Reflections from the conversion therapy battlefield. *The Counseling Psychologist*, 32, 750-759.
- Gonsiorek, J. C., Sell, R. L., & Weinrich, J. D. (1995). Definition and measurement of sexual orientation. *Suicide and Life-Threatening Behavior*, 25, 40-51.
- Goodenow, C., Szalacha L., & Westheimer K. (2006). School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools*, 43, 573-589.
- Goodheart, C. D., Kazdin, A. E., & Sternberg, R. J. (Eds.). (2006). *Evidence-based psychotherapy: Where practice and research meet*. Washington, DC: American Psychological Association.
- Graham, L. K. (1997). *Discovering images of God: Narratives of care among lesbians and gays*. Louisville, KY: Westminster John Knox Press.
- Gramick, J. (1984). Developing a lesbian identity. In T. Darty & S. Potter (Eds.), *Women-identified women* (pp. 31-44). Palo Alto, CA: Mayfield.
- Gray, J. J. (1970). Case conference: Behavior therapy in a patient with homosexual fantasies and heterosexual anxiety. *Journal of Behavior Therapy & Experimental Psychiatry*, 1, 225-232.
- Green, R. (1985). Gender identity in childhood and later sexual orientation: Follow-up of 78 males. *American Journal of Psychiatry*, 142, 339-441.
- Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.
- Green, R. J. (2003). When therapists do not want their clients to be homosexual: A response to Rosik's article. *Journal of Marital and Family Therapy*, 29, 29-38.
- Greenberg, S. (2004). *Wrestling with God and men: Homosexuality in the Jewish tradition*. Madison: University of Wisconsin.
- Greenspoon, J., & Lamal, P. A. (1987). A behavioristic approach. In L. Diamant (Ed), *Male and female homosexuality: Psychological approaches* (pp. 109-128). Washington, DC: Hemisphere.
- Gross, M. (2008). To be Christian and homosexual. From shame to identity-based claims. *Nova Religio*, 11, 77-101.
- Hage, S. M. (2006). A closer look at the role of spirituality in psychology training programs. *Professional Psychology: Research and Practice*, 37, 303-310.

- Halbertal, T. H., & Koren, I. (2006). Between "being" and "doing": Conflict and coherence in the identity formation of gay and lesbian orthodox Jews. In D. P. McAdams, R. Josselson, & A. Lieblich (Eds.), *Identity and story: Creating self in narrative* (p. 37-61). Washington, DC: American Psychological Association.
- Haldeman, D. C. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Consulting and Clinical Psychology, 62*, 221-227.
- Haldeman, D. C. (1996). Spirituality and religion in the lives of lesbians and gay men. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 881-896). Washington, DC: American Psychiatric Press.
- Haldeman, D. C. (2000). Gender atypical youth: Clinical and social issues. *School Psychology Review, 29*, 192-200.
- Haldeman, D. C. (2001). Therapeutic antidotes: Helping gay and bisexual men recover from conversion therapies. *Journal of Gay and Lesbian Psychotherapy, 5*(3-4), 117-130.
- Haldeman, D. C. (2002). Gay rights, patient rights: The implications of sexual orientation conversion therapy. *Professional Psychology, 33*, 200-204.
- Haldeman, D. C. (2004). When sexual and religious orientation collide: Considerations in working with conflicted same-sex attracted male clients. *The Counseling Psychologist, 32*, 691-715.
- Hall, M. E. L., & Johnson, E. J. (2001). Theodicy and therapy: Philosophical/theological contributions to the problem of suffering. *Journal of Psychoogy and Christianity, 20*, 5-17.
- Hallam, R. S., & Rachman, S. (1972). Some effects of aversion therapy on patients with sexual disorders. *Behaviour Research & Therapy, 10*, 171-180.
- Hallman, J. (2008). *The heart of female same-sex attraction*. Downer's Grove, IL: Intervarsity Press
- Halstead, J. M., & Lewicka, K. (1998). Should homosexuality be taught as an acceptable alternative lifestyle? A Muslim perspective. *Cambridge Journal of Education, 28*, 49-64.
- Hanson, R. W., & Adesso, V. J. (1972). A multiple behavioral approach to male homosexual behavior: A case study. *Journal of Behavior Therapy & Experimental Psychiatry, 3*, 323-325.
- Harper, G. W., Jamil, O. B., & Wilson, B. D. M. (2007). Collaborative community-based research as activism: Giving voice and hope to lesbian, gay, and bisexual youth. *Journal of Lesbian and Gay Psychotherapy, 11*(3/4), 99-119.
- Harper, G. W., Jernewall, N., & Zea, M. C. (2004). Giving voice to emerging science and theory for lesbian, gay, and bisexual people of color. *Cultural Diversity and Ethnic Minority Psychology, 10*, 187-199.
- Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color. *American Journal of Orthopsychiatry, 70*, 42-57.
- Harris, J. I., Cook, S. W., & Kashubeck-West, S. (2008). Religious attitudes, internalized homophobia, and identity in gay and lesbian adults. *Journal of Gay and Lesbian Mental Health, 12*, 205-225.
- Hart, T. A., & Heimberg, R. G. (2001). Presenting problems among treatment-seeking gay, lesbian, and bisexual youth. *Journal of Clinical Psychology, 57*, 615-627.
- Hartman, R. G. (2000). Adolescent autonomy: Clarifying an ageless conundrum. *Hastings Law Journal, 51*, 1265.
- Hartman, R. G. (2002). Coming of age: Devising legislation for adolescent medical decision-making. *American Journal of Law and Medicine, 28*, 409.
- Hathaway, W. L., Scott, S. Y., & Garver, S. A. (2004). Assessing religious/spiritual functioning: A neglected domain in clinical practice? *Professional Psychology: Research and Practice, 35*, 97-104.
- Hatzenbuehler, M. L., Nolen-Hoeksema, S. & Erickson, S. J. (2008). Depressive symptoms: Results from a prospective study of bereaved Gay men. *Health Psychology, 27*, 455-462.
- Hayduk, L. A., Stratkotter, R. F., & Rovers, M. W. (1997). Sexual orientation and the willingness of Catholic seminary students to conform to church teachings. *Journal for the Scientific Study of Religion, 36*(3), 455-467.
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2003). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guildford Press.
- Hays, D., & Samuels, A. (1989). Heterosexual women's perceptions of their marriages to bisexual or homosexual men. *Journal of Homosexuality, 18*(1-2), 81-100.
- Heinz, B., Gu, L., Inuzuka, A., & Zender, R. (2002). Under the rainbow flag: Webbing global gay identities. *International Journal of Sexuality & Gender Studies, 7*, 107-124.
- Hekma, G. (2002). Imams and homosexuality: A post-gay debate in the Netherlands. *Sexualities, 5*, 237-248.
- Helminiak, D. A. (2004). The ethics of sex: A call to the gay community. *Pastoral Psychology, 52*, 259-267.
- Helms, J. E. (1995). An update of Helms' White and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181-198). Thousand Oaks, CA: Sage.
- Heppner, P. P., & Heppner, M. J. (2008). The gender role conflict literature: Fruits of sustained commitment. *The Counseling Psychologist, 36*, 455-461.
- Herek, G. M. (1987). Religion and prejudice: A comparison of racial and sexual attitudes. *Personality and Social Psychology Bulletin, 13*, 56-65.
- Herek, G. M. (2003). Evaluating interventions to alter sexual orientation: Methodological and ethical considerations. *Archives of Sexual Behavior, 32*, 438-439.
- Herek, G. M. (2007). Confronting sexual stigma and prejudice: Theory and practice. *Journal of Social Issues, 63*, 905-925.

- Herek, G. M. (2009). Sexual stigma and sexual prejudice in the United States: A conceptual framework. In D. A. Hope (Ed.), *Nebraska Symposium on Motivation: Vol. 54. Contemporary perspectives on lesbian, gay, and bisexual identities* (pp. 65-111). New York: Springer.
- Herek, G. M., & Capitano, J. P. (1996). "Some of my best friends": Intergroup contact, concealable stigma, and heterosexuals' attitudes toward gay men and lesbians. *Personality and Social Psychology Bulletin*, 22, 412-424.
- Herek, G. M., Cogan, J. C., Gillis, J. R., & Glunt, E. K. (1998). Correlates of internalized homophobia in a community sample of lesbians and gay men. *Journal of the Gay and Lesbian Medical Association*, 2, 17-25.
- Herek, G. M., & Garnets, L. (2007). Sexual orientation and mental health. *Annual Review of Clinical Psychology*, 3, 353-375.
- Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology*, 56, 32-43.
- Herek, G. M., & Glunt, E. K. (1993). Interpersonal contact and heterosexuals' attitudes toward gay men: Results from a national survey. *The Journal of Sex Research*, 30, 239-244.
- Herman, S. H., Barlow, D. H., & Agras, W. S. (1974). An experimental analysis of exposure to "explicit" heterosexual stimuli as an effective variable in changing arousal patterns of homosexuals. *Behaviour Research & Therapy*, 12, 335-345.
- Herman, S. H., & Prewett, M. (1974). An experimental analysis of feedback to increase sexual arousal in a case of homo- and heterosexual impotence: A preliminary report. *Journal of Behavior Therapy & Experimental Psychiatry*, 5, 271-274.
- Hernandez, B. C., & Wilson, C. M. (2007). Another kind of ambiguous loss: Seventh-day Adventist women in mixed-orientation marriages. *Family Relations*, 56, 184-195.
- Hetrick, E. S., & Martin, A. D. (1987). Developmental issues and their resolution for gay and lesbian adolescents. *Journal of Homosexuality*, 14, 25-43.
- Higgins, D. J. (2006). Same-sex attraction in heterosexually partnered men: Reasons, rationales and reflections. *Sexual and Relationship Therapy*, 21, 217-228.
- Hill, L. G., & Betz, D. L. (2005). Revisiting the retrospective pretest. *American Journal of Evaluation*, 26, 501-517.
- Hoburg, R., Konik, J., Williams, M., & Crawford, M. (2004). Bisexuality among self-identified heterosexual college students. *Journal of Bisexuality*, 4(1/2), 25-36.
- Hoffman, L., Knight, S. K., Hoffman, J. L., Boscoe-Huffman, S., Galaska, D., & Arms, M., et al. (2007, August). *Examining the interplay of religious, spiritual, and homosexual dynamics of psychological health: A preliminary investigation*. Poster session presented at the annual meeting of the American Psychological Association, San Francisco.
- Holtzen, D. W., & Agriesti, A. A. (1990). Parental responses to gay and lesbian children: Differences in homophobia, self-esteem, and sex-role stereotypes. *Journal of Social & Clinical Psychology*, 9, 390-399.
- Hooker, E. A. (1957). The adjustment of the male overt homosexual. *Journal of Projective Techniques*, 21, 18-31.
- Hooker, E. A. (1969). Parental relations and male homosexuality in patient and nonpatient populations. *Journal of Consulting and Clinical Psychology*, 33, 140-142.
- Horlacher, G. T. (2006, October). *Religion and sexual orientation in conflict: Changing values of same-sex oriented Mormons*. Paper presented at the annual meeting of the Society for the Scientific Study of Religion, Portland, OR.
- Horne, S., & Noffsinger-Frazier, N. (2003). Reconciling with religion/exploring spirituality. In J. S. Whitman & C. J. Boyd (Eds.), *The therapist's notebook for lesbian, gay, and bisexual clients: Homework, handouts and activities for use in psychotherapy* (pp. 202-205). Binghamton, NY: Haworth Clinical Press.
- Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-69). New York: Oxford.
- Huff, F. W. (1970). The desensitization of a homosexual. *Behaviour Research & Therapy*, 8, 99-102.
- Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge, England: Cambridge University Press.
- Hunsberger, B., & Jackson, L. M. (2005). Religion, meaning, and prejudice. *Journal of Social Issues*, 61, 807-826.
- Hunt, E., & Carlson, J. (2007). The standards for conducting research on topics of immediate social relevance. *Intelligence*, 35, 393-399.
- Isay, R. A. (1987). Fathers and their homosexually-inclined sons in childhood. *Psychoanalytic Study of the Child*, 42, 275-294.
- Isay, R. A. (1998). Heterosexually married homosexual men: Clinical and developmental issues. *American Journal of Orthopsychiatry*, 68, 424-432.
- Isay, R. A. (2001). The development of sexual identity in homosexual men. In S. I. Greenspan & G. H. Pollock (Eds.), *The course of life: Adolescence* (Vol.4, pp. 469-491). Madison, CT: International Universities Press.
- Israel, T., & Hackett, G. (2004). Counselor education on lesbian, gay, and bisexual issues: Comparing information and attitude exploration. *Counselor Education & Supervision*, 43, 179-191.
- Israel, T., Ketz, K., Detrie, P. M., Burke, M. C., & Shulman, J. (2003). Identifying counselor competencies for working with lesbian, gay, and bisexual clients. *Journal of Gay & Lesbian Psychotherapy*, 7, 3-21.
- Iwasaki, Y., & Ristock, J. L. (2007). The nature of stress experienced by lesbians and gay men. *Anxiety, Stress & Coping: An International Journal*, 20, 299-319.

- James, B. (1962). Case of homosexuality treated by aversion therapy. *British Medical Journal*, 1, 768-770.
- James, S. (1978). Treatment of homosexuality: II. Superiority of desensitization/arousal as compared with anticipatory avoidance conditioning: Results of a controlled trial. *Behavior Therapy*, 9, 28-36.
- Jlang, Y., Costello, P., Fang, F., Huang, M. & He, S. (2006). A gender and sexual orientation dependent attentional effect of invisible images. *PNAS*, 103, 17048-17052.
- Johnson, W. B. (2001). To dispute or not to dispute: Ethical REBT with religious clients. *Cognitive and Behavioral Practice*, 8, 39-47.
- Johnson, W. B. (2004). Rational emotive behavior therapy for disturbance about sexual orientation. In P. S. Richards & A. E. Bergin (Eds.), *Casebook for a spiritual strategy in counseling and psychotherapy* (pp. 247-265). Washington, DC: American Psychological Association.
- Johnson, W. B., & Buhrke, R. A. (2006). Service delivery in a "don't ask, don't tell" world: Ethical care of gay, lesbian, and bisexual military personnel. *Professional Psychology: Research and Practice*, 37, 91-98.
- Jones, M.A., & Gabriel, M. A. (1999). Utilization of psychotherapy by lesbians, gay men, and bisexuals: Findings from a nationwide survey. *American Journal of Orthopsychiatry*, 69, 209-219.
- Jones, S. L., & Yarhouse, M. A. (2007). *Ex-gay? A longitudinal study of religiously mediated change in sexual orientation*. Downer's Grove, IL: Intervarsity Press.
- Jordan, K. M., & Deluty, R. H. (1998). Coming out for lesbian women: Its relation to anxiety, positive affectivity, self-esteem, and social support. *Journal of Homosexuality*, 35, 41-63.
- Kameny, F. (2009). How it all started. *Journal of Gay and Lesbian Mental Health*, 13, 76-81.
- Karten, E. (2006). Sexual reorientation efforts in dissatisfied same-sex attracted men: What does it really take to change? *Dissertation Abstracts International*, 67(01), 547B. (UMI No. 3201129)
- Katz, J. (1995). *Gay American history: Lesbians and gay men in the United States*. New York: Thomas Crowell.
- Kendrick, S. R., & McCullough, J. P. (1972). Sequential phases of covert reinforcement and covert sensitization in the treatment of homosexuality. *Journal of Behavior Therapy & Experimental Psychiatry*, 3, 229-231.
- Kennedy, S., & Cianciotto, J. (2006). *Homophobia at "hell house": Literally demonizing lesbian, gay, bisexual, and transgender youth*. Washington, DC: National Gay and Lesbian Task Force Policy Institute. Retrieved from www.thetaskforce.org/downloads/reports/reports/Homophobia_Hell_House.pdf
- Kerr, R. A. (1997). The experience of integrating gay identity with evangelical Christian faith. *Dissertation Abstracts International*, 58(09), 5124B. (UMI No. 9810055).
- Khan, K. S., Kunz, R., Kleijnen, J., & Antes, G. (2003). *Systematic reviews to support evidence-based medicine*. London: Royal Society of Medicine Press.
- Kimmel, D. C., & Yi, H. (2004). Characteristics of gay, lesbian, and bisexual Asians, Asian Americans, and immigrants from Asia to the USA. *Journal of Homosexuality*, 47, 143-172.
- King, L. A., & Hicks, J. A. (2007). Whatever happened to "what might have been"? Regret, happiness, and maturity. *American Psychologist*, 62, 625-636.
- King, L. A., & Smith, N. G. (2004). Gay and straight possible selves: Goals, identity, subjective well-being, and personality development. *Journal of Personality*, 72, 967-994.
- King, M., Semlyen, J., Killaspy, H., Nazareth, I., & Osborn, D. (2007). *A systematic review of research on counseling and psychotherapy for lesbian, gay, bisexual, & transgender people*. Leicestershire, England: British Association for Counseling & Psychotherapy.
- King, M., Smith, G., & Bartlett, A. (2004). Treatments of homosexuality in Britain since the 1950's—an oral history: The experience of professionals. *British Medical Journal*, 328, 429-432.
- Kinnish, K. K., Strassberg, D. S., & Turner, C. W. (2005). Sex differences in the flexibility of sexual orientation: A multidimensional retrospective assessment. *Archives of Sexual Behavior*, 34, 173-183.
- Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia: W.B. Saunders.
- Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. (1953). *Sexual behavior in the human female*. Philadelphia: W.B. Saunders.
- Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *The Counseling Psychologist*, 12, 43-55.
- Kitzinger, C., & Wilkinson, S. (1994). Re-viewing heterosexuality. *Feminism & Psychology*, 4, 330-336.
- Klein, F., & Schwartz, T. (Eds.). (2001). *Bisexual and gay husbands: Their stories, their words*. New York: Harrington Park Press.
- Klein, F., Sepekoff, B., & Wolf, T. J. (1985). Sexual orientation: A multi-variable dynamic process. *Journal of Homosexuality*, 11(1/2), 35-49.
- Knapp, S. J., & VandeCreek, L. (2003). *A guide to the 2002 revision of the American Psychological Association's Ethics Code*. Sarasota, FL: Professional Resource Press.
- Knapp, S. J., & VandeCreek, L. (2004). A principle-based analysis of the 2002 American Psychological Association Ethics Code. *Psychotherapy: Theory, Research, Practice, Training*, 41, 247-254.

- Knight, S. K., & Hoffman, L. (2007, August). *Sexual identity development and spiritual development: The impact of multiple lines of development*. Paper presented at the annual meeting of the American Psychological Association, San Francisco.
- Koenig, H. G., & Larson, D. B. (2001). Religion and mental health: Evidence for an association. *International Review of Psychiatry*, 13, 67-78.
- Koocher, G. P. (2003). Ethical issues in psychotherapy with adolescents. *Journal of Clinical Psychology*, 59, 1247-1256.
- Kosciw, J. G., & Diaz, E. M. (2006). *The 2005 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our schools*. New York: GLSEN.
- Krafft-Ebing, R., von. (1965). *Psychopathia sexualis*. New York: G. P. Putnam's. (Original work published 1886)
- Kuban, M., Barbaree, H. E., & Blanchard, R. (1999). A comparison of volume and circumference phallometry: Response magnitude and method agreement. *Archives of Sexual Behavior*, 28, 345-359.
- Kurdek, L. A. (2001). Differences between heterosexual non-parent couples and gay, lesbian, and heterosexual parent couples. *Journal of Family Issues*, 22, 727-754.
- Kurdek, L. A. (2003). Differences between gay and lesbian cohabiting couples. *Journal of Social Personal Relationships*, 20, 411-436.
- Kurdek, L. A. (2004). Are gay and lesbian cohabiting couples really different from heterosexual married couples? *Journal of Marriage and Family*, 66, 880-901.
- Kutz, G. D., & O'Connell, A. (2007). *Residential treatment programs: Concerns regarding abuse and neglect and death in certain programs for troubled youth*. Washington, DC: General Accounting Office. Retrieved January 5, 2008, from <http://www.gao.gov/new.items/d08146t.pdf>
- LaFromboise, T., Coleman, H. L. K., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin*, 114, 395-412.
- Lalumiere, M. L., & Earls, C. M. (1992). Voluntary control of penile responses as a function of stimulus duration and instructions. *Behavioral Assessment*, 14, 121-132.
- Lalumiere, M. L., & Harris, G. T. (1998). Common questions regarding the use of phallometric testing with sexual offenders. *Sexual Abuse: Journal of Research & Treatment*, 10, 227-237.
- Lam, T. C. M., & Bengo, P. (2003). A comparison of three retrospective self-reporting methods of measuring change in instructional practice. *American Journal of Evaluation*, 24, 65-80.
- Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, 38, 357-361.
- Langevin, R. (1983). *Sexual strands: Understanding and treating sexual anomalies in men*. New York: Erlbaum.
- Larson, D. E. (1970). An adaptation of the Feldman and MacCulloch approach to treatment of homosexuality by the application of anticipatory avoidance learning. *Behaviour Research & Therapy*, 8, 209-210.
- Lasser, J. S., & Gottlieb, M. C. (2004). Treating patients distressed regarding their sexual orientation: Clinical and ethical alternatives. *Professional Psychology: Research and Practice*, 35, 194-200.
- Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States*. Chicago: University of Chicago.
- Lavizzo-Mourey, R. J., & MacKenzie, E. (1995). Cultural competence: An essential hybrid for delivering high quality care in the 1990s and beyond. *Transactions of the American Clinical and Climatological Association*, 107, 226-237.
- Lawrence v. Texas, 539 U.S. 558 (2003).
- Lease, S., Horne, S., & Noffsinger-Frazier, N. (2005). Affirming faith experiences and psychological health for Caucasian lesbian, gay, and bisexual individual. *Journal of Counseling Psychology*, 52, 378-388.
- Lemoire, S. J., & Chen, C. P. (2005). Applying person-centered counseling to sexual minority adolescents. *Journal of Counseling & Development*, 83, 146-154.
- Lesser, R. C., & Schoenberg, E. (Eds.). (1999). *That obscure subject of desire: Freud's female homosexual revisited*. New York: Routledge.
- Levant, R. F. (1992). Toward the reconstruction of masculinity. *Journal of Family Psychology*, 5, 379-402.
- Levant, R. F. & Hasan, N. T. (2009). Evidence-based practice in psychology. *Professional Psychology: Research and Practice*, 39, 658-662.
- Levant, R. F., & Silverstein, L. B. (2006). Gender is neglected by both evidence-based practices and treatment as usual. In J. Norcross, L. Beutler, & R. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on fundamental questions* (pp. 338-345). Washington, DC: American Psychological Association.
- LeVay, S. (1996). *Queer science: The use and abuse of research in homosexuality*. Cambridge: Massachusetts Institute Technology Press.
- Levin, S. M., Hirsch, I. S., Shugar, G., & Kapche, R. (1968). Treatment of homosexuality and heterosexual anxiety with avoidance conditioning and systematic desensitization: Data and case report. *Psychotherapy: Theory, Research, & Practice*, 5, 160-168.
- Levine, M., Perkins, D. D., & Perkins, D. V. (2004). *Principles of community psychology: Perspectives and applications* (3rd ed.). New York: Oxford University Press.
- Levitt, H. M., Ovrebo, E., Anderson-Cleveland, M. B., Leone, C., Jeong, J. V., Arm, J. R., Bonin, B. P., et al. (2009). Balancing dangers: GLBT experience in a time of anti-GLBT legislation. *Journal of Counseling Psychology*, 56, 67-81.

- Liddle, B. J. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to ratings on helpfulness by gay and lesbian clients. *Journal of Counseling Psychology, 43*, 394-401.
- Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science, 2*, 53-70.
- Linehan, M. M., Dimeff, L. A., & Koerner, K. (Eds.). (2007). *Dialectical behavior therapy in clinical practice: Applications across disorders and settings*. New York: Guilford Press.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363-385.
- Liszc, A. M., & Yarhouse, M. A. (2005). Same-sex attraction: A survey regarding client-directed treatment goals. *Psychotherapy: Theory, Research, Practice, Training, 42*, 111-115.
- Lomax, J. W., Karff, S., & McKenny, G. P. (2002). Ethical considerations in the integration of religion and psychotherapy: Three perspectives. *Psychiatric Clinics of North America, 25*, 547-559.
- LoPiccolo, J. (1971). Case study: Systematic desensitization of homosexuality. *Behavior Therapy, 2*, 394-399.
- LoPiccolo, J., Stewart, R., & Watkins, B. (1972). Treatment of erectile failure and ejaculatory incompetence of homosexual etiology. *Journal of Behavior Therapy & Experimental Psychiatry, 3*, 233-236.
- Luhtanen, R. K. (2003). Identity, stigma management, and well-being: A comparison of lesbians/bisexual women and gay/bisexual men. *Journal of Lesbian Studies, 7*, 85-100.
- MacCulloch, M. J., & Feldman, M. P. (1967). Aversion therapy in management of 43 homosexuals. *British Medical Journal, 2*, 594-597.
- MacCulloch, M. J., Feldman, M. P., & Pinshoff, J. M. (1965). The application of anticipatory avoidance learning to the treatment of homosexuality II. *Behaviour Research & Therapy, 3*, 21-43.
- Mahaffy, K. A. (1996). Cognitive dissonance and its resolution: A study of lesbian Christians. *Journal for the Scientific Study of Religion, 35*, 392-402.
- Mahoney A., & Espin, O. M. (Eds.). (2008). Sin or salvation: The relationship between sexuality and spirituality in psychotherapy [Special issue]. *Women and Therapy, 31*(1).
- Malcolm, J. P. (2000). Sexual identity development in behaviourally bisexual married men. *Psychology, Evolution, & Gender, 2*, 263-299.
- Mallon, G. P. (2001). *Lesbian and gay youth issues: A practical guide for youth workers*. Washington, DC: CWLA Press.
- Malyon, A. K. (1982). Psychotherapeutic implications of internalized homophobia in gay men. In J. C. Gonsiorek (Ed.), *Homosexuality and psychotherapy: A practitioner's handbook of affirmative models* (pp. 59-69). Binghamton, NY: Haworth Press.
- Mankowski, E. S. (1997). *Community, identity, and masculinity: Changing men in a mutual support group*. Unpublished doctoral dissertation, University of Illinois at Urbana-Champaign.
- Mankowski, E. S. (2000). Reconstructing masculinity: Role models in the life stories of men's peer mutual support group members. In E. R. Barton (Ed.), *Mythopoetic perspectives of men's healing work: An anthology for therapists and others* (pp. 100-117). Westport, CT: Bergin & Garvey.
- Marcia, J. E. (1966). Development and validation of ego identity status. *Journal of Personality and Social Psychology, 5*, 551-558.
- Mark, N. (2008). Identities in conflict: Forging an orthodox gay identity. *Journal of Gay and Lesbian Mental Health, 12*, 179-194.
- Marquis, J. N. (1970). Orgasmic reconditioning: Changing sexual object choice through controlling masturbation fantasies. *Journal of Behavior Therapy & Experimental Psychiatry, 1*, 263-271.
- Martell, C. R., Safren, S. A., & Prince, S. E. (2004). *Cognitive-behavioral therapies with lesbian, gay, and bisexual clients*. New York: Guilford Press.
- Martin, A. D. (1982). Learning to hide: The socialization of the gay and lesbian adolescent. *Adolescent Psychiatry, 10*, 52-65.
- Martin, D. J. (2003, April). The dearth of cognitive and behavioral treatments for gays and lesbians. *Newsletter of the Academy of Cognitive Therapy, 2*(2). Retrieved from www.academyofct.org/Library/InfoManage/Guide.asp?FolderID=184&SessionID={ED2061C4-FAC9-4B6C-BC44-464343721CB9}
- Martinez, J., & Hosek, S. G. (2005). An exploration of the down-low identity: Nongay-identified young African-American men who have sex with men. *Journal of the National Medical Association, 97*, 1103-1112.
- Massad, J. (2002). Re-orienting desire: The gay international and the Arab world. *Public Culture, 14*, 361-386.
- Masters, W. H., & Johnson, V. E. (1979). *Homosexuality in perspective*. Boston: Little, Brown.
- Mathy, R., & Drescher, J. (Eds.). (2008). Childhood gender nonconformity and the development of adult homosexuality [Special Issue]. *Journal of Gay & Lesbian Mental Health, 12*(1/2), 1-165.
- Maton, K. I. (2000). Mutual-help and self-help. In A. E. Kazdin (Ed.), *Encyclopedia of psychology* (pp. 369-373). Washington, DC: American Psychological Association and Oxford University Press.
- Mattison, A. M., & McWhirter, D. P. (1995). Lesbians, gay men, and their families: Some therapeutic issues. *Psychiatric Clinics of North America, 18*, 123-137.

- Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology and Psychotherapy*, 14, 317-327.
- Mays, V. M., & Cochran, S. D. (1998). Kinsey and male homosexuality in the African-American population: A question of fit. *Sexualities*, 1, 98-100.
- Mays, V. M., & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health*, 91, 1869-1876.
- Mays, V. M., Cochran, S. D., & Barnes, N. W. (2007). Race, race-based discrimination, and health outcomes among African Americans. *Annual Review of Psychology*, 58, 201-225.
- Mays, V. M., Cochran, S. D., & Zamudio, A. (2004). HIV prevention research: Are we meeting the needs of African American men who have sex with men? *Journal of Black Psychology*, 30, 78-105.
- McCarn, S. R., & Fassinger, R. E. (1996). Revisioning sexual minority identity formation: A new model of lesbian identity and its implications for counseling and research. *The Counseling Psychologist*, 24, 508-534.
- McClennon, J. (1994). *Wondrous events*. Philadelphia: University of Pennsylvania Press.
- McConaghy, N. (1969). Subjective and penile plethysmograph responses following aversion-relief and Apomorphine aversion therapy for homosexual impulses. *British Journal of Psychiatry*, 115, 723-730.
- McConaghy, N. (1976). Is a homosexual orientation irreversible? *British Journal of Psychiatry*, 129, 556-563.
- McConaghy, N. (1987). Heterosexuality/homosexuality: Dichotomy or continuum. *Archives of Sexual Behavior*, 16, 411-424.
- McConaghy, N. (1999). Time to abandon the gay/heterosexual dichotomy? *Archives of Sexual Behavior*, 34, 1-2.
- McConaghy, N. (2003). Peer commentaries on Spitzer: Penile plethysmography and change in sexual orientation. *Archives of Sexual Behavior*, 32, 444-445.
- McConaghy, N., Armstrong, M. S., & Blaszczyński, A. (1981). Controlled comparison of aversive therapy and covert sensitization in compulsive homosexuality. *Behaviour Research & Therapy*, 19, 425-434.
- McConaghy, N., & Barr, R. F. (1973). Classical, avoidance, and backward conditioning treatment of homosexuality. *British Journal of Psychiatry*, 122, 151-162.
- McConaghy, N., Buhrich, N., & Silove, D. (1994). Opposite sex-linked behaviors and homosexual feelings in the predominantly heterosexual male majority. *Archives of Sexual Behavior*, 23, 565-577.
- McConaghy, N., Proctor, D., & Barr, R. (1972). Subjective and penile plethysmography responses to aversion therapy for homosexuality: A partial replication. *Archives of Sexual Behavior*, 2, 65-79.
- McCord, W., McCord, J., & Thurber, E. (1962). Some effects of parental absence on male children. *Journal of Abnormal and Social Psychology*, 64, 361-369.
- McCormick, J. (2006). Transition Beirut: Gay identities, lived realities: The balancing act in the Middle East. In S. Khalaf, & J. Gagnon (Eds.), *Sexuality in the Arab World* (pp. 243-260). London: SAQI.
- McCrary, R. E. (1973). A forward-fading technique for increasing heterosexual responsiveness in male homosexuals. *Journal of Behavior Therapy & Experimental Psychiatry*, 4, 257-261.
- McCullough, M. E. (1999). Research on religion-accommodative counseling: Review and meta-analysis. *Journal of Counseling Psychology*, 46, 92-98.
- McIntosh, P. (1990). *White privilege: Unpacking the invisible knapsack*. Retrieved August 18, 2009, from www.case.edu/president/aaction/UnpackingTheKnapsack.pdf
- McMinn, L. G. (2005). Sexual identity concerns for Christian young adults: Practical considerations for being a supportive presence and compassionate companion. *Journal of Psychology and Christianity*, 24, 368-377.
- McNemar, Q. (1969). *Psychological statistics* (4th ed.). New York: Wiley.
- Meeus, W., Iedema, J., Helsen, M., & Vollebergh, W. (1999). Patterns of adolescent identity development: Review of literature and longitudinal analysis. *Developmental Review*, 19, 419-461.
- Menveille, E. J. (1998). Gender identity disorder [Letter to the editor]. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 243-244.
- Menveille, J. D., & Tuerk, C. (2002). A support group for parents of gender-nonconforming boys. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41, 1010-1013.
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, 7, 9-25.
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129, 674-697.
- Meyer, I. H., & Wilson, P. A. (2009). Sampling lesbian, gay, and bisexual populations. *Journal of Counseling Psychology*, 56, 23-31.
- Miller, J. B. (1991). The development of a women's sense of self. In J. V. Jordan, A. G. Kaplan, J. B. Miller, I. P. Stiver, & J. L. Surrey (Eds.), *Women's growth in connection: Writings from the Stone Center* (pp. 11-26). New York: Guildford Press.
- Millett, G., Malebranche, D., Mason, B., & Spikes, P. (2005). Focusing "down low": Bisexual Black men, HIV risk and heterosexual transmission. *Journal of the National Medical Association*, 97, 585-595.
- Mintz, E. E. (1966). Overt male homosexuals in combined group and individual treatment. *Journal of Consulting Psychology*, 30, 193-198.

- Minwalla, O., Rosser, B. R. S., Feldman, J., & Varga, C. (2005). Identity experience among progressive gay Muslims in North America: A qualitative study within Al-Fatiha. *Culture, Health & Sexuality*, 7, 113-128.
- Mitchell, S. A. (1978). Psychodynamics, homosexuality, and the question of pathology. *International Journal of Psychoanalysis*, 15, 170-189.
- Mitchell, S. A. (1981). The psychoanalytic treatment of homosexuality: Some technical considerations. *International Review of Psycho-Analysis*, 8, 63-80.
- Miville, M. L., & Ferguson, A. D. (2004). Impossible "choices": Identity and values at a crossroads. *The Counseling Psychologist*, 32, 760-770.
- Moberly, E. (1983). *Homosexuality: A new Christian ethic*. Greenwood, SC: Attic Press.
- Mohr, J. J., & Fassinger, R. E. (2003). Self-acceptance and self-disclosure of sexual orientation in lesbian, gay, and bisexual adults: An attachment perspective. *Journal of Counseling Psychology*, 50, 282-295.
- Molnar, B. E. (1997). Juveniles and psychiatric institutionalization: Toward better due process and treatment review in the United States. *Health and Human Rights*, 2, 98-116.
- Moradi, B., Mohr, J. J., Worthington, R. L., & Fassinger, R. E. (2009). Counseling psychology research on sexual (orientation) minority issues: Conceptual and methodological challenges and opportunities. *Journal of Counseling Psychology*, 56, 5-22.
- Moran, M. E. (2007). *An examination of women's sexuality and spirituality: The effects of conversion therapy—A mixed study*. Unpublished doctoral dissertation, University of Utah, Salt Lake City.
- Morey, M. (2006). The civil commitment of state dependent minors: Resonating discourses that leave her heterosexuality and his homosexuality vulnerable to scrutiny. *New York University Law Review*, 81, 2129.
- Morgan, E. M., & Thompson, E. M. (2006). Young women's sexual experiences within same-sex friendships: Discovering and defining bisexual and bi-curious identity. *Journal of Bisexuality*, 6, 7-34.
- Morris, J. F. (1997). Lesbian coming out as a multidimensional process. *Journal of Homosexuality*, 3, 1-22.
- Morrissey-Kane, E., & Prinz, R. J. (1999). Engagement in child and adolescent treatment: The role of parental cognitions and attributions. *Clinical Child and Family Psychology Review*, 2, 183-198.
- Morrow, D. F. (2003). Cast into the wilderness: The impact of institutionalized religion on lesbians. *Journal of Lesbian Studies*, 7, 109-123.
- Morrow, S. L. (2000). First do no harm: Therapist issues in psychotherapy with lesbian, gay, and bisexual clients. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 137-156). Washington, DC: American Psychological Association.
- Morrow, S. L., & Beckstead, A. L. (2004). Conversion therapies for same-sex attracted clients in religious conflict: Context, predisposing factors, experiences, and implications for therapy. *The Counseling Psychologist*, 32, 641-650.
- Murphy, T. F. (1992). Redirecting sexual orientation: Techniques and justifications. *Journal of Sex Research*, 29, 501-523.
- Murphy, T. F. (1997). *Gay science: The ethics of sexual orientation research*. New York: Columbia University Press.
- Mustanski, B. S., Chivers, M. L., & Bailey, J. M. (2002). A critical review of recent biological research on human sexual orientation. *Annual Review of Sex Research*, 13, 89-140.
- Mutcherson, K. M. (2006). Minor discrepancies: Forging a common understanding of adolescent competence in healthcare decision-making and criminal responsibility. *Nevada Law Journal*, 6, 927.
- Myers, L. J., Speight, S. L., Highlen, P. S., Cox, C. I., Reynolds, A. L., Adams, E. M., & Hanley, P. (1991). Identity development and worldview: Toward an optimal conceptualization. *Journal of Counseling & Development*, 70, 54-63.
- Nahas, O. (2004). Yoesuf: An Islamic idea with Dutch quality. *Journal of Gay and Lesbian Social Services*, 16, 53-64.
- Nakajima, G. A. (2003). The emergence of an international lesbian, gay, and bisexual psychiatric movement. *Journal of Gay & Lesbian Psychotherapy*, 7(1/2), 165-188.
- Nathan, P. E., Stuart, S. P., & Dolan, S. L. (2000). Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis? *Psychological Bulletin*, 126, 964-981.
- National Association of Social Workers. (1997). Policy statement: Lesbian, gay, and bisexual issues [approved by NASW Delegate Assembly, August 1996]. In *Social work speaks: NASW policy* (4th ed., pp. 198-209). Washington, DC: Author.
- National Association of Social Workers. (2000). "Reparative" and "conversion" therapies for lesbians and gay men: Position statement. Retrieved July 7, 2008, from: <http://www.socialworkers.org/diversity/lgb/reparative.asp>
- Nicolosi, J. (1991). *Reparative therapy of male homosexuality*. Northvale, NJ: Jason Aronson.
- Nicolosi, J. (1993). *Healing homosexuality*. Northvale, NJ: Jason Aronson.
- Nicolosi, J. (2003). Finally, recognition of a long-neglected population. *Sexual Behavior*, 32, 445-447.
- Nicolosi, J., Byrd, A. D., & Potts, R. W. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports*, 86, 1071-1088.
- Nicolosi, J., & Nicolosi, L. A. (2002). *A parent's guide to preventing homosexuality*. Downers Grove, IL: InterVarsity Press.

- Nielsen, S. L. (2001). Accommodating religion and integrating religious material during rational emotive behavior therapy. *Cognitive & Behavior Practice*, 8, 29-34.
- Nolen-Hoeksema, S., & Davis, C. G. (2002). Positive responses to loss: Perceiving benefits and growth. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 598-606). New York: Oxford University Press.
- Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.
- Norcross, J.C., & Hill, C.E. (2004). Empirically supported therapy relationships. *The Clinical Psychologist*, 57, 19-24.
- Norman, G. (2003). Hi! How are you? Response shift, implicit theories, and differing epistemologies. *Quality of Life Research*, 12, 238-249.
- O'Connor, N., & Ryan, J. (1993). *Wild desires and mistaken identities: Lesbianism and psychoanalysis*. New York: Columbia University Press.
- Olson, C. (Ed.). (2007). *Celibacy and religious traditions*. New York: Oxford University Press.
- Olyam, S. C., & Nussbaum, M. C. (Eds.). (1998). *Sexual orientation & human rights in American religious discourse*. New York: Oxford University Press.
- Omer, H., & Strenger, C. (1992). The pluralistic revolution: From the one true meaning to an infinity of constructed ones. *Psychotherapy: Theory, Research, Practice, Training*, 29, 253-261.
- Omoto, A., & Kurtzman, H. S. (Eds.). (2006). *Sexual orientation and mental health: Examining identity and development in lesbian, gay, and bisexual people*. Washington, DC: American Psychological Association.
- O'Neil, J. M. (2008). Summarizing 25 years of research on men's gender role conflict using the gender role conflict scale: New research paradigms and clinical implications. *The Counseling Psychologist*, 36, 358-445.
- O'Neill, C., & Ritter, K. (1992). *Coming out within: Stages of spiritual awakening for lesbians and gay men*. San Francisco: Harper.
- Ortiz, E. T., & Scott, P. R. (1994). Gay husbands and fathers: Reasons for marriage among homosexual men. *Journal of Gay and Lesbian Social Services*, 1, 59-71.
- Oser, F. K. (1991). Toward a logic of religious development. In K. N. Nipkow, J. W. Fowler, & F. Schweitzer (Eds.), *Stages of religious development: Implications for church, education, and society* (pp. 37-64). New York: Crossroad Publishing.
- O'Sullivan, L., & McCrudden, M. C., & Tolman, D. L. (2006). To your sexual health! Incorporating sexuality into the health perspective. In J. Worell & C. D. Goodheart (Eds.), *Handbook of girls' and women's psychological health: Gender and well-being across the lifespan* (pp. 192-199). New York: Oxford University Press.
- Ovesey, L. (1969). *Homosexuality and pseudohomosexuality*. New York: Science House.
- Oxford American Dictionary*. (2007). New York: Oxford University Press.
- Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin*, 133, 328-345.
- Pachankis, J. E., & Goldfried, M. R. (2004). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychotherapy: Theory, Research, Practice, Training*, 41, 227-246.
- Pachankis, J. E., Goldfried, M. R., & Ramrattan, M. E. (2008). Extension of the rejection sensitivity construct to the interpersonal functioning of gay men. *Journal of Consulting and Clinical Psychology*, 76, 306-317.
- Paloutzian, R.F., & Park, C.L. (Eds.). (2005). *Handbook of the psychology of religion and spirituality*. New York: Guilford Press.
- Pan American Health Organization & World Health Organization. (2000, May 19-22). *Promotion of sexual health: Recommendations for action*. Proceedings of a regional consultation convened in collaboration with the World Association for Sexology, Antigua, Guatemala. Retrieved from www.paho.org/English/HCP/HCA/PromotionSexualHealth.pdf
- Pargament, K. I. (2002). The bitter and the sweet: An evaluation of the costs and benefits of religiousness. *Psychological Inquiry*, 13, 168-181.
- Pargament, K. I., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2001). Religious struggle as a predictor of mortality among medically ill elderly patients: A two-year longitudinal study. *Archives of Internal Medicine*, 161, 1881-1885.
- Pargament, K. I., & Mahoney, A. (2002). Spirituality: Discovering and conserving the sacred. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 646-659). New York: Oxford University Press.
- Pargament, K. I., & Mahoney, A. (2005). Sacred matters: Sanctification as a vital topic for the psychology of religion. *The International Journal for the Psychology of Religion*, 15, 179-198.
- Pargament, K. I., Maygar-Russell, G. M., & Murray-Swank, N. A. (2005). The sacred and the search for significance: Religion as a unique process. *Journal of Social Issues*, 61, 665-687.
- Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 37, 710-724.
- Park, C. L. (2005). Religion as a meaning-making framework in coping with life stress. *Journal of Social Issues*, 61, 707-729.
- Patterson, C. J. (2008). Sexual orientation across the lifespan: Introduction to the special section. *Developmental Psychology*, 44, 1-4.

- Pattison, E. M., & Pattison, M. L. (1980). "Ex-gays": Religiously mediated change in homosexuals. *American Journal of Psychiatry*, 137, 1553-1562.
- Paul, W., Weinrich, J. D., Gonsiorek, J. C., & Hotvedt, M. E. (Eds.). (1982). *Homosexuality: Social, psychological, and biological issues*. Beverly Hills, CA: Sage.
- Peplau, L. A., & Garnets, L. D. (2000). A new paradigm for understanding women's sexuality and sexual orientation. *Journal of Social Issues*, 56, 329-350.
- Peplau, L. A., & Fingerhut, A. W. (2007). The close relationships of lesbians and gay men. *Annual Review of Psychology*, 58, 405-424.
- Perez, R. M., DeBord, K. A., & Bieschke, K. J. (Eds.). (2000). *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients*. Washington, DC: American Psychological Association.
- Perrin, E. C. (2002). *Sexual orientation in child and adolescent health care*. New York: Kluwer/Plenum.
- Peters, A. J. (2003). *Isolation or inclusion: Creating safe spaces for lesbian and gay youth, families in society* (Vol. 84, pp. 331-337). Milwaukee, WI: Alliance for Children & Families.
- Peters, D. K., & Cantrell, P. J. (1991). Factors distinguishing samples of lesbian and heterosexual women. *Journal of Homosexuality*, 21, 1-15.
- Petticrew, M. (2001). Systematic reviews from astronomy to zoology: Myths and misconceptions. *British Medical Journal*, 322, 98-101.
- Pew Forum on Religion and Public Life. (2003). *Republicans unified, Democrats split on gay marriage: Religious beliefs underpin opposition to homosexuality*. Washington, DC: Pew Research Center. Retrieved March 24, 2009, from <http://pewforum.org/docs/index.php?DocID=37>.
- Pew Forum on Religion and Public Life. (2008). *U.S. Religious Landscape Survey*. Washington, DC: Pew Research Center. Retrieved March 18, 2008, from <http://religions.pewforum.org/reports>
- Pharr, S. (1988). *Homophobia: A weapon of sexism*. New York: Chardon Press.
- Phillips, J. C. (2004). A welcome addition to the literature: Non-polarized approaches to sexual orientation and religiosity. *The Counseling Psychologist*, 32, 771-777.
- Phy-Olsen, A. (2006). *Same-sex marriage*. Santa Barbara, CA: Greenwood Press.
- Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. F. Levant & W. S. Pollack (Eds.), *A new psychology of men* (pp. 11-32). New York: Plenum.
- Plugge-Foust, C., & Strickland, G. (2000). Homophobia, irrationality, and Christian ideology: Does a relationship exist? *Journal of Sex Education and Therapy*, 25, 240-244.
- Ponseti, J., Bosinski, H. A., Wolff, S., Peller, M., Jansen, O., Mehdorn, H. M., et al. (2006). A functional endophenotype for sexual orientation in humans. *NeuroImage*, 33, 825-833.
- Ponticelli, C. M. (1999). Crafting stories of sexual identity reconstruction. *Social Psychology Quarterly*, 62, 157-172.
- Pope, K. S., & Vasquez, M. J. T. (2007). *Ethics in psychotherapy and counseling: A practical guide* (3rd ed.). San Francisco: Jossey-Bass.
- Porter, N. (1995). Therapist self-care: A proactive ethical approach. In E. J. Rave and C. C. Larsen (Eds.), *Ethical decision making in therapy: A feminist approach* (pp. 247-266). New York: Guilford Press.
- Probst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Counseling Psychology*, 60, 94-103.
- Quinn, J. T., Harbison, J. J. M., & McAllister, H. (1970). An attempt to shape human penile responses. *Behaviour Research & Therapy*, 8, 213-216.
- Quinsey, V. L., & Lalumiere, M. L. (2001). *Assessment of sexual offenders against children*. Thousand Oaks, CA: Sage.
- Radkowsky, M., & Siegel, L. J. (1997). The gay adolescent: Stressors, adaptations, and psychosocial interventions. *Clinical Psychology Review*, 17, 191-216.
- Rado, S. (1940). A critical examination of the concept of bisexuality. *Psychosomatic Medicine*, 2, 459-467.
- Rahman, Q., & Wilson, G. D. (2005). *Born gay: The psychobiology of sexual orientation*. London: Peter Owens.
- Redding, R. E. (1993). Children's competence to provide informed consent for mental health treatment. *Washington & Lee Law Review*, 50, 695.
- Rehm, L. P., & Rozensky, R. H. (1974). Multiple behavior therapy techniques with a homosexual client: A case study. *Journal of Behavior Therapy & Experimental Psychiatry*, 5, 53-57.
- Reich, K. H. (1991). The role of complementary reasoning in religious development. *New Directions for Child Development*, 52, 77-89.
- Rekers, G. A. (1979). Sex-role behavior change: Intrasubject studies of boyhood gender disturbance. *Journal of Psychology*, 103, 255-269.
- Rekers, G. A. (1981). Childhood sexual identity disorders. *Medical Aspects of Human Sexuality*, 15, 141-142.
- Rekers, G. A. (1982). *Shaping your child's sexual identity*. Grand Rapids, MI: Baker Book House.
- Rekers, G. A., Bentler, P. M., Rosen, A. C., & Lovaas, O. I. (1977). Child gender disturbances: A clinical rationale for intervention. *Psychotherapy: Theory, Research, & Practice*, 14, 2-11.
- Rekers, G. A., Kilgus, R., & Rosen, A. C. (1990). Long-term effects of treatment for childhood gender disturbance. *Journal of Psychology and Human Sexuality*, 3, 121-153.
- Rekers, G. A., & Lovaas, O. I. (1974). Behavioral treatment of deviant sex-role behaviors in a male child. *Journal of Applied Behavioral Analysis*, 7, 173-190.

- Remafedi, G., Farrow, J. A., & Deisher, R. W. (1991). Risk factors of attempted suicide in gay and bisexual youth. *Pediatrics*, 87, 869-875.
- Richards, P. S., & Bergin, A. E. (Eds.). (2000). *Handbook of psychotherapy and religious diversity*. Washington, DC: American Psychological Association.
- Richards, P. S., & Bergin, A. E. (Eds.). (2004). *Casebook for a spiritual strategy in counseling and psychotherapy*. Washington, DC: American Psychological Association.
- Richards, P. S., & Bergin, A.E. (2005). *A spiritual strategy for counseling and psychotherapy*. Washington, DC: American Psychological Association.
- Richards, P. S., Berrett, M. E., Hardman, R. K., & Eggett, D. L. (2006). Comparing efficacy of spirituality, cognitive, and emotional support groups for treating eating disorder inpatients. *Eating Disorders*, 14, 401-415.
- Ritter, K. Y., & O'Neill, C. W. (1989). Moving through loss: The spiritual journey of gay men and lesbian women. *Journal of Counseling & Development*, 68, 9-14.
- Ritter, K. Y., & O'Neill, C. W. (1995). Moving through loss: The spiritual journey of gay men and lesbian women. In M. T. Burke & J. G. Miranti (Eds.), *Counseling: The spiritual dimension* (pp. 126-141). Alexandria, VA: American Counseling Association.
- Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York: Guilford Press.
- Robb, H.B. (2001). Facilitating rational emotive behavior therapy by including religious beliefs. *Cognitive & Behavior Practice*, 8, 34-39.
- Robinson, J. W. (1998). *Understanding the meaning of change for married Latter-Day Saint men with histories of homosexual activity*. Unpublished doctoral dissertation, Brigham Young University, Provo.
- Roccas, S. (2005). Religion and value systems. *Journal of Social Issues*, 61, 747-759.
- Rodriguez, E. M. (2006). At the intersection of church and gay: Religion, spirituality, conflict, and integration in gay, lesbian, and bisexual people of faith. *Dissertation Abstracts International*, 67(3-B), 1742. (UMI No. 3213142)
- Rodriguez, E. M., & Ouellette, S. C. (2000). Gay and lesbian Christians: Homosexual and religious identity integration in the members and participants of a gay-positive church. *Journal for the Scientific Study of Religion*, 39, 334-347.
- Roffman, D. M. (2000). A model for helping schools address policy options regarding gay and lesbian youth. *Journal of Sex Education and Therapy*, 25(2/3), 130-136.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103.
- Rogers, C. (1961). *On becoming a person*. Boston: Houghton Mifflin.
- Rosario, M., Rotheram-Borus, M. J., & Reid, H. (1996). Gay-related stress and its correlates among gay and bisexual male adolescents of predominantly Black and Hispanic background. *Journal of Community Psychology*, 24, 136-159.
- Rosario, M., Schrimshaw, E., Hunter, J. (2004). Ethnic/racial differences in the coming-out process of lesbian, gay, and bisexual youths: A comparison of sexual identity development over time. *Cultural Diversity and Ethnic Minority Psychology*, 10, 215-228.
- Rosario, M., Schrimshaw, E., Hunter, J., & Braun, L. (2006, February). Sexual identity development among lesbian, gay, and bisexual youths: Consistency and change over time. *Journal of Sex Research*, 43, 46-58.
- Rosario, M., Yali, A. M., Hunter, J., & Gwadz, M. V. (2006). Religion and health among lesbian, gay, and bisexual youths: An empirical investigation and theoretical explanation. In A. Omoto & H. Kurtzman (Eds.), *Sexual orientation and mental health: Examining identity and development in lesbian, gay, and bisexual people* (pp. 117-141). Washington, DC: American Psychological Association.
- Rose, S. M., & Zand, D. (2000). Lesbian dating and courtship from young adulthood to midlife. *Journal of Gay and Lesbian Social Services*, 11(2-3), 77-104.
- Rose, S. M., & Zand, D. (2002). Lesbian dating and courtship from young adulthood to midlife. *Journal of Lesbian Studies*, 6, 85-109.
- Rosik, C. H. (2001). Conversion therapy revisited: Parameters and rationale for ethical care. *Journal of Pastoral Counseling*, 55, 47-67.
- Rosik, C. H. (2003). Motivational, ethical, and epistemological foundations in the treatment of unwanted homoerotic attractions. *Journal of Marital and Family Therapy*, 29, 13-28.
- Rosik, C. H. (2007). Ideological concerns in the operationalization of homophobia: Part II. The need for interpretive sensitivity with conservatively religious persons. *Journal of Psychology & Theology*, 35, 132-144.
- Rosner, R. (2004a). Adolescents' rights to refuse treatment. *Adolescent Psychiatry*. Retrieved October 10, 2007, from http://findarticles.com/p/articles/mi_qa3882/is_200401/ai_n9383804
- Rosner, R. (2004b). A four-step model for legal regulation of the practice of adolescent psychiatry and adolescents' rights to refuse treatment. *Adolescent Psychiatry*. Retrieved October 10, 2007, from http://findarticles.com/p/articles/mi_qa3882/is_200401/ai_n9383804
- Ross, M. A. (1989). Relation of implicit theories to the construction of personal histories. *Psychological Review*, 96, 341-357.
- Ross, M. W. (1989). Married homosexual men: Prevalence and background. *Marriage & Family Review*, 14(3-4), 35-57.

- Rostosky, S. S., Riggle, E. D. B., Horne, S. G., & Miller, A. D. (2009). Marriage amendments and psychological distress in lesbian, gay, and bisexual (LGB) adults. *Journal of Counseling Psychology*, 59, 56-66.
- Russell, G. M., & Bohan, J. S. (2007). Liberating psychotherapy: Liberation psychology and psychotherapy with LGBT clients. *Journal of Gay and Lesbian Psychology*, 11(3/4), 59-77.
- Rust, P. C. (1996). Managing multiple identities: Diversity among bisexual women and men. In B. A. Firestein (Ed.), *Bisexuality: The psychology and politics of an invisible minority* (pp. 53-83). Thousand Oaks, CA: Sage.
- Rust, P. C. (2003). Reparative science and social responsibility: The concept of a malleable core as theoretical challenge and psychological comfort. *Archives of Sexual Behavior*, 32, 449-451.
- Ryan, C. (2001). Counseling lesbian, gay, and bisexual youths. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian, gay, and bisexual identities and youth* (pp. 224-250). New York: Oxford University Press.
- Ryan, C., & Diaz, R. (2005, February). *Family responses as a source of risk and resiliency for LGBT youth*. Paper presented at the Child Welfare League of America Preconference Institute, Washington, DC.
- Ryan, C., & Futterman, D. (1997). Lesbian and gay youth: Care and counseling. *Adolescent Medicine: State of the Art Reviews*, 8, 207-324.
- Ryan, C., Huebner, D., Diaz, R.M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 129, 346-352.
- Ryan, R. M. (1995). Psychological needs and the facilitation of integrative processes. *Journal of Personality*, 63, 397-427.
- Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R.B., & Richardson, W. S. (1996). Evidence-based medicine: What it is and what it isn't. *British Medical Journal*, 312(7023), 71-72.
- Safren, S. A., & Heimberg, R. G. (1999). Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *Journal of Consulting and Clinical Psychology*, 67, 859-866.
- Safren, S. A., & Rogers, T. (2001). Cognitive-behavioral therapy with gay, lesbian, and bisexual clients. *Journal of Clinical Psychology*, 57, 629-643.
- Saldaina, D. H. (1994). Acculturative stress: Minority status and distress. *Hispanic Journal of Behavioral Sciences*, 16, 116-128.
- Salzburg, S. (2004). Learning that an adolescent child is gay or lesbian: The parent experience. *Social Work*, 49, 109-118.
- Salzburg, S. (2007). Narrative therapy pathways for re-authoring with parents of adolescents coming-out as lesbian, gay, and bisexual. *Contemporary Family Therapy*, 29, 57-69.
- Sanchez, D. (2007). "Ex-Gay" movement making strides. *Southern Poverty Law Center Intelligence Report*. Retrieved from www.splcenter.org/intel/intelreport/article.jsp?aid=844
- Sandford, D. A., Tustin, R. D., & Priest, P. N. (1975). Increasing heterosexual arousal in two adult male homosexuals using a differential reinforcement procedure. *Behavior Therapy*, 6, 689-696.
- Sandfort, T. G. M. (2003). Studying sexual orientation change. *Journal of Gay & Lesbian Psychotherapy*, 7, 15-29.
- Savic, I., & Lindstrom, P. (2008). PET and MRI show differences in cerebral asymmetry and functional connectivity between homo- and heterosexual subjects. *Proceedings of the National Academy of Sciences*. Retrieved from <http://www.pnas.org/content/105/27/9403.full>
- Savin-Williams, R. C. (1989). Parental influences on the self-esteem of gay and lesbian youths: A reflected appraisals model. *Journal of Homosexuality*, 17(1/2), 93-109.
- Savin-Williams, R. C. (1994). Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: Associations with school problems, running away, substance abuse, prostitution, and suicide. *Journal of Consulting and Clinical Practice*, 62, 261-269.
- Savin-Williams, R. C. (1998). The disclosure to families of same-sex attractions by lesbian, gay, and bisexual youths. *Journal of Research on Adolescence*, 8, 49-68.
- Savin-Williams, R. C. (2004). Boy-on-boy sexuality. In N. Way & J. Y Chu (Eds.), *Adolescent boys: Exploring diverse cultures of boyhood* (pp. 271-292). New York: New York University Press.
- Savin-Williams, R. C. (2005). *The new gay teenager*. Cambridge, MA: Harvard University Press.
- Savin-Williams, R. C., & Cohen, K. M. (2004). Homoerotic development during childhood and adolescence. *Child and Adolescent Psychiatric Clinics of North America*, 13, 529-549.
- Sbordone, A. J. (2003). An interview with Charles Silverstein, PhD. *Journal of Gay & Lesbian Psychotherapy*, 7, 49-61.
- Scasta, D. (1998). Issues in helping people come out. *Journal of Gay and Lesbian Psychotherapy*, 2, 89-98.
- Schaeffer, K. W., Hyde, R. A., Kroencke, T., McCormick, B., & Nottebaum, L. (2000). Religiously motivated sexual orientation change. *Journal of Psychology & Christianity*, 19, 61-70.
- Schilder, A. J., Kennedy, C., Goldstone, I., Ogden, R. D., Hogg, R. S., & O'Shaughnessy, M. V. (2001). "Being dealt with as a whole person." Care seeking and adherence: The benefits of culturally competent care. *Social Science & Medicine*, 52, 1643-1659.
- Schneider, M. S. (1991). Developing services for lesbian and gay adolescents. *Canadian Journal of Community Mental Health*, 10, 133-151.

- Schneider, M. S., Brown, L. S., & Glassgold, J. M. (2002). Implementing the resolution on appropriate therapeutic responses to sexual orientation: A guide for the perplexed. *Professional Psychology: Research and Practice*, 33, 265-276.
- Schnoor, R. F. (2006). Being gay and Jewish: Negotiating intersecting identities. *Sociology of Religion* 67, 43-60.
- Schreier, B. A. (1998). Of shoes, and ships, and sealing wax: The faulty and specious assumptions of sexual reorientation therapies. *Journal of Mental Health Counseling*, 20, 305-314.
- Schroeder, M., & Shidlo, A. (2001). Ethical issues in sexual orientation conversion therapies: An empirical study of consumers. *Journal of Gay & Lesbian Psychotherapy*, 5(3/4), 131-166.
- Schuck, K. D., & Liddle, B. J. (2001). Religious conflicts experienced by lesbian, gay, and bisexual individuals. *Journal of Gay and Lesbian Psychotherapy*, 5, 63-82.
- Schulte, L. J., & Battle, J. (2004). The relative importance of ethnicity and religion in predicting attitudes toward gays and lesbians. *Journal of Homosexuality*, 47, 127-142.
- Schwartz, B. (2000). Self-determination: The tyranny of freedom. *American Psychologist*, 55, 79-88.
- Schwartz, C. E., & Rapkin, B. D. (2004). Reconsidering the psychometrics of quality of life assessment in light of response shift and appraisal. *Health Quality Life Outcomes*, 2, 16.
- Schwartz, J. P., & Lindley, L. D. (2005). Religious fundamentalism and attachment: Predictors of homophobia. *International Journal for the Psychology of Religion*, 15, 145-157.
- Schwartzberg, S., & Rosenberg, L. G. (1998). Being gay and being male: Psychotherapy with gay and bisexual men. In W. S. Pollack & R. F. Levant (Eds.), *New psychotherapy for men* (pp. 259-281). New York: Wiley.
- Schwarz, N., & Clore, G. L. (1985). Mood as information: 20 years later. *Psychological Inquiry*, 14, 196-303.
- Schwarz, N., Hippler, H. J., Deutsch, B., & Strack, F. (1985). Response scales: Effects of category range on reported behavior and comparative judgments. *Public Opinion Quarterly*, 49, 388-395.
- Segal, B., & Sims, J. (1972). Covert sensitization with a homosexual: A controlled replication. *Journal of Consulting & Clinical Psychology*, 39, 259-263.
- Sell, R. L. (1997). Defining and measuring sexual orientation: A review. *Archives of Sexual Behavior*, 26, 643-658.
- Selvidge, M. M. D., Matthews, C. R., & Bridges, S. K. (2008). The relationship of minority stress and flexible coping to psychological well being in lesbian and bisexual women. *Journal of Homosexuality*, 55, 450-470.
- Seto, M. C. (2004). Pedophilia and sexual offenses against children. *Annual Review of Sex Research*, 15, 321-361.
- Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Boston: Houghton Mifflin.
- Shafranske, E. P. (2000). Religious involvement and professional practices of psychiatrists and other mental health professionals. *Psychiatric Annals*, 30, 525-532.
- Shallenberger, D. (1996). Reclaiming the spirit: The journeys of gay men and lesbian women toward integration. *Qualitative Sociology*, 19, 195-215.
- Shannon, J. W., & Woods, W. J. (1991). Affirmative psychotherapy for gay men. *The Counseling Psychologist*, 19, 197-215.
- Sherry, A. (2007). Internalized homophobia and adult attachment: Implications for clinical practice. *Psychotherapy: Theory, Research, Practice, Training*, 44, 219-225.
- Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumer's report. *Professional Psychology: Research and Practice*, 33, 249-259.
- Shidlo, A., Schroeder, M., & Drescher, J. (Eds.). (2002). *Sexual conversion therapy: Ethical, clinical, and research perspectives* (pp. 87-115). New York: Haworth Press.
- Shively, M. G., & DeCecco, J. P. (1977). Components of sexual identity. *Journal of Homosexuality*, 3, 41-48.
- Siegelman, M. (1974). Parental background of male homosexuals and heterosexuals. *Archives of Sexual Behavior*, 3, 3-18.
- Siegelman, M. (1979). Adjustment of homosexual and heterosexual women: A cross-national replication. *Archives of Sexual Behavior*, 8, 371-378.
- Siegelman, M. (1981). Parental backgrounds of homosexual and heterosexual men: A cross national replication. *Archives of Sexual Behavior*, 10, 505-513.
- Silberman, I. (2005). Religion as a meaning system: Implications for the new millennium. *Journal of Social Issues*, 61(4), 641-663.
- Silverstein, C. (1991). Psychological and medical treatments of homosexuality. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 101-114). Newbury Park, CA: Sage.
- Silverstein, C. (2007). Wearing two hats: The psychologist as activist and therapist. *Journal of Gay & Lesbian Psychotherapy*, 11(3/4), 9-35.
- Sipe, A. W. R. (1990). *A secret world: Sexuality and the search for celibacy*. New York: Routledge.
- Sipe, A. W. R. (2003). *Celibacy in crisis: A secret world revisited*. New York: Brunner/Routledge.
- Slater, B. R. (1988). Essential issues in working with lesbian and gay youth. *Professional Psychology: Research and Practice*, 2, 226-235.
- Smith, G., Bartlett, A. & King, M. (2004). Treatments of homosexuality in Britain since 1950—an oral history: The experience of patients. *British Medical Journal*, 328(7437), 427-429.

- Smith, T. B., McCullough, M. E., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin*, 129(4), 614-636.
- Sobocinski, M. R. (1990). Ethical principles in the counseling of gay and lesbian adolescents: Issues of autonomy, competence, and confidentiality. *Professional Psychology: Research and Practice*, 21, 240-247.
- Socarides, C. W. (1968). *The overt homosexual*. New York: Grune & Stratton.
- Society for Prevention Research. (2005). *Standards of evidence: Criteria for efficacy, effectiveness and dissemination*. Retrieved from <http://www.preventionresearch.org/commlmon.php#SofE>
- Solyom, L., & Miller, S. (1965). A differential conditioning procedure as the initial phase of behavior therapy of homosexuality. *Behaviour Research and Therapy*, 3, 147-160.
- Sophie, J. (1987). Internalized homophobia and lesbian identity. *Journal of Homosexuality*, 14(1/2), 53-65.
- Southern Poverty Law Center. (2005, Spring). *A might army*. Retrieved February 2, 2009, from www.splcenter.org/intel/intelreport/article.jsp?aid=524
- Sperry, L., & Shafranske, E. P. (2004). *Spiritually oriented psychotherapy*. Washington, DC: American Psychological Association.
- Spilka, B., Hood, R., Hunsberger, B., & Gorsuch, R. (2003). *The psychology of religion: An empirical approach* (3rd ed.). New York: Guilford Press.
- Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? Two hundred participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior*, 32, 403-417.
- Sprangers, M. (1989). Subject bias and the retrospective pretest in retrospect. *Bulletin of the Psychonomic Society*, 27, 11-14.
- Stålström, O., & Nissinen, J. (2003). The Spitzer Study and the Finnish Parliament. *Journal of Gay & Lesbian Psychotherapy*, 7, 83-95.
- Steenbarger, B. N. (1991). All the world is not a stage: Emerging contextualistic themes in counseling and development. *Journal of Counseling & Development*, 70, 288-296.
- Stein, E. (1999). *The mismeasure of desire: The science, theory, and ethics of sexual orientation*. New York: Oxford University Press.
- Stevenson, I., & Wolpe, J. (1960). Recovery from sexual deviations through overcoming nonsexual neurotic responses. *American Journal of Psychiatry*, 116, 737-742.
- Stokes, J. P., Miller, R. L., & Mundhenk, R. (1998). Toward an understanding of behaviourally bisexual men: The influence of context and culture. *The Canadian Journal of Human Sexuality*, 7, 101-114.
- Stone, K. C. (2008). Sexual messages, self-schema, and contentment: An influential threesome for women's sexuality? *Dissertation Abstracts International: Section B: Sciences and Engineering*, 68(8-B), 5639. (UMI No. 3276731)
- Storms, M. D. (1980). Theories of sexual orientation. *Journal of Personality and Social Psychology*, 38, 783-792.
- Streib, H. (2001). Faith development theory revisited: The religious styles perspective. *International Journal for the Psychology of Religion*, 11, 143-158.
- Streib, H. (2005). Faith development research revisited: Accounting for diversity in structure, content, and narrativity of faith. *International Journal for the Psychology of Religion*, 15, 99-121.
- Sue, S., & Zane, N. (2006). Ethnic minority populations have been neglected by evidence-based practices. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 329-337). Washington, DC: American Psychological Association.
- Surrey, J. L. (1991). The "self-in-relation": A theory of women's development. In J. V. Jordan, A. G. Kaplan, J. B. Miller, I. P. Stiver, & J. L. Surrey (Eds.), *Women's growth in connection: Writings from the Stone Center* (pp. 51-66). New York: Guilford Press.
- Szalacha, L. A. (2003). Safer sexual diversity climates: Lessons learned from an evaluation of Massachusetts Safe Schools Program for Gay and Lesbian Students. *American Journal of Education*, 110, 58-88.
- Szymanski, D. M., & Carr, E. R. (2008). The roles of gender role conflict and internalized heterosexism in gay and bisexual men's psychological distress: Testing two mediation models. *Journal of Men & Masculinity*, 9, 40-54.
- Szymanski, D. M., & Kashubeck-West, S. (2008). Internalized heterosexism: Clinical implications and training considerations. *The Counseling Psychologist*, 36, 615-630.
- Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008). Internalized heterosexism: A historical and theoretical overview. *The Counseling Psychologist*, 36, 510-524.
- Tan, E. (2008). Mindfulness in sexual identity therapy: A case study. *Journal of Psychology and Christianity*, 27, 274-278.
- Tanner, B. A. (1974). A comparison of automated aversive conditioning and a waiting list control in the modification of homosexual behavior in males. *Behavior Therapy*, 5, 29-32.
- Tanner, B. A. (1975). Avoidance training with and without booster sessions to modify homosexual behavior in males. *Behavior Therapy*, 6, 649-653.
- Taylor, S. (1983). Adjustment to threatening events: A theory of cognitive adaptation. *American Psychologist*, 38, 1161-1173.
- Thompson, E. M., & Morgan, E. M. (2008). "Mostly straight" young women: Variations in sexual behavior and identity development. *Developmental Psychology*, 44, 15-21.

- Thorpe, J. G., Schmidt, E., Brown, P. T., & Castell, D. (1964). Aversion-relief therapy: A new method for general application. *Behaviour Research & Therapy*, 2, 71-82.
- Thorpe, J. G., Schmidt, E., & Castell, D. (1963). A comparison of positive and negative (aversive) conditioning in the treatment of homosexuality. *Behaviour Research & Therapy*, 1, 357-362.
- Throckmorton, W. (2002). Initial empirical and clinical findings concerning the change process for ex-gays. *Professional Psychology: Research and Practice*, 33, 242-248.
- Throckmorton, W., & Welton, G. (2005). Counseling practices as they relate to ratings of helpfulness by consumers of sexual reorientation therapy. *Journal of Psychology and Christianity*, 24, 332-342.
- Throckmorton, W. & Yarhouse, M. A. (2006). *Sexual identity therapy: Practice guidelines for managing sexual identity conflicts*. Unpublished paper. Retrieved August 21, 2008, from <http://wthrockmorton.com/wp-content/uploads/2007/04/sexualidentitytherapyframeworkfinal.pdf>
- Thumma, S. (1991). Negotiating a religious identity: The case of the gay evangelical. *Sociological Analysis*, 52, 333-347.
- Toro-Alfonso, J. (2007, August). *Latino perspectives on sexual orientation: The desire that we do not dare to name*. Retrieved September 21, 2007, from www.apa.org/pi/oema/homepage.html
- Townes, B. D., Ferguson, M. D., & Gillem, S. (1976). Differences in psychological sex, adjustment, and familial influences among homosexual and nonhomosexual populations. *Journal of Homosexuality*, 1, 261-272.
- Tozer, E. E., & Hayes, J. A. (2004). The role of religiosity, internalized homonegativity, and identity development: Why do individuals seek conversion therapy? *The Counseling Psychologist*, 32, 716-740.
- Tozer, E. E., & McClanahan, M. K. (1999). Treating the purple menace: Ethical considerations of conversion therapy and affirmative alternatives. *The Counseling Psychologist*, 27, 722-742.
- Treadway, L., & Yoakum, J. (1992). Creating a safer school environment for lesbian and gay students. *Journal of School Health*, 352-357.
- Tremble, B., Schneider, M., & Appathurai, C. (1989). Growing up gay or lesbian in a multicultural context. In G. H. Herdt (Ed.), *Gay and lesbian youth* (pp. 253-267). Ithaca, NY: Haworth Press.
- Trenholm, P., Trent, J., & Compton, W. C. (1998). Negative religious conflict as a predictor of panic disorder. *Journal of Clinical Psychology*, 54, 59-65.
- Treyger, S., Ehlers, N., Zajicek, L., & Trepper, T. (2008). Helping spouses cope with partners coming out: A solution-focused approach. *American Journal of Family Therapy*, 36, 30-47.
- Troiden, R. R. (1988). Homosexual identity development. *Journal of Adolescent Health Care*, 9, 105-113.
- Troiden, R. R. (1989). The formation of homosexual identities. *Journal of Homosexuality*, 17(1-2), 43-73.
- Troiden, R. R. (1993). The formation of homosexual identities. In L. Garnets & D. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male experiences* (pp. 191-217). New York: Columbia University Press.
- Trujillo, A. (2000). Psychotherapy with Native Americans: A view into the role of religion and spirituality. In P. S. Richards & A. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 445-466). Washington, DC: American Psychological Association.
- Tyler, F. B., Pargament, K. I., & Gatz, M. (1983). The resource collaborator role: A model for interactions involving psychologists. *American Psychologist*, 38, 388-398.
- Ullerstam, L. (1966). *The erotic minorities: A Swedish view*. New York: Grove.
- Van Voorst, R. E. (Ed.). (2005). Homosexuality and the church. *Reformed Review: A Theological Journal of Western Theological Seminary*, 59(1).
- Vasey, P. L., & Rendall, D. (2003). Sexual diversity and change along a continuum of bisexual desire. *Archives of Sexual Behavior*, 32, 453-455.
- Wakefield, J. C. (2003). Sexual reorientation therapy: Is it ever ethical? Can it ever change sexual orientation? *Archives of Sexual Behavior*, 32, 457-461.
- Walters, K. L., Evans-Campbell, T., Simoni, J. M., Ronquillo, T., & Bhuyan, R. (2006). My spirit in my heart: Identity experiences and challenges among American Indian two-spirit women. *Journal of Lesbian Studies*, 10(1/2), 125-149.
- Walters, K. L., Simoni, J. M., & Horwath, P. F. (2001). Sexual orientation bias experiences and service needs of gay, lesbian, bisexual, transgendered, and two-spirited American Indians. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research*, 13(1-2), 133-149.
- Wax, E. (2008, November 15). For gays in India, fear rules, blackmailers thrive using law that makes homosexuality a crime. *Washington Post Foreign Service*, A13.
- Weeks, J. (1995). Histories, desire and identities. In R. G. Parker & J. H. Gagnon (Eds.), *Conceiving sexualities* (pp. 33-50). New York: Routledge.
- Wei, M., Ku, T.-Y., Russell, D. W., Mallinckrodt, B., & Liao, K. Y.-H. (2008). Moderating effects of three coping strategies and self-esteem on perceived discrimination and depressive symptoms: A minority stress model for Asian international students. *Journal of Counseling Psychology*, 55, 451-462.
- Weinberg, G. (1972). *Society and the healthy homosexual*. New York: St. Martin's Press.
- Weinrich, J. D., & Williams, W. L. (1991). Strange customs, familiar lives: Homosexualities in other cultures. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 44-59). Newbury Park, CA: Sage.

- Weithorn, L. A. (1987). Mental hospitalization of troublesome youth: An analysis of skyrocketing admission rates. *Stanford Law Review*, 40, 773-838.
- Wester, S. R. (2008). Male gender role conflict and multiculturalism: Implications for counseling psychology. *The Counseling Psychologist*, 36, 294-324.
- Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services. *American Psychologist*, 62, 563-574.
- Wilber, S., Ryan, C., & Marksamer, J. (2006). *CWLA, Best practice guidelines*. Washington, DC: Child Welfare League of America.
- Wilcox, M. M. (2001). Dancing on the fence: Researching lesbian, gay, bisexual, and transgender Christians. In J. V. Spickard, J. S. Landres, & M. B. McGuire (Eds.), *Personal knowledge and beyond: Reshaping the ethnography of religion*. New York: New York University Press.
- Wilcoxon, F. (1945). Individual comparisons by ranking methods. *Biometrics*, 1, 80-83.
- Williams, A. (2005, July 17). Gay teenager stirs a storm. *The New York Times*, Style Section, pp. 1, 6.
- Williams, M. (2008). Homosexuality anxiety: A misunderstood form of OCD. In L. V. Sebeki (Ed.), *Leading-edge health education issues* (pp. 195-205). Hauppauge, NY: Nova Science.
- Wilson, A. E., & Ross, M. (2001). From chump to champ: People's appraisal of their earlier and present selves. *Journal of Personality and Social Psychology*, 80, 572-584.
- Wilson, B. D. M. & Miller, R. L. (2002). Strategies for managing heterosexism used among African American gay and bisexual men. *Journal of Black Psychology*, 28, 371-391.
- Winnicott, D. W. (1965). *The maturational process and the facilitating environment*. New York: International Universities Press.
- Wilson, G. T., & Davison, G. C. (1974). Behavior therapy and homosexuality: A critical perspective. *Behavior Therapy*, 5, 16-28.
- Wilson, M. L., & Green, R. L. (1971). Personality characteristics of female homosexuals. *Psychological Reports*, 28, 407-412.
- Wolkomir, M. (2001). Emotion work, commitment, and the authentication of the self: The case of gay and ex-gay Christian support groups. *Journal of Contemporary Ethnography*, 30, 305-334.
- Wolkomir, M. (2006). *Be not deceived: The sacred and sexual struggles of gay and ex-gay Christian men*. New Brunswick, NJ: Rutgers University Press.
- Wolowelsky, J. B., & Weinstein, B. L. (1995). Initial religious counseling for a male orthodox adolescent homosexual. *Tradition*, 29, 49-55.
- Worthington, E. L., Kurusu, T. A., McCullough, M. E., & Sandage, S. J. (1996). Empirical research on religion and psychotherapeutic process outcomes: A 10-year review and research prospectus. *Psychological Bulletin*, 119, 448-487.
- Worthington, R. L. (2003). Heterosexual identities, sexual reorientation therapies, and science. *Archives of Sexual Behavior*, 32, 460-461.
- Worthington, R. L. (2004). Sexual identity, sexual orientation, religious identity, and change: Is it possible to depolarize the debate? *The Counseling Psychologist*, 32, 741-749.
- Worthington, R. L., Dillon, F. R., & Becker-Schutte, A. M. (2005). Development, reliability, and validity of the LGB knowledge and attitudes scale for heterosexuals (LGB-KASH). *Journal of Counseling Psychology*, 52, 104-118.
- Worthington, R. L., Navarro, R. L., Savoy, H. B., & Hampton, D. (2008). Development, reliability, and validity of the measure of sexual identity exploration and commitment (MoSIEC). *Developmental Psychology*, 44, 22-44.
- Worthington, R. L., & Reynolds, A. L. (2009). Within group differences in sexual orientation and identity. *Journal of Counseling Psychology*, 56, 44-55.
- Worthington, R. L., Savoy, H., Dillon, F. R., & Vernaglia, E. R. (2002). Heterosexual identity development: A multidimensional model of individual and group identity. *The Counseling Psychologist*, 30, 496-531.
- Wright, E. R., & Perry, B. L. (2006). Sexual identity distress, social support, and the health of gay, lesbian, and bisexual youth. *Journal of Homosexuality*, 51, 81-110.
- Wulff, D. M. (1997). *Psychology of religion: Classic and contemporary* (2nd ed.). Oxford, England: Wiley.
- Wyers, N. (1987, March/April). Homosexuality in the family: Lesbian and gay spouses. *Social Work*, 143-148.
- Yarhouse, M. A. (1998a). When clients seek treatment for same-sex attraction: Ethical issues in the "right to choose" debate. *Psychotherapy: Theory, Research, Practice, Training*, 35, 248-259.
- Yarhouse, M. A. (1998b). When families present with concerns about an adolescent's experience of same-sex attraction. *The American Journal of Family Therapy*, 26, 321-330.
- Yarhouse, M. A. (2001). Sexual identity development: The influence of evaluative frameworks on identity synthesis. *Psychotherapy: Theory, Research, Practice, Training*, 38, 331-341.
- Yarhouse, M. A. (2005a). Christian explorations in sexual identity. *Journal of Psychology and Christianity*, 24, 291-292.
- Yarhouse, M. A. (2005b). Constructive relationships between religion and the scientific study of sexuality. *Journal of Psychology and Christianity*, 24, 29-35.
- Yarhouse, M. A. (2005c). Same-sex attraction, homosexual orientation, and gay identity: A three-tier distinction for counseling and pastoral care. *Journal of Pastoral Care & Counseling*, 59, 201-212.

- Yarhouse, M. A. (2008). Narrative sexual identity therapy. *American Journal of Family Therapy*, 39, 196-210.
- Yarhouse, M., & Beckstead, A. L. (2007, August). Sexual identity group therapy to navigate religious and spiritual conflicts. In M. Yarhouse & A. L. Beckstead (Chairs), *Sexual identity therapy to address religious and spiritual conflicts*. Symposium conducted 116th Convention of the American Psychological Association, San Francisco.
- Yarhouse, M. A., Brooke, H. L., Pisano, P., & Tan, E. S. N. (2005). Project Inner Compass: Young adults experiencing sexual identity confusion. *Journal of Psychology and Christianity*, 24, 352-360.
- Yarhouse, M. A., & Burkett, L. A. (2002). An inclusive response to LGB and conservative religious persons: The case of same-sex attraction and behavior. *Professional Psychology: Research and Practice*, 33, 235-241.
- Yarhouse, M. A., Burkett, L. A., Kreeft, E. M. (2001). Competing models for shepherding those in the church who contend with same-sex attraction. *Journal of Psychology and Christianity*, 20, 53-65.
- Yarhouse, M. A., & Fisher, W. (2002). Levels of training to address religion in clinical practice. *Psychotherapy: Theory, Research, Practice, Training*, 39, 171-176.
- Yarhouse, M. A., & Pawlowski, L. M., & Tan, E. S. N. (2003). Intact marriages in which one partner dis-identifies with experiences of same-sex attraction. *American Journal of Family Therapy*, 31, 369-388.
- Yarhouse, M. A., & Seymore, R. L. (2006). Intact marriages in which one partner dis-identifies with experiences of same-sex attraction: A follow-up study. *The American Journal of Family Therapy*, 34, 151-161.
- Yarhouse, M. A., & Tan, E. S. N. (2004). *Sexual identity synthesis: Attributions, meaning-making, and the search for congruence*. Lanham, MD: University Press of America.
- Yarhouse, M. A., & Tan, E. S. N. (2005a). Addressing religious conflicts in adolescents who experience sexual identity confusion. *Professional Psychology: Research and Practice*, 6, 530-536.
- Yarhouse, M. A., & Tan, E. S. N. (2005b). Sexual identity and being a Christian. *Journal of Psychology and Christianity*, 24, 60-64.
- Yarhouse, M. A., Tan, E. S. N., & Pawlowski, L. M. (2005). Sexual identity development and synthesis among LGB-identified and LGB dis-identified persons. *Journal of Psychology and Theology*, 33, 3-16.
- Yarhouse, M. A., & Throckmorton, W. (2002). Ethical issues in attempts to ban reorientation therapies. *Psychotherapy: Theory, Research, Practice, Training*, 39, 66-75.
- Yarhouse, M. A., & VanOrman, B. T. (1999). When psychologists work with religious clients: Applications of the general principles of ethical conduct. *Professional Psychology: Research and Practice*, 30, 557-562.
- Yi, K., & Shorter-Gooden, K. (1999). Ethnic identity formation: From stage theory to a constructivist narrative model. *Psychotherapy: Theory, Research, Practice, Training*, 36, 16-26.
- Yip, A. K. T. (2000). Leaving the church to keep my faith: The lived experiences of non-heterosexual Christians. In L. J. Francis & Y. J. Katz (Eds.), *Joining and leaving religion: Research perspectives* (pp. 129-145). Leominster, MA: Gracewing.
- Yip, A. K. T. (2002). The persistence of faith among nonheterosexual Christians. *Journal for the Scientific Study of Religion*, 41, 199-212.
- Yip, A. K. T. (2003). The self as the basis of religious faith: Spirituality of gay, lesbian, and bisexual Christians. In G. Davie, L. Woodhead, & P. Heelas (Eds.), *Predicting religion* (pp. 135-146). Aldershot, England: Ashgate.
- Yip, A. K. T. (2004). Embracing Allah and sexuality? South Asian non-heterosexual Muslims in Britain. In K. A. Jacobsen & P. P. Kumar (Eds.), *South Asians in the Diaspora* (pp. 294-310). Leiden, Netherlands: Brill.
- Yip, A. K. T. (2005). Queering religious texts: An exploration of British non-heterosexual Christians' and Muslims' strategy of constructing sexuality-affirming hermeneutics. *Sociology*, 39, 47-65.
- Zahniser, J. H., & Boyd, C. A. (2008). The work of love, the practice of compassion and the homosexual neighbor. *Journal of Psychology and Christianity*, 27, 215-226.
- Zahniser, J. H., & Cagle, L. (2007). Homosexuality: Toward an informed, compassionate response. *Christian Scholar's Review*, 36, 323-348.
- Zaslav, M. R. (1998). Shame-related states of mind in psychotherapy. *Journal of Psychotherapy Practice and Research*, 7, 154-166.
- Zea, M. C., Diaz, R. M., & Reisen, C. A. (2003). Methodological issues in research with Latino gay and bisexual men. *American Journal of Community Psychology*, 31, 281-291.
- Zea, M. C., Mason, M. A., & Muruia, A. (2000). Psychotherapy with members of Latino/Latina religious and spiritual traditions. In P. S. Richards, & A. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 397-419). Washington, DC: American Psychological Association.
- Zucker, K. J. (2008). Reflections on the relation between sex-typed behavior in childhood and sexual orientation in adulthood. *Journal of Gay & Lesbian Mental Health*, 12(1/2), 29-59.
- Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.

APPENDIX A: RESOLUTION ON APPROPRIATE AFFIRMATIVE RESPONSES TO SEXUAL ORIENTATION DISTRESS AND CHANGE EFFORTS

Research Summary

The longstanding consensus of the behavioral and social sciences and the health and mental health professions is that homosexuality per se is a normal and positive variation of human sexual orientation (Bell, Weinberg, & Hammersmith, 1981; Bullough, 1976; Ford & Beach 1951; Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). Homosexuality per se is not a mental disorder (APA, 1975). Since 1974, the American Psychological Association (APA) has opposed stigma, prejudice, discrimination, and violence on the basis of sexual orientation and has taken a leadership role in supporting the equal rights of lesbian, gay, and bisexual individuals (APA, 2005).

APA is concerned about ongoing efforts to mischaracterize homosexuality and promote the notion that sexual orientation can be changed and about the resurgence of sexual orientation change efforts (SOCE).^{A1} SOCE has been controversial due to tensions between the values held by some faith-based organizations, on the one hand, and those held by lesbian, gay, and bisexual rights organizations and professional and scientific organizations, on the other (Drescher, 2003; Drescher & Zucker, 2006).

Some individuals and groups have promoted the idea of homosexuality as symptomatic of developmental defects or spiritual and moral failings and have argued that SOCE, including psychotherapy and religious efforts, could alter homosexual feelings and behaviors (Drescher & Zucker, 2006; Morrow & Beckstead, 2004). Many of these individuals and groups appeared to be embedded within the larger context of conservative religious political movements that have supported the stigmatization of homosexuality on political or religious grounds (Drescher, 2003; Drescher & Zucker, 2006; Southern Poverty Law Center, 2005). Psychology, as a science, and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints. The APA concludes that psychology must rely on proven methods of scientific inquiry based on empirical data, on which hypotheses and propositions are confirmed or disconfirmed, as the basis to explore and understand human behavior (APA, 2008a, 2008c).

In response to these concerns, APA appointed the Task Force on Appropriate Therapeutic Responses to Sexual Orientation to review the available research on SOCE and to provide recommendations to the association. The task force reached the following findings.

Recent studies of participants in SOCE identify a population of individuals who experience serious distress related to same-sex sexual attractions. Most of these participants are Caucasian males who report that their religion is extremely important to them (Beckstead & Morrow, 2004; Nicolosi, Byrd, & Potts,

^{A1} APA uses the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a same-sex sexual orientation to heterosexual, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Shidlo & Schroeder, 2002, Spitzer, 2003). These individuals report having pursued a variety of religious and secular efforts intended to help them change their sexual orientation. To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals.

There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation. Scientifically rigorous older work in this area (e.g., Birk, Huddleston, Miller, & Cohler, 1971; James, 1978; McConaghy, 1969, 1976; McConaghy, Proctor, & Barr, 1972; Tanner, 1974, 1975) found that sexual orientation (i.e., erotic attractions and sexual arousal oriented to one sex or the other, or both) was unlikely to change due to efforts designed for this purpose. Some individuals appeared to learn how to ignore or limit their attractions. However, this was much less likely to be true for people whose sexual attractions were initially limited to people of the same sex.

Although sound data on the safety of SOCE are extremely limited, some individuals reported being harmed by SOCE. Distress and depression were exacerbated. Belief in the hope of sexual orientation change followed by the failure of the treatment was identified as a significant cause of distress and negative self-image (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002).

Although there is insufficient evidence to support the use of psychological interventions to change sexual orientation, some individuals modified their sexual orientation identity (i.e., group membership and affiliation), behavior, and values (Nicolosi et al., 2000). They did so in a variety of ways and with varied and unpredictable outcomes, some of which were temporary (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Based on the available data, additional claims about the meaning of those outcomes are scientifically unsupported.

On the basis of the task force's findings, the APA encourages mental health professionals to provide assistance to those who seek sexual orientation change by utilizing affirmative multiculturally competent (Bartoli & Gillem, 2008; Brown, 2006) and client-centered approaches (e.g., Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Lasser & Gottlieb, 2004) that recognize the negative impact of social stigma on sexual minorities (Herek, 2009; Herek &

Garnets, 2007)^{A2} and balance ethical principles of beneficence and nonmaleficence, justice, and respect for people's rights and dignity (APA, 1998, 2002; Davison, 1976; Haldeman, 2002; Schneider, Brown, & Glassgold, 2002).

Resolution

WHEREAS, The American Psychological Association expressly opposes prejudice (defined broadly) and discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status (APA, 1998, 2000, 2002, 2003, 2005, 2006, 2008c);

WHEREAS, The American Psychological Association takes a leadership role in opposing prejudice and discrimination (APA, 2008b, 2008c), including prejudice based on or derived from religion or spirituality, and encourages commensurate consideration of religion and spirituality as diversity variables (APA, 2008c);

WHEREAS, Psychologists respect human diversity including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (APA, 2002) and psychologists strive to prevent bias from their own spiritual, religious, or nonreligious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists (APA, 2008c);

WHEREAS, Psychologists are encouraged to recognize that it is outside the role and expertise of psychologists, as psychologists, to adjudicate religious or spiritual tenets, while also recognizing that psychologists can appropriately speak to the psychological implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist (APA, 2008c);

WHEREAS, Those operating from religious/spiritual traditions are encouraged to recognize that it is outside their role and expertise to adjudicate empirical scientific issues in psychology, while

^{A2} We use the term *sexual minority* (cf. Blumenfeld, 1992; McCarn & Fassinger, 1996; Ullerstam, 1966) to designate the entire group of individuals who experience significant erotic and romantic attractions to adult members of their own sex, including those who experience attractions to members of both their own and the other sex. This term is used because we recognize that not all sexual minority individuals adopt an LGB bisexual identity.

also recognizing they can appropriately speak to theological implications of psychological science (APA, 2008c);

WHEREAS, The American Psychological Association encourages collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles (APA, 2008c);

WHEREAS, Societal ignorance and prejudice about a same-sex sexual orientation places some sexual minorities at risk for seeking sexual orientation change due to personal, family, or religious conflicts, or lack of information (Beckstead & Morrow, 2004; Haldeman, 1994; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001);

WHEREAS, Some mental health professionals advocate treatments based on the premise that homosexuality is a mental disorder (e.g., Nicolosi, 1991; Socarides, 1968);

WHEREAS, Sexual minority children and youth are especially vulnerable populations with unique developmental tasks (Perrin, 2002; Ryan & Futterman, 1997) who lack adequate legal protection from involuntary or coercive treatment (Arriola, 1998; Burack & Josephson, 2005; Molnar, 1997) and whose parents and guardians need accurate information to make informed decisions regarding their development and well-being (Cianciatto & Cahill, 2006; Ryan & Futterman, 1997); and

WHEREAS, Research has shown that family rejection is a predictor of negative outcomes (Remafedi, Farrow, & Deisher, 1991; Ryan, Huebner, Diaz, & Sanchez, 2009; Savin-Williams, 1994; Wilber, Ryan, & Marksamer, 2006) and that parental acceptance and school support are protective factors (D'Augelli, 2003; D'Augelli, Hersherberger, & Pilkington, 1998; Goodenow, Szalacha, & Westheimer, 2006; Savin-Williams, 1989) for sexual minority youth;

THEREFORE, BE IT RESOLVED, That the American Psychological Association affirms that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

BE IT FURTHER RESOLVED, That the American Psychological Association reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that the emerging knowledge on affirmative multiculturally competent treatment provides a foundation for an appropriate evidence-based practice with children, adolescents and adults who are distressed by or seek to change their sexual orientation (Bartoli & Gillem, 2008; Brown, 2006; Martell, Safren, & Prince, 2004; Norcross, 2002; Ryan & Futterman, 1997);

BE IT FURTHER RESOLVED, That the American Psychological Association advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages practitioners to consider the ethical concerns outlined in the 1997 APA Resolution on Appropriate Therapeutic Response to Sexual Orientation (APA, 1998), in particular the following standards and principles:

Bases for Scientific and Professional Judgments, Beneficence and Harm, Justice, and Respect for People's Rights and Dignity;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages practitioners to be aware that age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status may interact with sexual stigma and contribute to variations in sexual orientation identity development, expression, and experience;

BE IT FURTHER RESOLVED, That the American Psychological Association opposes the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion and will take a leadership role in responding to such distortions;

BE IT FURTHER RESOLVED, That the American Psychological Association supports the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based in lack of knowledge about sexual orientation; and

BE IT FURTHER RESOLVED, That the American Psychological Association encourages advocacy groups, elected officials, mental health professionals, policymakers, religious professionals and organizations, and other organizations to seek areas of collaboration that may promote the well-being of sexual minorities.

REFERENCES

- American Psychological Association. (1975). Policy statement on discrimination against homosexuals. *American Psychologist*, 30, 633.
- American Psychological Association. (1998). Resolution on appropriate therapeutic responses to sexual orientation. *American Psychologist*, 43, 934-935.
- American Psychological Association. (2000). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist*, 55, 1440-1451.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073.
- American Psychological Association. (2003). *Lawrence v. Texas: Brief for amicus curiae, Supreme Court of the United States*. Washington, DC. Retrieved February 25, 2008, from <http://www.apa.org/pi/lgbc/policy/amicusbriefs.html#lawrence>
- American Psychological Association. (2005). *APA policy statements on lesbian, gay, and bisexual concerns*. Retrieved July 4, 2008, from <http://www.apa.org/pi/lgbc/policy/pshome.html>
- American Psychological Association. (2006). Resolution on prejudice, stereotypes, and discrimination. *American Psychologist*, 62, 475-481.
- American Psychological Association. (2008a). Resolution rejecting intelligent design as scientific and reaffirming support for evolutionary theory. *American Psychologist*, 63, 426-427.
- American Psychological Association. (2008b). Resolution opposing discriminatory legislation and initiatives aimed at lesbian, gay, and bisexual persons. *American Psychologist*, 63, 428-430.
- American Psychological Association. (2008c). Resolution on religious, religion-related and/or religion-derived prejudice. *American Psychologist*, 63, 431-434.
- Arriola, E. R. (1998). The penalties for puppy love: Institutionalized violence against lesbian, gay, bisexual, and transgender youth. *The Journal of Gender, Race, and Justice*, 429, 1-43.
- Bartoli, E., & Gillem, A. R. (2008). Continuing to depolarize the debate on sexual orientation and religious identity and the therapeutic process. *Professional Psychology: Research and Practice*, 39, 202-209.
- Beckstead, L., & Israel, T. (2007). Affirmative counseling and psychotherapy focused on issues related to sexual orientation conflicts. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 221-244). Washington, DC: American Psychological Association.

- Beckstead, A. L., & Morrow, S. L. (2004). Mormon clients' experiences of conversion therapy: The need for a new treatment approach. *The Counseling Psychologist, 32*, 651-690.
- Bell, A. P., Weinberg, M. S., & Hammersmith, S. K. (1981). *Sexual preference: Its development in men and women*. Bloomington: Indiana University Press.
- Birk, L., Huddleston, W., Miller, E., & Cohler, B. (1971). Avoidance conditioning for homosexuality. *Archives of General Psychiatry, 25*, 314-323.
- Blumenfeld, W. J. (1992). Introduction. In W. J. Blumenfeld (Ed.), *Homophobia: How we all pay the price* (pp. 1-19). New York: Beacon Press.
- Brown, L. S. (2006). The neglect of lesbian, gay, bisexual, and transgendered clients. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 346-353). Washington, DC: American Psychological Association.
- Bullough, V. L. (1976). *Sexual variance in society and history*. Chicago: University of Chicago Press.
- Burack, C., & Josephson, J. J. (2005). *A report from "Love Won Out: Addressing, Understanding, and Preventing Homosexuality."* New York: National Gay and Lesbian Task Force Policy Institute. Retrieved from www.thetaskforce.org/downloads/reports/reports/LoveWonOut.pdf
- Cianciatto, J., & Cahill, S. (2006). *Youth in the crosshairs: The third wave of ex-gay activism*. New York: National Gay and Lesbian Task Force Policy Institute.
- D'Augelli, A. R. (2003). Lesbian and bisexual female youths aged 14 to 21: Developmental challenges and victimization experiences. *Journal of Lesbian Studies, 7*, 9-29.
- D'Augelli, A. R., Hershberger, S. L., & Pilkington, N. W. (1998). Lesbian, gay, and bisexual youth and their families: Disclosure of sexual orientation and its consequences. *American Journal of Orthopsychiatry, 68*, 361-371.
- Davison, G. C. (1976). Homosexuality: The ethical challenge. *Journal of Consulting and Clinical Psychology, 44*, 157-162.
- Drescher, J. (2003). The Spitzer study and the culture wars. *Archives of Sexual Behavior, 32*, 431-432.
- Drescher, J., & Zucker, K. J. (Eds.). (2006). *Ex-gay research: Analyzing the Spitzer study and its relation to science, religion, politics, and culture*. New York: Harrington Park Press.
- Ford, C. S., & Beach, F. A. (1951). *Patterns of sexual behavior*. New York: Harper & Row.
- Glassgold, J. M. (2008). Bridging the divide: Integrating lesbian identity and Orthodox Judaism. *Women and Therapy, 31*, 59-73.
- Goodenow, C., Szalacha, L., & Westheimer, K. (2006). School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools, 43*, 573-589.
- Haldeman, D. C. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Consulting and Clinical Psychology, 62*, 221-227.
- Haldeman, D. C. (2002). Gay rights, patient rights: The implications of sexual orientation conversion therapy. *Professional Psychology: Research and Practice, 33*, 200-204.
- Haldeman, D. C. (2004). When sexual and religious orientation collide: Considerations in working with conflicted same-sex attracted male clients. *The Counseling Psychologist, 32*, 691-715.
- Herek, G. M. (2009). Sexual stigma and sexual prejudice in the United States: A conceptual framework. In D. A. Hope (Ed.), *Nebraska Symposium on Motivation: Vol. 54. Contemporary perspectives on lesbian, gay, and bisexual identities* (pp. 65-111). New York: Springer.
- Herek, G. M., & Garnets, L. D. (2007). Sexual orientation and mental health. *Annual Review of Clinical Psychology, 3*, 353-375.
- James, S. (1978). Treatment of homosexuality II. Superiority of desensitization/arousal as compared with anticipatory avoidance conditioning: Results of a controlled trial. *Behavior Therapy, 9*, 28-36.
- Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia: W. B. Saunders.
- Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. (1953). *Sexual behavior in the human female*. Philadelphia: W. B. Saunders.
- Lasser, J. S., & Gottlieb, M. C. (2004). Treating patients distressed regarding their sexual orientation: Clinical and ethical alternatives. *Professional Psychology: Research and Practice, 35*, 194-200.
- Martell, C. R., Safren, S. A., & Prince, S. E. (2004). *Cognitive-behavioral therapies with lesbian, gay, and bisexual clients*. New York: Guilford Press.
- McCarn, S. R., & Fassinger, R. E. (1996). Revisioning sexual minority identity formation: A new model of lesbian identity and its implications for counseling and research. *The Counseling Psychologist, 24*, 508-534.
- McConaghy, N. (1969). Subjective and penile plethysmograph responses following aversion-relief and Apomorphine aversion therapy for homosexual impulses. *British Journal of Psychiatry, 115*, 723-730.
- McConaghy, N. (1976). Is a homosexual orientation irreversible? *British Journal of Psychiatry, 129*, 556-563.
- McConaghy, N., Proctor, D., & Barr, R. (1972). Subjective and penile plethysmography responses to aversion therapy for homosexuality: A partial replication. *Archives of Sexual Behavior, 2*, 65-79.
- Molnar, B. E. (1997). Juveniles and psychiatric institutionalization: Toward better due process and treatment review in the United States. *Health and Human Rights, 2*, 98-116.

- Morrow, S. L., & Beckstead, A. L. (2004). Conversion therapies for same-sex attracted clients in religious conflict: Context, predisposing factors, experiences, and implications for therapy. *The Counseling Psychologist*, 32, 641–650.
- Nicolosi, J. (1991). *Reparative therapy of male homosexuality*. Northvale, NJ: Jason Aronson.
- Nicolosi, J., Byrd, A. D., & Potts, R. W. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports*, 86, 1071–1088.
- Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.
- Perrin, E. C. (2002). *Sexual orientation in child and adolescent health care*. New York: Kluwer/Plenum.
- Ponticelli, C. M. (1999). Crafting stories of sexual identity reconstruction. *Social Psychology Quarterly*, 62, 157–172.
- Remafedi, G., Farrow, J. A., & Deisher, R. W. (1991). Risk factors of attempted suicide in gay and bisexual youth. *Pediatrics*, 87, 869–875.
- Ryan, C., & Futterman, D. (1997). Lesbian and gay youth: Care and counseling. *Adolescent Medicine: State of the Art Reviews*, 8, 207–374.
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 129, 346–352.
- Savin-Williams, R. C. (1989). Parental influences on the self-esteem of gay and lesbian youths: A reflected appraisals model. *Journal of Homosexuality*, 17(1/2), 93–109.
- Savin-Williams, R. C. (1994). Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: Associations with school problems, running away, substance abuse, prostitution, and suicide. *Journal of Consulting and Clinical Practice*, 62, 261–269.
- Schaeffer, K. W., Hyde, R. A., Kroencke, T., McCormick, B., & Nottebaum, L. (2000). Religiously motivated sexual orientation change. *Journal of Psychology & Christianity*, 19, 61–70.
- Schneider, M. S., Brown, L., & Glassgold, J. (2002). Implementing the Resolution on Appropriate Therapeutic Responses to Sexual Orientation: A guide for the perplexed. *Professional Psychology: Research and Practice*, 33, 265–276.
- Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumer's report. *Professional Psychology: Research and Practice*, 33, 249–259.
- Socarides, C. W. (1968). *The overt homosexual*. New York: Grune & Stratton.
- Southern Poverty Law Center. (2005, Spring). *A might army*. Retrieved February 2, 2009, from www.splcenter.org/intel/intelreport/article.jsp?aid=524
- Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? Two hundred participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior*, 32, 403–417.
- Tanner, B. A. (1974). A comparison of automated aversive conditioning and a waiting list control in the modification of homosexual behavior in males. *Behavior Therapy*, 5, 29–32.
- Tanner, B. A. (1975). Avoidance training with and without booster sessions to modify homosexual behavior in males. *Behavior Therapy*, 6, 649–653.
- Ullerstam, L. (1966). *The erotic minorities: A Swedish view*. New York: Grove.
- Wilber, S., Ryan, C., & Marksamer, J. (2006). *CWLA, best practice guidelines*. Washington, DC: Child Welfare League of America.
- Wolkomir, M. (2001). Emotion work, commitment, and the authentication of the self: The case of gay and ex-gay Christian support groups. *Journal of Contemporary Ethnography*, 30, 305–334.

APPENDIX B: STUDIES INCLUDED ($N = 55$)
IN THE SYSTEMATIC REVIEW (CHAPTERS 3 AND 4)

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Experimental studies							
McConaghy, 1969	40	100	Clinical (6 by court order; 18 with arrest history)	3 withdrawals	4 treatment group randomized experiment	Immediate and delayed aversion apomorphine therapy and aversion relief therapy	Penile circumference
McConaghy, 1976	157	100	Clinical (21 by court order)	None reported	4 experimental substudies (<i>ns</i> = 40, 40, 46, 31, respectively) with random assignment to one of two or three treatment alternatives	Aversive apomorphine therapy or aversion-relief; aversive therapy or apomorphine or avoidance conditioning; classical, or avoidance, or backward conditioning; classical aversive therapy or positive conditioning	Sexual feelings; sexual behavior; penile circumference; sexual orientation
McConaghy & Barr, 1973	46	100	Clinical	26 had incomplete treatment exposure; 2 of 20 with complete exposure lost to follow-up	3 treatment group randomized experiment	Classical conditioning, avoidance conditioning, backward conditioning	Heart rate; penile circumference; galvanic skin response
McConaghy, Proctor, & Barr, 1972	40	100	Clinical (police and psychiatric referrals)	16 with incomplete follow-up data and 2 withdrawals	4 treatment group randomized experiment	Immediate and delayed aversive apomorphine therapy; immediate and delayed anticipatory avoidance learning	Penile circumference
Tanner, 1974	16	100	Clinical	None reported	Random assignment experiment with wait list control	Aversive shock therapy	Penile circumference; sexual behavior; personality
Tanner, 1975	10	100	Clinical	None reported	2 treatment group randomized experiment	Aversive shock therapy with/without booster sessions	Penile circumference; self-reported arousal; sexual behavior; personality

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Quasi-experimental studies							
Birk, Huddleston, Miller, & Cohler, 1971	18	100	Clinical	2 withdrew participation	Nonequivalent 2 treatment group comparison design	Aversive shock therapy vs. associative conditioning	Sexual behavior; clinical judgment; personality
S. James, 1978	40	100	Court-referred	None reported	Nonequivalent 2 treatment group comparison design	Anticipatory avoidance, desensitization, hypnosis, anticipatory avoidance	Sexual orientation; personality
McConaghy, Armstrong, & Blaszczynski, 1981	20	100	Clinical	None reported	Nonequivalent 2 treatment group comparison design	Aversive therapy; covert sensitization	Sexual feelings
Nonexperimental studies							
Bancroft, 1969	16	100	Clinical	6 withdrew participation prior to treatment and 1 during treatment	Case study	Aversive shock therapy	Sexual behavior
Barlow & Agras, 1973	3	100	Clinical	None reported	Case study	Fading	Penile circumference; sexual urges; sexual fantasies
Barlow, Agras, Abel, Blanchard, & Young, 1975	3	100	Clinical	None reported	Single case pre-post within-subject	Biofeedback	Penile circumference
Beckstead & Morrow, 2004	50	80	Purposive	None	Qualitative retrospective, grounded theory	Conversion therapy, ex-gay ministries, and/or support groups	Subjective experiences of treatment; subjective appraisal of sexual orientation identity, attraction, & behavior
Birk, 1974	66	100	Clinical	13 withdrew participation	Pre-post within-subject	Psychotherapy	Sexual orientation
Blitch & Haynes, 1972	1	0	Clinical	None reported	Case study	Relaxation therapy and masturbation reconditioning	Sexual behavior
Callahan & Leitenberg, 1973	23	100	Clinical with 2 by court order	9 men withdrew participation and 8 excluded from data analyses	Pre-post within-subject	Aversion shock therapy and covert sensitization	Penile circumference
Colson, 1972	1	100	Clinical	None reported	Case study	Olfactory aversion therapy	Sexual behavior

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Conrad & Winze, 1976	4	100	Clinical	None reported	Case study	Orgasmic reconditioning	Sexual behavior; sexual fantasies; penile circumference
Curtis & Presly, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Sexual orientation
Feldman & MacCulloch, 1965	43	100	Clinical	7 withdrawals	Pre-post within-subject	Anticipatory avoidance	Sexual orientation
Fookes, 1960	27	100	Clinical (7 exhibitionists, 5 fetishists, and 15 bisexual and homosexual men)	None reported	Pre-post within-subject	Aversion shock therapy and calorie deprivation	Clinical judgment
Freeman & Meyer, 1975	9	100	Clinical	None reported	Pre-post within-subject	Aversion shock therapy and masturbation reconditioning	Sexual behavior; sexual orientation
Freund, 1960	67	100	Clinical	20 withdrawals	Pre-post within-subject	Aversion apomorphine therapy	Clinical judgment
Gray, 1970	1	100	Clinical	None reported	Case study	Desensitization and masturbation reconditioning	Sexual behavior
Hallam & Rachman, 1972	7	100	Clinical (2 pedophiles, 1 fetishist, 3 bisexual and homosexual men, and 1 voyeur)	None reported	Pre-post within-subject	Aversion shock therapy	Heart rate; galvanic skin response
Hanson & Adesso, 1972	1	100	Clinical	None reported	Case study	Desensitization and aversive counter-conditioning	Sexual behavior
Herman, Barlow, & Agras, 1974	4	100	Clinical	None reported	Case study	Counter-conditioning	Penile circumference; self-reported arousal
Herman & Prewett, 1974	1	100	Clinical	None reported	Case study	Biofeedback	Penile circumference
Huff, 1970	1	100	Clinical	None reported	Case study	Desensitization	Sexual behavior; personality
B. James, 1962	1	100	Clinical	Treatment stopped due to adverse reaction	Case study	Aversion apomorphine therapy	Sexual fantasies; sexual behavior
Kendrick & McCullough, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Sexual fantasies; sexual behavior
Larson, 1970	3	100	Clinical	None reported	Case study	Anticipatory avoidance	Sexual fantasies; sexual behavior
Levin, Hirsch, Shugar, & Kapche, 1968	1	100	Clinical	None reported	Case study	Desensitization, avoidance conditioning	Personality

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
LoPiccolo, 1971	1	100	Clinical	None reported	Case study	Desensitization	Masturbation fantasies
LoPiccolo, Stewart, & Watkins, 1972	1	100	Clinical	None reported	Case study	Orgasmic reconditioning	Sexual behavior
MacCulloch & Feldman, 1967	43	?	Clinical (18 by court order and 4 psychiatric referrals)	7 withdrawals	Pre-post within-subject	Anticipatory avoidance with aversion shock therapy	Sexual orientation; sexual behavior
MacCulloch, Feldman, & Pinshoff, 1965	4	100	Clinical (3 by court order)	1 withdrawal	Case study	Anticipatory avoidance with aversion shock therapy	Attractions; pulse rate
Marquis, 1970	14	79	Clinical	None reported	Case study	Orgasmic reconditioning	Clinical judgment
McCrady, 1973	1	100	Clinical	None reported	Case study	Forward fading	Sexual preference, sexual behavior
Mintz, 1966	10	100	Clinical	5 withdrawals	Case study	Therapy	Clinical judgment
Nicolosi, Byrd, & Potts, 2000	882	78	Convenience (NARTH and ex-gay ministry members)	None reported	Retrospective pretest	Conversion therapy	Sexual orientation; sexual behavior
Pattison & Pattison, 1980	11	100	Convenience	None reported; 19 declines to participate	Qualitative retrospective case study	Religious folk therapy	Subjective experience
Ponticelli, 1999	15	0	Purposive (ex-gay ministry)	None reported	Ethnography	Ex-gay ministry	None
Quinn, Harbison, & McAllister, 1970	1	100	Clinical	None reported	Case study	Desensitization and hydration deprivation	Penile circumference
Rehm & Rozensky, 1974	1	100	Clinical	None reported	Case study	Therapy and orgasmic reconditioning	Sexual behavior
Sandford, Tustin, & Priest, 1975	2	100%	Clinical	1 withdrawal reported	Case study	Differential reinforcement and punishment	Penile circumference
Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000	248	74	Convenience (Exodus International conference attendees)	None reported	Retrospective pretest	Varied counseling and conversion therapies	Sexual behavior; sexual feelings; sexual orientation identity
Schroeder & Shidlo, 2001	150	91	Convenience	None reported	Qualitative retrospective case study	Varied, including behavior therapy; psychoanalysis; aversive therapies; hypnosis; spiritual counseling; psychotropic medication; in-patient treatment.	Perceived harmfulness or helpfulness of SOCE

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Segal & Sims, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Self-report of continued need for treatment
Shidlo & Schroeder, 2002	202	90	Convenience	None reported	Qualitative retrospective case study	Varied including behavior therapy; psychoanalysis; aversive therapies; hypnosis; spiritual counseling; psychotropic medication; in-patient treatment.	Sexual orientation; sexual orientation identity
Solyom & Miller, 1965	6	100	Clinical	None reported	Case study	Aversive shock therapy	Galvanic skin responses; penile circumference
Spitzer, 2003	200	71	Convenience (Ex-gay ministry members)	None reported; 74 not eligible	Retrospective pretest	Varied including ex-gay and religious support groups and therapy.	Sexual attraction; sexual orientation identity; sexual behavior;
Thorpe, Schmidt, & Castell, 1963	1	100	Clinical	None reported	Case study	Classical conditioning	Sexual fantasy; ability to orgasm in response to female stimuli
Thorpe, Schmidt, Brown, & Castell, 1964	8	75	Clinical (referred for variety of mental health concerns)	2 withdrawals	Case study	Aversion relief	Anxiety; personality
Wolkomir, 2001	n/a		Purposive	None reported	Ethnography	2 Bible study support groups	Subjective experience

