UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO.: 9:18-CV-80771-ROSENBERG/REINHART

ROBERT W. OTTO, PH.D., LMFT,and
JULIE H. HAMILTON, PH.D., LMFT,

Plaintiffs,

v.

CITY OF BOCA RATON, FLORIDA, and
COUNTY OF PALM BEACH, FLORIDA,

Defendants.
_____/

DECLARATION OF HELENE HVIZD

I, Helene Hvizd, declare:

1. I am a Senior Assistant County Attorney with the Palm Beach County Attorney's office. I submit this declaration in support of Defendant Palm Beach County's Reply to Plaintiffs' Consolidated Response in Opposition to Defendants' Motions to Dismiss. I have personal knowledge of the information set forth herein.

2. I drafted Palm Beach County's Ordinance No. 2017-046 ("Ordinance") and have personal knowledge of which documents the Ordinance cites.

3. Attached hereto as Exhibit 1 is a true and correct copy of Ordinance No. 2017-046 [PBC 000001 – PBC 000014].

4. Attached hereto as Exhibit 2 is the 1993 American Academy of Pediatrics Position Statement [PBC 000015 – PBC 000020] and is a true and correct copy of the article referred to in the second Whereas clause of the Ordinance.

5. Attached hereto as Exhibit 3 is the 1998 American Psychiatric Association Position Statement [PBC 000021] and is a true and correct copy of the opposition paper referred to in the third Whereas clause of the Ordinance.

6. Attached hereto as Exhibit 4 is the 2009 American Psychological Association Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation [PBC 007493 – PBC 007632] and is a true and correct copy of the resolution referred to in the fourth Whereas clause of the Ordinance.

7. Attached hereto as Exhibit 5 is the American Psychological Associations August 2009 Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts [PBC 000022 – PBC 000026] and is a true and correct copy of the research summary referred to in the fifth Whereas clause of the Ordinance.

8. Attached hereto as Exhibit 6 is the June 2012 American Psychoanalytic Association Position Statement [PBC 000027] and is a true and correct copy of the position statement referred to in the sixth Whereas clause of the Ordinance.

9. Attached hereto as Exhibit 7 is the 2012 American Academy of Child & Adolescent Psychiatry Position Statement [PBC 000028 – PBC 000045] and is a true and correct copy of the article referred to in the seventh Whereas clause of the Ordinance.

10. Attached hereto as Exhibit 8 is the 2012 Pan American Health Organization news release [PBC 000046 – PBC 000050] and is a true and correct copy of the news release referred to in the eighth Whereas clause of the Ordinance.

11. Attached hereto as Exhibit 9 is the 2012 Pan American Health Organization Position Statement [PBC 015765 – PBC 015768] and is a true and correct copy of the position statement referred to in the eighth Whereas clause of the Ordinance.

12. Attached hereto as Exhibit 10 is the 2014 American School Counsel Association Position Statement [PBC 015763 – PBC 015764] and is a true and correct copy of the statement referred to in the ninth Whereas clause of the Ordinance.

13. Attached hereto as Exhibit 11 is the 2015 Substance Abuse and Mental Health Services Administration Position [PBC 000053 – PBC 000128] and is a true and correct copy of the report referred to in the tenth Whereas clause of the Ordinance.

14. Attached hereto as Exhibit 12 is the 2015 American College of Physicians Position Statement [PBC 000129 – PBC 000163] and is a true and correct copy of the position paper referred to in the eleventh Whereas clause of the Ordinance.

15. On September 10, 2018, I accessed www.aamft.org/About_AAMFT/Position_On_Couples.aspx and Exhibit 13 [PBC 015783 – PBC 015785] is a true and correct copy of what was found at that website.

Pursuant to Fla. Stat. 92.525, under penalty of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

Helene Hvizd, Esquire
Senior Assistant County Attorney
Florida Bar No. 868442

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on September 10, 2018, I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send an electronic notice to the authorized CM/ECF filers.

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
CASE NO. 18-CIV-80771-RLR

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Homosexuality and Adolescence

Committee on Adolescence

The American Academy of Pediatrics issued its first statement on homosexuality and adolescence in 1983. The past decade has witnessed increased awareness of homosexuality, changing attitudes toward this sexual orientation, and the growing impact of the human immunodeficiency virus (HIV). Therefore, an updated statement on homosexuality and adolescence is timely.

Homosexuality is the persistent sexual and emotional attraction to members of one's own gender and is part of the continuum of sexual expression. Many gay and lesbian youths first become aware of and experience their sexuality during adolescence. Therefore, pediatricians who care for teenagers need to understand the unique medical and psychosocial issues facing homosexually oriented youths (see Table 1 for a definition of terms).

ETIOLOGY AND PREVALENCE

Homosexuality has existed in most societies for as long as recorded descriptions of sexual beliefs and practices have been available. Societal attitudes toward homosexuality have had a decisive impact on the extent to which individuals have hidden or made known their sexual orientation.

In 1973, the American Psychiatric Association reclassified homosexuality as a sexual orientation/expression rather than as a mental disorder.[1] The etiology of homosexuality remains unclear, but the current literature and the vast majority of scholars in this field state that one's sexual orientation is not a choice, that is, individuals no more choose to be homosexual than heterosexual.[2,3] However, the expression of sexual behaviors and lifestyle is a choice for all teenagers regardless of sexual orientation.

During the adolescent years, many youths engage in sexual experimentation. Sexual behavior during this period does not predict future sexual orientation. Gay, lesbian, and heterosexual youths may engage in sexual activities with members of the same or opposite sex. Kinsey et al,[4,5] from their studies in the 1930s and 1940s, reported that 37% of men had at least one homosexual experience resulting in orgasm. From the same cohort, Kinsey reported that 4% of women and 10% of men were exclusively homosexual for at least 3 years of their lives. Sorenson[6] surveyed a group of 16- to 19-year-olds and reported that 6% of females and 17% of males had at least one homosexual experience. While the Kinsey data suggest that 4% of adult men and 2% of adult women are exclusively homosexual in their behavior and fantasies, the current prevalence of homosexual behavior and identity among adolescents remains to be defined.

This statement has been approved by the Council on Child and Adolescent Health.

The recommendations in this policy statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations taking into account individual circumstances, may be appropriate.

SPECIAL CONCERNS

Gay and lesbian adolescents share many of the developmental tasks of their heterosexual peers. These include establishing a sexual identity and deciding on sexual behaviors, whether choosing to engage in sexual intercourse or to abstain. Due to the seriousness of sexually transmitted diseases (STDs), abstinence should be promoted as the safest choice for all adolescents. However, not all youths will choose abstinence. The current reality is that a large number of adolescents are sexually active. Therefore, all adolescents should receive sexuality education and have access to health care resources. It is important to provide appropriate anticipatory guidance to all youths regardless of their sexual orientation. Physicians must also be aware of the important medical and psychosocial needs of gay and lesbian youths.[7]

HIV

The epidemic of the HIV infection highlights the urgency of making preventive services and medical care available to all adolescents regardless of sexual orientation or activity. Heterosexual and homosexual transmission of HIV infection is well established. The role of injectable drugs of abuse in HIV transmission is also well known.[3,8] Sex between males accounts for about half of the non–transfusion-associated cases of acquired immunodeficiency syndrome (AIDS) among males between the ages of 13 and 19 years.[8] While not all gay adolescents engage in high-risk sex (or even have sex), their vulnerability to HIV infection is well recognized. The pediatrician should encourage adolescents to practice abstinence. However, many will not heed this important message. Thus, practical, specific advice about condom use and other forms of safer sex should be included in all sexuality education and prevention discussions.

Issue of Trust

Quality care can be facilitated if the pediatrician recognizes the specific challenges and rewards of providing services for gay and lesbian adolescents. This care begins with the establishment of trust, respect, and confidentiality between the pediatrician and the adolescent. Many gay and lesbian youths avoid health care or discussion of their sexual orientation out of fear that their sexual orientation will be

TABLE 1. Definitions of Terms

Coming out	The acknowledgment of one's homosexuality and the process of sharing that information with others.
Gender identity	The personal sense of one's integral maleness or femaleness; typically occurs by 3 years of age.
Gender role	The public expression of gender identity; the choices and actions that signal to others a person's maleness or femaleness; one's sex role.
Heterosexist bias	The conceptualization of human experience in strictly heterosexual terms and consequently ignoring, invalidating, or derogating homosexual behaviors and sexual orientation.[19]
Homophobia	The irrational fear or hatred of homosexuality, which may be expressed in stereotyping, stigmatization, or social prejudice[18]; it may also be internalized in the form of self-hatred.
In the closet	Nondisclosure or hiding one's sexual orientation from others.
Sexual orientation	The persistent pattern of physical and/or emotional attraction to members of the same or opposite sex. Included in this are homosexuality (same-gender attractions); bisexuality (attractions to members of both genders); and heterosexuality (opposite-gender attractions). The terms preferred by most homosexuals today are lesbian women or gay men.
Transsexual	An individual who believes himself or herself to be of a gender different from his or her assigned biologic gender (gender identity does not match anatomic gender).
Transvestite	An individual who dresses in the clothing of the opposite gender and derives pleasure from this action. This is not indicative of one's sexual orientation.

disclosed to others. The goal of the provider is not to identify all gay and lesbian youths, but to create comfortable environments in which they may seek help and support for appropriate medical care while reserving the right to disclose their sexual identity when ready. Pediatricians who are not comfortable in this regard should be responsible for seeing that such help is made available to the adolescent from another source.

SPECIAL ASPECTS OF CARE

History

A sexual history that does not presume exclusive heterosexuality should be obtained from all adolescents.[3,9] Confidentiality must be emphasized except in cases in which sexual abuse has occurred. It is vital to identify high-risk behavior (anal or vaginal coitus, oral sex, casual and/or multiple sex partners, substance abuse, and others).

Physical Examination

A thorough and sensitive history provides the groundwork for an accurate physical examination for youths who are sexually experienced.[10] Depending on the patient's sexual practices, a careful examination includes assessment of pubertal staging, skin lesions (including cutaneous manifestations of STDs, bruising, and other signs of trauma), lymphadenopathy (including inguinal), and anal pathology (including discharge, venereal warts, herpetic lesions, fissures, and others). Males need evaluation of the penis (ulcers, discharge, skin lesions), scrotum, and prostate (size, tenderness). Females need assessment of their breasts, external genitalia, vagina, cervix, uterus, and adnexa.

Laboratory Studies

All males engaging in sexual intercourse with other males should be routinely screened for STDs, including gonorrhea, syphilis, chlamydia, and enteric pathogens. The oropharynx, rectum, and urethra should be examined and appropriate cultures obtained when indicated.[3,9]

Immunity to hepatitis B virus should be assessed. Immunization is recommended for all sexually active adolescents and should be provided for all males who are having or anticipate having sex with other males.[11] HIV testing with appropriate consent should be offered; this includes counseling before and after voluntary testing.

Women who have sex exclusively with other women have a low incidence of STDs, but can transmit STDs and potentially HIV if one partner is infected. Since lesbian women who engage in unprotected sex with men face risks of both sexually acquired infections and pregnancy, the pediatrician should offer them realistic birth control information and counseling on STD prevention.

PSYCHOSOCIAL ISSUES

The psychosocial problems of gay and lesbian adolescents are primarily the result of societal stigma, hostility, hatred, and isolation.[12] The gravity of these stresses is underscored by current data that document that gay youths account for up to 30% of all completed adolescent suicides.[13] Approximately 30% of a surveyed group of gay and bisexual males have attempted suicide at least once.[14] Adolescents struggling with issues of sexual preference should be reassured that they will gradually form their own identity[15] and that there is no need for premature labeling of one's sexual orientation.[16] A theoretical model of stages for homosexual identity development composed by Troiden[17] is summarized in Table 2. The health care professional should explore each adolescent's perception of homosexuality, and any youth struggling with sexual orientation issues should be offered appropriate referrals to providers and programs that can affirm the adolescent's intrinsic worth regardless of sexual identity. Providers who are unable to be objective because of religious or other personal convictions should refer patients to those who can.

Gay or lesbian youths often encounter considerable difficulties with their families, schools, and communities.[16,18,19] These youths are severely hindered by societal stigmatization and prejudice, limited knowledge of human sexuality, a need for secrecy, a lack of opportunities for open socialization, and limited communication with healthy role models. Subjected to overt rejection and harassment at the hands of family members, peers, school officials, and others

TABLE 2. Stages of Homosexual Identity Formation*

Sensitization	The feeling of differentness as a prepubertal child or adolescent. The first recognition of attraction to members of the same gender before or during puberty.
Sexual identity confusion	Confusion and turmoil stemming from self-awareness of same-gender attractions. Often this first occurs during adolescence. This confusion usually is not so much due to a questioning of one's feelings as it is to the attempt to reconcile the feelings with negative societal stereotypes. The lack of accurate knowledge about homosexuality, the scarcity of positive gay and lesbian role models, and the absence of an opportunity for open discussion and socialization as a gay or lesbian person contribute to this confusion. During this stage the adolescent develops a coping strategy to deal with social stigma.
Sexual identity assumption	The process of acknowledgment and social and sexual exploration of one's own gay or lesbian identity and consideration of homosexuality as a lifestyle option. This stage typically persists for several years during and after late adolescence.
Integration and commitment	The stage at which a gay or lesbian person incorporates his/her homosexual identity into a positive self-acceptance. This gay or lesbian identity is then increasingly and confidently shared with selected others. Many gays and lesbians may never reach this stage; those who do are typically in adulthood when this acceptance occurs.

* From Troiden.[17]

in the community, they may seek, but not find, understanding and acceptance by parents and others. Parents may react with anger, shock, and/or guilt when learning that their child is gay or lesbian.

Peers may engage in cruel name-calling, ostracize, or even physically abuse the identified individual. School and other community figures may resort to ridicule or open taunting, or they may fail to provide support. Such rejection may lead to isolation, runaway behavior, homelessness, domestic violence, depression, suicide, substance abuse, and school or job failure. Heterosexual and/or homosexual promiscuity may occur, including involvement in prostitution (often in runaway youths) as a means to survive. Pediatricians should be aware of these risks and provide or refer such youths for appropriate counseling.

Disclosure

The gay or lesbian adolescent should be allowed to decide when and to whom to disclose his/her sexual identity. In particular, the issue of informing parents should be carefully explored so that the adolescent is not exposed to violence, harassment, or abandonment. Parents and other family members may derive considerable benefit and gain understanding from organizations such as Parents and Friends of Lesbians and Gays (PFLAG).[3,18]

Concept of Therapy

Confusion about sexual orientation is not unusual during adolescence. Counseling may be helpful for young people who are uncertain about their sexual orientation or for those who are uncertain about how to express their sexuality and might profit from an attempt at clarification through a counseling or psychotherapeutic initiative. Therapy directed specifically at changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation. While there is no current literature clarifying whether sexual abuse can induce confusion in one's sexual orientation, those with a history of sexual abuse should always receive counseling with appropriate mental health specialists. Therapy may also be helpful in addressing personal, family, and environmental difficulties that are often concomitants of the emerging expression of homosexuality. Family therapy may also be useful and should always be made available to the entire family when major family difficulties are identified by the pediatrician as parents and siblings cope with the potential added strain of disclosure.

SUMMARY OF PHYSICIAN GUIDELINES

Pediatricians should be aware that some of the youths in their care may be homosexual or have concerns about sexual orientation. Caregivers should provide factual, current, nonjudgmental information in a confidential manner. These youths may present to physicians seeking information about homosexuality, STDs, substance abuse, or various psychosocial difficulties. The pediatrician should ensure that each youth receives a thorough medical history and physical examination (including appropriate laboratory tests), as well as STD (including HIV) counseling and, if necessary, appropriate treatment. The health care professional should also be attentive to various potential psychosocial difficulties and offer counseling or refer for counseling when necessary.

The American Academy of Pediatrics reaffirms the physician's responsibility to provide comprehensive health care and guidance for all adolescents, including gay and lesbian adolescents and those young people struggling with issues of sexual orientation. The deadly consequences of AIDS and adolescent suicide underscore the critical need to address and seek to prevent the major physical and mental health problems that confront gay and lesbian youths in their transition to a healthy adulthood.

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Homosexuality and Adolescence
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Homosexuality and Adolescence
Pediatrics 1993;92;631

Position Statement on Psychiatric Treatment and Sexual Orientation

Approved by the Board of Trustees, December 1998
Approved by the Assembly, November 1998

"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – *APA Operations Manual.*

The Board of Trustees of the American Psychiatric Association (APA) removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973 after reviewing evidence that it was not a mental disorder. In 1987 ego-dystonic homosexuality was not included in the revised third edition of DSM (DSM-III-R) after a similar review.

APA does not currently have a formal position statement on treatments that attempt to change a person's sexual orientation, also known as "reparative therapy" or "conversion therapy." In 1997 APA produced a fact sheet on homosexual and bisexual issues, which states that "there is no published scientific evidence supporting the efficacy of "reparative therapy" as a treatment to change one's sexual orientation."

The potential risks of "reparative therapy" are great and include depression, anxiety, and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone "reparative therapy" relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian are not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed. APA recognizes that in the course of ongoing psychiatric treatment, there may be appropriate clinical indications for attempting to change sexual behaviors.

Several major professional organizations, including the American Psychological Association, the National Association of Social Workers, and the American Academy of Pediatrics, have made statements against "reparative therapy" because of concerns for the harm caused to patients. The American Psychiatric Association has already taken clear stands against discrimination, prejudice, and unethical treatment on a variety of issues, including discrimination on the basis of sexual orientation.

Therefore, APA opposes any psychiatric treatment, such as "reparative" or "conversion" therapy, that is based on the assumption that homosexuality per se is a mental disorder or is based on the a priori assumption that the patient should change his or her homosexual orientation.

An initial version of this position statement was proposed in September 1998 by the Committee on Gay, Lesbian, and Bisexual Issues of the Council on National Affairs. It was revised and approved by the APA Assembly in November 1998. The revised version was approved by the Board of Trustees in December 1998. The committee members as of September 1998 were Lowell D. Tong, M.D. (chairperson), Leslie G. Goransson, M.D., Mark H. Townsend, M.D., Diana C. Miller, M.D., Cheryl Ann Clark, M.D., Kenneth Ashley, M.D. (consultant); corresponding members*: Stuart M. Sotsky, M.D., Howard C. Rubin, M.D., Daniel W. Hicks, M.D., Ronald L. Cowan, M.D.; Robert J. Mitchell, M.D. (Assembly liaison), Karine Igartua, M.D. (APA/Glaxo Wellcome Fellow), Steven Lee, M.D. (APA/Bristol-Myers Squibb Fellow), and Petros Levounis, M.D. (APA/Center for mental Health Services Fellow).*

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

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Appropriate Therapeutic Responses to Sexual Orientation

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

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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.

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CONTENTS

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 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.

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.

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 Nonmaleficense), 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.

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 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.)

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 variant[3] 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).

[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.

[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).

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 harmful[6] 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 stigma[7] 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 multicultural 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 accept and adopt a gay or lesbian identity (e.g., Browning et al., 1991; Shannon & Woods, 1991), the recent research on sexual orientation identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation identity are 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 expression[8]; (e) the sex[9] and gender of their partner; and (f) the forms of their relationships.

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.

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 Psychology[11] (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; Syzmanski & 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; 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-

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.

[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; Saldaina, 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).

[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.

[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.

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 reliously-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

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*, 2003, *32*[5]; *The Counseling Psychologist*, 2004, *32*[5]; *Journal of Psychology and Christianity*, 2005, *24*[4]) have specifically considered the interactions among scientific views of sexual orientation, religious beliefs, psychotherapy, and professional ethics. 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.

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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 goals[16]) (W. 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 self[17]) (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

[16] These conflicts are not unique to religious individuals but are applicable to individuals making commitments and decisions about how 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.

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 & Ouellette, 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 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 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 other[20] 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 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.

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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 homophile[21] 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 se[22] 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).

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 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.

[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 review[26] 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 literature[27] and lay material. In this chapter, we provide an overview of the review and a detailed report on the methodological concerns that affect the validity[28] 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 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-quality[30] 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; Wolkimir, 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 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.

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;

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).

[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 experimental[32] 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 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.

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, & Michals, 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; Hoburg, 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; Wolkomir, 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.

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.

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 experiements 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 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 research findings from early and recent studies may have limited applicability to non-Whites, youth, or women.

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 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

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.

[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, 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.

The recent empirical literature provides little basis for concluding whether SOCE has any effect on sexual orientation.

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, Blitch 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 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.

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 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

[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.

[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.

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 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).

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.

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 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.

Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life.

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 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 the needs of this population so that an affirmative therapeutic approach may be developed.

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.

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

[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.

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 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 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 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).

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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; Horalcher, 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 heath 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 Jews[41] (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 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 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 in other ways than SOCE.

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 (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).

[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.

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 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.

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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 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.

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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 intrinsic[43] 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 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 to resolve the distress caused by conflicts between religious values and sexual orientation.

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; Hoburg 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 theaw 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 approach[45] (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 (Bronfennbrenner, 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).

The empathic therapeutic environment aspires to be a place of compassionate caring and respect that facilitates development... by exploring issues without criticism or condemnation and reducing distress caused by isolation, stigma, and shame.

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, 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).

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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 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.

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.

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, & 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).

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.

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 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,

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.

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, 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.

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 identity[49] 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 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).

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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; Kitzinger, & 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 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.

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.

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 ADULTS[50]

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 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.

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.

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 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.

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.

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 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; Wolkomir, 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.

… 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-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).

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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 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).

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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 adolescents[58] 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 involuntary[60] 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. Menveille, 1998; E. J. Menveille & 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 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 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 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).

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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; 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).

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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 Refuge[63] 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 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).

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.

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 (Radkowsky & 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 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.

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 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 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).

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.

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

[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/.

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 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).

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.

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; Mustanksi 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; Wolkomir, 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; Hoburg 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 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

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).

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 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.

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.

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 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.

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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.

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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, Hershberger, & 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.

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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 (*n*s = 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, Agrus, Abel, Blanchard, & Young, 1975	3	100	Clinical	None reported	Single case pre–post within-subject	Biofeeback	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 & Wincze, 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

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).[1] 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, 2008b).

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, 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 to 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 orien-

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tation (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[2] (Herek, 2009; Herek & Garnets, 2007) 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 (APA) 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, 2008b); and

WHEREAS the APA 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, 2008b); and

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, 2008b); and

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, 2008b); and

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 also recognizing they can appropriately speak to theological implications of psychological science (APA, 2008b); and

WHEREAS the APA 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, 2008b); and

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); and

WHEREAS some mental health professionals advocate treatments based on the premise that homosexuality is a mental disorder (e.g., Nicolosi, 1991; Socarides, 1968); and

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 (Cianciotto & 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, Hershberger, & Pilkington, 1998; Goodenow, Szalacha, & Westheimer, 2006; Savin-Williams, 1989) for sexual minority youth;

THEREFORE BE IT RESOLVED that the APA 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 APA 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 APA concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation;

BE IT FURTHER RESOLVED that the APA 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 APA 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 APA 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 APA 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 APA 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: scientific bases for professional judgments, benefit and harm, justice, and respect for people's rights and dignity;

BE IT FURTHER RESOLVED that the APA 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 APA 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 APA 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;

BE IT FURTHER RESOLVED that the APA 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 wellbeing of sexual minorities.

ENDNOTES

1. The APA uses the term *sexual orientation change efforts* to describe all means to change sexual orientation (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches). This includes those efforts by mental health professionals, lay individuals, including religious professionals, religious leaders, social groups, and other lay networks such as self-help groups.
2. The Task Force uses 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 the Task Force recognizes that not all sexual minority individuals adopt a lesbian, gay, or bisexual identity.

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2012 - Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression

The American Psychoanalytic Association affirms the right of all people to their sexual orientation, gender identity and gender expression without interference or coercive interventions attempting to change sexual orientation, gender identity or gender expression.

As with any societal prejudice, bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice.

Psychoanalytic technique does not encompass purposeful attempts to "convert," "repair," change or shift an individual's sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes.

Adopted June 2012. This position statement replaces APsaA's December 1999 position statement on reparative therapy

Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents

Children and adolescents who are growing up gay, lesbian, bisexual, gender nonconforming, or gender discordant experience unique developmental challenges. They are at risk for certain mental health problems, many of which are significantly correlated with stigma and prejudice. Mental health professionals have an important role to play in fostering healthy development in this population. Influences on sexual orientation, gender nonconformity, and gender discordance, and their developmental relationships to each other, are reviewed. Practice principles and related issues of cultural competence, research needs, and ethics are discussed. J. Am. Acad. Child Adolesc. Psychiatry, 2012;51(9):957–974. **Key Words:** sexual orientation, homosexuality, bisexuality, gender identity disorder, gender discordant.

Scientific studies demonstrating the healthy, adaptive functioning of the great majority of gay and lesbian adults paved the way toward removal of homosexuality as an illness from the *DSM* in 1973.[1] Homosexuality is now recognized as a nonpathological variant of human sexuality. Although the great majority of gay and lesbian individuals have normal mental health, as a group they experience unique stressors and developmental challenges. Perhaps in part as a consequence of these challenges, adult and adolescent members of sexual minorities (defined below) develop depression, anxiety disorders, substance abuse, and suicidality at rates that are elevated in comparison with those in the general population.[2,3] Thus, psychosocial distress may account for the different rates in depression, hopelessness, and current suicidality seen between gay, lesbian, and bisexual adolescents and their heterosexual peers.[4] Studies in the U.S. and the Netherlands document this problem continuing into adulthood, and show a significant association among stigma, prejudice, discrimination, and poor mental health.[2,5,6]

Sexual development comprises biological, psychological, and social aspects of experience. Extensive scientific research, described below, has been conducted on the influence of these factors on sexual orientation and gender in recent years. Much of what has been learned scientifically about sexual orientation and gender development in the last generation has occurred in parallel with societal changes in attitudes toward sexual orientation and gender roles. While bias against sexual minorities is declining in many segments of society, intolerance is still widespread. Children and adolescents are exposed to these negative attitudes and are affected by them. This Practice Parameter is intended to foster clinical competence in those caring for children and adolescents who are growing up to be gay, lesbian, bisexual, gender variant, or transgender, reflecting what is currently known about best clinical practices for these youth.

METHODOLOGY

The list of references for this Practice Parameter was developed by online searches of Medline and PsycINFO. A search of PsycINFO articles published since 1806 and Medline articles published from 1950 through April 27, 2010, of key-word terms "sexual orientation," "gay," "homosexuality," "male homosexuality," "lesbianism," "bisexuality," "transgender," "transsexualism," "gender variant," "gender atypical," "gender identity disorder," and "homosexuality, attitudes toward" limited to English language, hu-

man subjects, and ages 0–17 years (PsycINFO) or 0–18 years (Medline) produced 7,825 unique and 967 duplicate references.

To take full advantage of the MeSH Subject Headings database, a subsequent search was conducted of articles in the Medline database through May 3, 2010 using MeSH Subject Headings terms "homosexuality," "male homosexuality," "female homosexuality," "bisexuality," "transsexualism," and limiting articles to those written in English and related to human subjects, all child and adolescent ages (0–18 years). This search produced 2,717 references.

Similarly, to take full advantage of the Thesaurus Terms (Descriptors) database, a subsequent search was conducted of articles in the PsycINFO articles through May 14, 2010 using Thesaurus Terms (Descriptors) "sexual orientation," "homosexuality," "male homosexuality," "female homosexuality," "lesbianism," "bisexuality," "transgender," "transsexualism," "gender identity disorder," and "homosexuality (attitudes toward)" and limiting articles to those written in English and related to human subjects of childhood age (0–12) and adolescent age (13–17). This search produced 1,751 references.

The combined search in Medline MeSH Subject Headings and PsycINFO Thesaurus Terms (Descriptors) databases produced 4,106 unique references and 361 duplicate references. Of the 4,106 unique references, the following were winnowed out: 345 books or book sections; 94 dissertation abstracts; 18 editorials; 13 articles whose focus was primarily historical; 104 theoretical formulation or comment without peer review; 163 case reports or brief series; 32 related primarily to policy or law; 19 related to news; 74 related primarily to research methods; 736 primarily about human immunodeficiency virus (HIV)/acquired immune deficiency sydrome (AIDS) and an additional 404 about early HIV/AIDS or other sexually transmitted illness; one each related to an award, book review, or interview; 168 that dealt primarily with diseases, reproduction, paraphilia or intersex conditions beyond the scope of the Parameter; an additional 8 that fell outside the specified age range; an additional 26 duplicates that were found; and 10 dating from 1960 to 1975 related to aversive or "reparative" techniques intended to change sexual orientation that are inconsistent with current ethical position statements of the American Psychiatric Association.[7] This winnowing process yielded 1,889 references.

To help ensure completeness of the search strategies, the search results using Medline MeSH terms and PsycINFO Thesaurus terms (Descriptors) were compared to key-word terms of the Medline and PsycINFO databases. This comparison demonstrated 1,113 overlapping references, with 6,712 unique to the key-word search and 2,993 unique to the combined Thesaurus Term (Descriptor) and MeSH searches.

An updated Medline search of articles through March 3, 2011, of the MeSH database using the same Subject Headings and limits used in the previous search produced 138 references. An updated PsycINFO search of articles through March 3, 2011, of the Thesaurus database using the same Terms (Descriptors) and limits used in the previous search produced 107 references.

Throughout the search, the bibliographies of source materials including books,[8-10] book chapters,[11] and review articles.[12-14] were consulted for additional references that were not produced by the online searches. Bibliographies of publications by the following experts were also examined to find additional pertinent articles not produced by online searches: Jennifer I. Downey, M.D., Jack Drescher, M.D., Richard C. Friedman, M.D., Gilbert Herdt, Ph.D., Richard Isay, M.D., Ellen Perrin, M.D., Heino F. L. Meyer-Bahlburg, Dr. rer. nat., Gary Remafedi, M.D., M.P.H., and Kenneth Zucker, Ph.D. Recent studies and discussions at scientific meetings in the past decade were considered for inclusion.

From the list of references assembled in this way, references were selected whose primary focus was mental health related to sexual orientation, gender nonconformity, and gender discordance in children and adolescents. References that were not a literature review, published in peer-reviewed literature, or based on methodologically sound strategies such as use of population-based, controlled, blinded, prospective, or multi-site evidence were eliminated. References were selected that illustrated key points related to clinical practice. When more than one reference illustrated a key point around which there is general consensus, preference was given to those that were more recent, relevant to the U.S. population, most illustrative of key clinical concepts, based upon larger samples, prospective study design, or meta-analysis. When discussing issues around which consensus is not yet established,

citations illustrating a representative sample of multiple viewpoints were selected.

DEFINITIONS

Many terms related to sexual development are being continually updated. The following definitions reflect current terminology, and are used in this Practice Parameter.

- *Sex*, in the sense of being male or female, refers to a person's anatomical sex. (Although usually considered dichotomously male or female, disorders of sex development can lead to intersex conditions, which are beyond the scope of this Practice Parameter).
- *Gender* refers to the perception of a person's sex on the part of society as male or female.
- *Gender role behavior* refers to activities, interests, use of symbols, styles, or other personal and social attributes that are recognized as masculine or feminine.
- *Gender identity* refers to an individual's personal sense of self as male or female. It usually develops by age 3, is concordant with a person's sex and gender, and remains stable over the lifetime. For a small number of individuals, it can change later in life.
- *Identity* refers to one's abstract sense of self within a cultural and social matrix. This broader meaning (equivalent to ego identity) is distinct from gender identity, and usually consolidated in adolescence.
- *Sexual orientation* refers to the sex of the person to whom an individual is erotically attracted. It comprises several components, including sexual fantasy, patterns of physiological arousal, sexual behavior, sexual identity, and social role.
  - *Homosexual* people are attracted erotically to people of the same sex, and are commonly referred to as gay in the case of males, and gay or lesbian in the case of females.
  - *Heterosexual* people are attracted erotically to people of the other sex.
  - *Bisexual* people are attracted erotically to people of both sexes.
- *Sexual minority* refers to homosexual and bisexual youth and adults.
- *Sexual prejudice* (or more archaically, *homophobia*) refers to bias against homosexual people. "Homophobia" is technically not a phobia; like other prejudices, it is characterized by hostility and is thus a misnomer, but the term is used colloquially.[15]
- *Internalized sexual prejudice* (or colloquially, *internalized homophobia)* is a syndrome of self-loathing based upon the adoption of anti-homosexual attitudes by homosexual people themselves.
- *Heterosexism* refers to individual and societal assumptions—sometimes not explicitly recognized—promoting heterosexuality to the disadvantage of other sexual orientations.
- *Childhood gender nonconformity* refers to variation from norms in gender role behavior such as toy preferences, rough-and-tumble play, aggression, or playmate gender. The terms *gender variance* and *gender atypicality* have been used equivalently in the literature.
- *Gender discordance* refers to a discrepancy between anatomical sex and gender identity. The term *gender identity variance* has been used to denote a spectrum of gender-discordant phenomena in the literature.
  - *Transgender* people have a gender identity that is discordant with their anatomical sex.
  - *Transsexuals* are transgender people who make their perceived gender and/or anatomical sex conform with their gender identity through strategies such as dress, grooming, hormone use and/or surgery (known as *sex reassignment*).
- *Gender minority* refers to gender nonconforming and gender-discordant children, adolescents, and adults.

HOMOSEXUALITY

Homosexuality comprises multiple components, and can refer to several aspects of same-sex attraction, including physiological arousability, erotic fantasy, sexual behavior, psychological identity, or social role. These facets of homosexuality can be congruent or incongruent in any given person.[9,16] Many men and women with homosexual desire suppress their feelings or behavior, agonize over sexual orientation, or have homosexual relationships they keep secret while maintaining a heterosexual public identity.

Not surprisingly, rates of homosexuality vary depending upon definition and study method. In one study, adult males reported same-sex experience rates of 2.7% for the past year, 4.9% since age 18 years, and approximately 7–9% since puberty; for women, rates were 1.3%, 4.1%, and approximately 4%, respectively.[16] Homosexual-

ity was correlated with higher education and urban residence. In another study, rates of lifetime same-sex experience were 6.7% for men and 14.2% for women, and 3% of men and 4% of women reported a same-sex partner in the preceding 12 months.[17]

One large sample of predominantly white but geographically and socioeconomically diverse junior and senior high school students found that 10.1% of males and 11.3% of females were "unsure" of their sexual orientation, and 1.5% of males and 1.1% of females said they were "bisexual or predominantly homosexual." Same-sex attractions were reported by 4.5% of males and 5.7% of females, same-sex fantasies by 2.2% of males and 3.1% of females, and same-sex sexual behavior by 1.6% of males and 0.9% of females. Of youth with homosexual experience, only 27.1% identified themselves as gay, consistent with a struggle with identity and group affiliation.[18]

Influences on Sexual Orientation

There is evidence that biological factors influence sexual orientation.[19] Evidence from a variety of animal and human studies indicate that prenatal neuroendocrine factors, including levels of sex hormones, influence sexual organization of the brain in utero when neuronal patterns are laid down, and activate their sexual function beginning in puberty.

Neuroendocrine Factors. The *neurohormonal theory* of sexual orientation posits that prenatal sex hormone levels influence development of gender role behavior in childhood and sexual orientation in adulthood.[20] However, evidence of the organizing effects of sex hormones in females, and of the degree to which animal studies may be relevant to humans is limited.[21] Although sex hormone levels during fetal brain development may influence childhood gender variance and adult sexual orientation, neither homosexuality nor gender variance is an indication for endocrine, genetic, or any other special medical evaluation.

Genetic Factors. There is evidence of a genetic influence on gender role behavior in childhood and sexual orientation in adulthood from family, twin, and molecular studies.[19] One study found that, among gay adult males, 52% of monozygotic co-twins were homosexual, whereas only 22% of dizygotic co-twins and 11% of adoptive brothers were homosexual.[22] Another study found that, among adult lesbians, 48% of monozygotic co-twins, 16% of dizygotic co-twins, and 6% of adoptive sisters were also lesbian.[23] These data suggest a substantial heritable influence on sexual orientation.

Neuroanatomy. Limited evidence suggests that the size of certain neuroanatomical features may correlate with sexual orientation. In males, these may include the third anterior interstitial nucleus of the hypothalamus (INAH-3)[24] and the suprachiasmatic nucleus (SCN).[19] Further research is needed to confirm these results and to establish their significance. When used appropriately, information about biological influences on sexual orientation can be relevant to patients, families, and clinicians. However, such influences do not constitute an illness.

Psychological and Social Factors. Before the shift to empirically based psychiatry following the publication of *DSM-III*, prevailing psychiatric theory ascribed homosexuality to character pathology.[1] However, this view was revised because of a lack of empirical evidence. Although homosexuality is associated with somewhat elevated rates of certain psychiatric disorders such as depression and anxiety, there is no evidence from any controlled scientific study that most gay and lesbian people suffer from character pathology, or from any other mental illness; on the contrary, the vast majority do not.[2,3] In addition, studies of character profiles and defense mechanisms have found no differences between nonheterosexuals and the general population.[25,26] Another theory, that male homosexuality resulted from overly close mothers and hostile or distant fathers, was similarly not supported by empirical study of nonclinical populations.[27] Rather, nonclinical groups of gay adults, especially males, appear to have childhood histories of gender nonconformity; their family relationships may be the result rather than the cause of gender nonconformity, and may possibly be subject to a degree of recall bias.[28,29]

Social learning does not appear to influence sexual orientation at the level of erotic fantasy or physiological arousal, although it can influence identity and social role in both positive and negative ways. Knowledge of other homosexual people is not necessary for the development of a homosexual orientation.[9] The effect of parents'

sexual orientation on their children's own gender development and sexual orientation has been investigated in longitudinal studies of community samples in the U.S. and the United Kingdom.[30-33] Parents' sexual orientation had no effect on gender development in general. This was true even though tolerance for gender nonconformity was more common among lesbian parents than among heterosexual ones. Boys raised by lesbian couples demonstrated greater gender role flexibility such as helping with housework, on average, a social strength that was also observed in some heterosexual-parent families, and that appears to be influenced more by parental attitudes than by parental sexual orientation. Regarding sexual orientation in adolescents who were raised by same-sex parents (including same-sex attraction, same-sex relationships, and gay identity), compared with the general population, no differences in sexual attraction are found; the large majority of adolescents raised by lesbian couples identify as heterosexual. However, in the minority of cases, when they do experience same-sex attractions, adolescent girls raised by lesbian parents appear to experience less stigma about acting on those feelings than those raised by heterosexual parents, and are accordingly slightly more likely to identify as bisexual.[33] Data on children raised by gay male couples is relatively lacking, but preliminary evidence appears to be consistent with the findings in children raised by lesbian couples.[30]

Exposure to anti-homosexual attitudes can induce shame and guilt in those growing up gay, leading them to suppress a gay identity or same-sex behavior; conversely, well-adjusted gay or lesbian adults can provide positive role models for youth.[7] There is no rational basis for depriving gay youth of such role models, as stereotyped views of homosexual adults as being more likely to commit sexual abuse of minors is not supported by evidence.[34,35]

Psychosexual Development and Homosexual Orientation

Children display aspects of sexuality from infancy, and develop sexual feelings almost universally by adolescence or earlier. Although most people are predominantly heterosexual, some develop predominantly same-sex attractions and fantasies in or before adolescence. Most boys, whether heterosexual or homosexual, experience a surge in testosterone levels and sexual feelings in puberty, and almost all begin to masturbate then.[36] Most girls experience more gradually increasing sexual desires. A majority of girls, although a smaller majority than among boys, also begin to masturbate, and they do so over a broader age range. Erotic fantasizing often accompanies masturbation, and may crystallize sexual orientation.[37] Whether heterosexual or homosexual, most men experience more frequent interest in sex and fantasies involving explicit sexual imagery, whereas women's sexual fantasies more often involve romantic imagery.[38] Sexual behavior with others typically begins in or after mid-to-late adolescence, although the age of onset of activity, number of partners, and practices vary greatly among individuals.[16]

One possible developmental pathway of male homosexuality proceeds from same-sex erotic fantasy to same-sex experience, then homosexual identity (self-labeling as gay), and finally a homosexual social role (identifying oneself as gay to others).[39] In comparison with those who first identify as gay in adulthood, those who identify as gay in adolescence may be somewhat more likely to self-label as gay before same-sex experience, and to achieve the foregoing gay developmental milestones earlier. This developmental path appears to be more common in recent cohorts than it once was,[40] perhaps reflecting the consolidation of a gay identity earlier in recent generations as the result of the increasing visibility of gay role models for adolescents. Developmental pathways may be more variable in females, whose sexuality is generally more fluid than that of males.[41] Compared with men, women are more likely to experience homosexual as well as heterosexual attraction across the lifespan.[12] This may occur only in youth, may emerge in adulthood, or may be stable through life.[42]

Certainty about sexual orientation and identity—both gay and straight—increases with age, suggesting "an unfolding of sexual identity during adolescence, influenced by sexual experience and demographic factors."[18] Although it may be difficult to tell which developmental path a particular adolescent is on at a given moment, a consistently homosexual pattern of fantasy, arousal, and attraction suggests a developmental path toward adult homosexuality. Retrospectively, many gay men and lesbians report same-sex erotic attraction from youth onward.[28]

Development of Gender Role Behavior. Boys and girls generally exhibit different patterns of gender role behavior. These are quite distinct from erotic feelings, instead involving such areas as toy preferences, play patterns, social roles, same-sex or opposite-sex peer preferences, gesture, speech, grooming, dress, and whether aggression is expressed physically or through social strategies.[43,44] For example, most boys are more likely than girls to engage in rough-and-tumble play. Most boys exhibit aggression physically, whereas most girls do so through verbal and social means. When given a choice, most boys are more likely to select conventionally masculine toys such as cars, trains, and adventure or fighting games, whereas most girls more frequently select conventionally feminine toys such as dolls, jewelry, and nurturing games. Most children exhibit a preference in middle childhood for same-sex playmates, or "sex-segregated play."

Social, psychological, and biological factors, including genetic and environmental ones, interactively influence childhood gender role behavior and gender identity.[45,46] Sex differences exist at multiple levels of brain organization, and there is evidence of neuroanatomic differences between gender-typical and gender-atypical individuals. At the same time, part of a developing child's cognitive understanding of gender—for example, whether competitiveness and aggression can be feminine, or whether empathic, nurturing activities can be masculine—is related to societal norms.[47] As science has progressed, the complexity of the way in which factors related to gender role behavior such as genes, hormones, and the environment (including the social environment) interact have come to be better appreciated. Psychological experience is presumably reflected in brain structure or function, and each may influence the other. Previous questions about the roles of nature and nurture in causing childhood gender role differences have come to be understood as overly simplistic, and have been replaced by models showing biological and environmental factors influencing one another bidirectionally during critical periods in neurodevelopmental processes that are sometimes modifiable and sometimes fixed.

Gender Nonconformity and Its Developmental Relationship to Homosexuality. Most boys and girls display some variability in gender role behavior. However, some children display toy, play, and peer preferences that are typical of the other gender. They have been referred to as "gender atypical," "gender variant," or, increasingly, "gender nonconforming" in scholarly literature. Childhood gender nonconformity often is a developmental precursor of homosexuality in males, and sometimes in females.[48]

Although childhood gender nonconformity does not predict adult homosexuality with certainty, many gay men recall boyhood aversion to rough-and-tumble play, aggressive behavior, and competitive athletics.[49] In females, gender nonconformity (e.g., being a "tomboy") is sometimes associated with adult homosexual orientation, although less consistently than in males.[50] Many gay people report having felt "different" from others long before the development of erotic feelings as such due to childhood gender nonconformity, which can elicit teasing, low peer status, and poor self-esteem; boys, who may particularly value adherence to gender norms, may be especially distressed.[51]

Although gender nonconforming children may experience discomfort or marked anxiety if forced to participate in gender-typical behaviors, their gender identity is entirely congruent with their sex. They do not express a wish to be, or belief they are, the other sex. On the contrary, gender nonconforming boys in particular may be upset by feelings they are insufficiently masculine, especially in contexts in which gender norms are highly valued.[9]

Adolescence, Sexual Orientation, and Identity Formation. Adolescence normally brings increased sexual and aggressive drives, social role experimentation, and separation and individuation for all youth. For those who are developing as gay, lesbian, bisexual, or transgender, the challenge of establishing one's ego identity—including a sense of one's sexual identity—is uniquely complex. Although most heterosexual youth take social acceptance of their sexual orientation for granted, sexual and gender minority youth usually cannot.[9] They must cope with feeling different, ostracism, and dilemmas about revealing a sexual identity that is discrepant from family and social expectations ("coming out").[13] These adolescents are at somewhat elevated risk for having suicidal thoughts[52-54]; however, only a minority actually do, indicating a capacity for resilient coping in most.

Increasing social acceptance may encourage gay, lesbian, or bisexual adolescents to come out more frequently and at younger ages. However, some youth who become aware that they have homosexual feelings may be unprepared to cope with possible negative attitudes that they may encounter among their own family or peers.[55]

Clinical Issues in Homosexuality

Effects of Stigma, Peer Rejection, Bias, and Bullying. Despite increasing tolerance, gender and sexual minority youth may experience criticism, ostracism, harassment, bullying, or rejection by peers, family, or others, even in relatively tolerant, cosmopolitan settings.[56] These can be associated with significant social problems, distress, and psychological symptoms.[57] They may be shunned or disparaged when they long for peer acceptance. A poor developmental fit between children's gender nonconformity or sexual orientation and parents' expectations can result in distress for both parent and child.[11]

Internalized Sexual Prejudice. Even when not personally threatened, homosexual youths may be indirectly or overtly disparaged by family or peers. They may observe other gay people experiencing disrespect, humiliation, lower social status, or fewer civil rights. This experience may create difficulty reconciling the simultaneous developmental needs to form a sexual identity on the one hand and to feel socially acceptable on the other, typically a painful developmental conflict for gay youth.[13] They may identify with others who are emotionally important to them but sexually prejudiced, leading to a syndrome of self-loathing (internalized sexual prejudice, or "internalized homophobia"). This may adversely affect self-esteem, lead to denial of same-sex attractions, cause difficulty identifying with other gay people, and prevent formation of healthy relationships.[8]

Revealing a Homosexual Orientation to Others. Many gay and lesbian youth hide their identity from others.[55] The dilemma over whether to reveal a homosexual orientation—to "come out of the closet" or "come out"—is a unique aspect of the psychological development of sexual and gender minority youth. They must decide whether to hide their sexual orientation (remain "in the closet," or "closeted") or risk rejection. Coming out is usually a highly significant event that may be anticipated with dread. There is no single answer to the question whether a particular gay youth should come out, or to whom. This requires judgment about the youth's maturity and coping, as well as the social context. For some, coming out brings great relief. Others in hostile environments may come out with bravado before it is safe; for them, remaining closeted or in denial may be adaptive.

GENDER IDENTITY AND GENDER DISCORDANCE

For the vast majority of people, gender identity is established in toddlerhood, is consistent with biological sex, and remains fixed. This holds true for many children with gender-nonconformity in toy, play, and playmate preferences. However, some children experience not only gender nonconformity, but also discomfort with their biological sex. They derive comfort from being perceived as, or a wish to be, the other sex. The desire leads to discordance between gender identity and phenotypic sex, a core feature of gender identity disorder (GID) as conceptualized in the *DSM-IV*.[58] The diagnosis of GID in children is controversial, and the degree to which *DSM-IV* criteria reflect an illness or social bias against gender nonconformity has been debated.[59,60]

Several different categories of gender discordance, each characterized by a unique developmental trajectory, have been described.[61] They differ in regard to whether gender discordance emerges in childhood, adolescence or adulthood; whether the gender discordance is persistent or transient; and whether there is a post-transition homosexual or heterosexual orientation. These heterogeneous developmental trajectories may subsume different causes of gender discordance.

In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2%[62] to 11.9%[63] continuing to experience gender discordance. Rather, 75% become homosexual or bisexual in fantasy and 80% in behavior by age 19; some gender-variant behavior may persist.[63] The desistence of gender discordance may reflect the resolution of a "cognitive confusion factor,"[64] with increasing flexibility as children mature in thinking about gender identity and realize that one

can be a boy or girl despite variation from conventional gender roles and norms.

In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood.[65] This gender discordance may lead to life-long efforts to pass socially as the other sex through cross-dressing and grooming, or to seek sex reassignment through hormones or surgery.

Many of the clinical issues pertaining to gay and lesbian youth doubtlessly affect youth with gender discordance as well. In addition, children and especially adolescents with gender discordance have been found to have behavior problems and anxiety.[66,67] Proposed causes include family and social opprobrium, the discrepancy between psychological and anatomic gender, and maternal and family psychopathology.[65,68]

Factors Influencing Development of Gender Discordance

Causes of gender discordance may include biological factors.[59] Genetic males with gender discordance tend to have a later birth order, more male siblings, and lower birth weight, suggesting an influence of prenatal events that is poorly understood. Individuals with gender discordance may differ in central nervous system lateralization from the general population. Consistent with this hypothesis, they are more likely to be non-righthanded, to have abnormal EEG findings, and to have lateral otoacoustic processing consistent with their gender identity compared to a non-gender discordant population.[59] As with sexual orientation, variations in prenatal sex hormones may influence later gender identity, but do not appear to fully determine it.[69] There is evidence that the central bed nucleus of the stria terminalis (BSTc), a hypothalamic structure implicated in sexual behavior, is small in male to female transsexuals, similar to most females.[70]

A hypothesis that inappropriately close maternal and overly distant paternal relationships causes gender discordance in boys was not borne out by empirical study, which found both mothers and fathers to be distant from sons with gender discordance, possibly a result, rather than the cause, of gender discordance.[62] A theory that predisposing biological factors, temperamental anxiety, and parental tolerance for gender nonconformity interact to cause gender discordance has not been empirically tested.[71] A controlled study found increased rates of psychopathology in mothers of boys with gender discordance, but was not designed to assess a causal relationship.[68]

PRINCIPLES

Principle 1. A comprehensive diagnostic evaluation should include an age-appropriate assessment of psychosexual development for all youths.

The psychiatric evaluation of every patient should take into consideration psychosexual development in a way that is appropriate to developmental level and the clinical situation. Questions about sexual feelings, experiences, and identity or about gender role behavior and gender identity can help clarify any areas of concern related to sexuality. The history should be obtained in a nonjudgmental way, for example without assuming any particular sexual orientation or implying that one is expected. This can be conveyed, for example, by the use of gender-neutral language related to the aim of affection (e.g., asking "is there someone special in your life?" rather than "do you have a boyfriend/girlfriend?") until the adolescent reveals a particular sexual orientation.

Sexual and gender minority adolescents very frequently face unique developmental challenges, as described above. If an initial screen indicates that issues of sexual orientation, gender nonconformity, or gender identity are of clinical significance, these challenges can be explored in greater depth.

Principle 2. The need for confidentiality in the clinical alliance is a special consideration in the assessment of sexual and gender minority youth.

Issues of confidentiality are important with all patients; they are particularly so with sexual and gender minority youth, who require a clinical environment in which they can explore their developing orientation and identity. Prior experiences of rejection and hostility may lead them to watch social cues vigilantly to determine whether they can safely reveal their sexual orientation to others without fear of bias or judgment. Any sign of these in a mental health professional may induce shame and undermine the clinical alliance.

Clinicians should bear in mind potential risks to patients of premature disclosure of sexual

orientation, such as family rejection or alienation from support systems, which might precipitate a crisis. They should be familiar with standard confidentiality practices for minors, and should protect confidentiality when possible to preserve the clinical alliance. This is particularly true when using media such as electronic health records, in which sensitive information can be easily disseminated. It is often helpful to emphasize reasonable expectations of privacy in the clinical relationship with sexual and gender minority youth—not to express shame, but to permit the exploration of sexual identity free from fear and with a sense of control over disclosure. As the development of sexual identity is variable, it is often desirable to allow youth to set the pace of self-discovery.

Principle 3. Family dynamics pertinent to sexual orientation, gender nonconformity, and gender identity should be explored in the context of the cultural values of the youth, family, and community.

Families of sexual or gender minority youth may consult mental health professionals for a variety of reasons, for example, to ask whether a disclosure of being gay represents a temporary stage, to request support for an adolescent, or to address problems such as bullying, anxiety, or depression. Just as some adults try to alter their sexual orientation,[72] some parents may similarly hope to prevent their children from being gay. Difficulty coping with prejudice and stigma are often the appropriate focus of treatment.

Families treat gay or gender-discordant children with considerable variation. Whereas some accept their children, others explicitly or implicitly disparage or reject them, evoking shame and guilt; some force them to leave home. Although some are surprised by a child's coming out, others are not, and some are supportive. Families may have to fundamentally alter their ideas about a child who comes out, confront misconceptions, and grieve over lost hopes and/or expectations. Most parents experience distress following a child's coming out, frequently experiencing cognitive dissonance or feelings of anxiety, anger, loss, shame, or guilt; despite this, over time the majority become affirming and are not distressed.[73] Children frequently predict their parents' reactions poorly. Ideally, families will support their child as the same person they have known and loved, although doing so may require time.

Youth who are rejected by their parents can experience profound isolation that adversely affects their identity formation, self-esteem, and capacity for intimacy; stigmatized teens are often vulnerable to dropping out of school, homelessness (which may lead to exploitation or heightened sexual risk), substance abuse, depression and suicide.[53] Clinicians should aim to alleviate any irrational feelings of shame and guilt, and preserve empathic and supportive family relationships where possible. They should assess parents' ideas about what constitutes normal, acceptable behavior, their cultural background, and any misconceptions or distorted expectations about homosexuality. These may include fears that their child will have only casual relationships, is fated to contract HIV/AIDS, cannot become a parent if desired, or will be ostracized. Stereotyped views of gay males as engaging only in numerous, indiscriminate sexual encounters are not supported by empirical research except in rare cases.[12] If such behavior is present and cannot be explained as part of normal adolescent sexual drive or identity formation, factors known to be associated with excessive sexuality in youth, such as a history of sexual abuse, family dysfunction, a pattern of conduct problems, or mood disorder such as bipolar disorder or depression, should be considered. Clinicians should screen for all forms of abuse or neglect (as in any evaluation), with careful attention to adverse family reactions to a youth's sexual or gender development. If these are suspected, they should involve child protective services as clinical appropriateness and ethical and legal mandates warrant. Support groups may be helpful for families in distress. In cases of protracted turmoil or family pathology, referrals to family therapy, individual or couples therapy may be appropriate.

Sexual and gender minority youth may experience unique developmental challenges relating to the values and norms of their ethnic group.[74] Various groups may place different emphasis on ideals of masculinity or femininity, on family loyalty, or on social conformity; some with authoritarian parenting ideals may sanction youth who reject traditional mores.

For gay and lesbian adolescents who are also members of ethnic minorities, the deleterious effect of anti-homosexual bias may be compounded by the effect of racial prejudice. In

response to unique pressures to gain group acceptance, they may give particular weight to negative group stereotyping of gay people. Gay and lesbian youth who are also members of ethnic minorities may be less likely than nonminority youth to be involved in gay-related social activities, to be comfortable with others knowing they are gay, or to disclose a gay identity.[75] In caring for youth who are members of both ethnic and sexual minorities, mental health professionals should take into account the unique complexities of identity formation for these groups.

Religion, often a valued aspect of identity, can vary widely regarding tolerance for sexual minorities. Membership in relatively more liberal or conservative religious groups is a significant influence on one's "sexual script," or social pattern in the expression of sexuality.[16] Some minority denominations hold strong religious injunctions against homosexuality and stricter views about gender roles. As a result, members of certain religious groups can experience special challenges in integrating their sexual identity with family and community values. However, many religious groups are reconciling their traditions with more inclusive values. This remains an area of active social and cultural debate and change. Clinicians should respect the religious values of their patients, and should be aware of ongoing developments in religious thinking that may provide opportunities to integrate the religious and sexual aspects of identity.

Principle 4. Clinicians should inquire about circumstances commonly encountered by youth with sexual and gender minority status that confer increased psychiatric risk.

Bullying. Gay, lesbian, bisexual, and gender nonconforming youth are regularly exposed to hostile peers. Victims of peer harassment experience serious adverse mental health consequences including chronic depression, anxiety, and suicidal thoughts.[76-78] Sexual and gender minority youth may benefit from support for coping with peer harassment. School programs including no-tolerance policies for bullying have proved effective.[79] Family treatment may be useful when sexual and gender minority youth are harassed in their families. Psychotherapy may help to avert or alleviate self-loathing related to identification with the aggressor. Clinicians should consider environmental interventions such as consultation or advocacy with schools, police, or other agencies and institutions advocating enforcement of zero tolerance policies to protect youth who may be victims of harassment or bullying.

Suicide. Rates of suicidal thoughts and suicide attempts among gay, lesbian, and gender-variant youth are elevated in comparison with the general population.[52-54] The developmental interval following same-sex experience but before self-acceptance as gay may be one of especially elevated risk.[54] Suicidal thoughts, depression, and anxiety are especially elevated among gay males who were gender-variant as children.[80,81] Family connectedness, adult caring, and school safety are highly significant protective factors against suicidal ideation and attempts.[82]

High-Risk Behaviors. Unique factors promoting risk-taking among gay and lesbian youth include maladaptive coping with peer, social and family ostracism, emotional and physical abuse, and neglect.[83] Fear of rejection may lead some youth to be truant, run away, become homeless, be sexually exploited, or become involved in prostitution. Positive coping skills and intact support systems can act as protective factors. Lesbian youth have higher rates of unintended pregnancy than heterosexual female youth, perhaps due to anxiety about their same-sex attractions and a desire to "fit in," an assumption birth control is unnecessary, or high-risk behavior rooted in psychological conflict.[84] Clinicians should monitor for these risks or provide anticipatory guidance for them when appropriate.

Substance Abuse. Some adolescents explore a gay identity in venues such as dance clubs and bars where alcohol and drugs are used. These youth may be at heightened risk of substance abuse because of peer pressure and availability of drugs. Lesbian and bisexual girls and boys describing themselves as "mostly heterosexual" (as opposed to unambiguously hetero- or homosexual) are at increased risk for alcohol use.[85] A subgroup of gay youth displays higher rates of use of alcohol and drugs including marijuana, cocaine, inhalants, designer, and injectable drugs.[52] They may use drugs and alcohol to achieve a sense of belonging or to relieve painful affects such as shame, guilt, and a lack of confidence associated with their romantic and sexual feelings.

HIV/AIDS and Other Sexually Transmitted Illnesses. Adolescents are at risk for acquiring sexually transmitted illnesses included HIV infection through sexual risk taking, especially those who feel invulnerable or fatalistic, or who lack mature judgment, self-confidence, or the mature interpersonal skills needed to negotiate safe sexual experiences. Programs aimed at reducing adolescent sexual risk taking that are successful not only increase information about how HIV and sexually transmitted diseases are acquired and prevented, but also provide emotionally relevant and practical help in having safe sexual experiences that are developmentally relevant to youth.[86] Adolescent gay males may be at particular risk of acquiring HIV sexually because of its high prevalence among men who have sex with men. Factors such as substance abuse or internalized homophobia associated with shame, guilt, or low self-esteem may interfere with an individual's motivation to use knowledge effectively about how to protect oneself from acquiring HIV infection. If present, these issues should be addressed clinically. Special HIV-prevention programs have been developed for and tested in gay youth and have demonstrated promising results.[87,88]

Principle 5. Clinicians should aim to foster healthy psychosexual development in sexual and gender minority youth and to protect the individual's full capacity for integrated identity formation and adaptive functioning.

Protecting the opportunity to achieve full developmental potential is an important clinical goal in working with sexual and gender minority youth. The psychological acceptability of homosexual feelings to an individual and his or her family, and the individual's capacity to incorporate them into healthy relationships, can change with therapeutic intervention, and are an appropriate focus of clinical attention.[9] Clinicians should strive to support healthy development and honest self-discovery as youth navigate family, peer, and social environments that may be hostile. Family rejection and bullying are often the proper focus of psychiatric treatment rather than current or future sexual orientation.

Sometimes questions about a youth's future sexual orientation come to psychiatric attention. When they do, it may be most useful to explore what this issue means to the adolescent and significant persons in his/her life. It may be preferable to indicate that it is too early to know an adolescent's sexual orientation rather than to refer to such feelings as a "phase," which may have connotations of disapproval.

When working clinically with youth whose sexual orientation or gender identity is uncertain, protecting the opportunity for healthy development without prematurely foreclosing any developmental possibility is an important goal. Clinicians should evaluate and support each child's ability to integrate awareness of his or her sexual orientation into his or her sexual identity while developing age-appropriate capacities in the areas of emotional stability, behavior, relationships, academic functioning, and progress toward an adult capacity for work, play, and love.

The availability of role models for sexual and gender minority youth varies greatly. The increasing visibility of gay people in society may decrease the isolation and loneliness of some gay youth, but others may be confronted with information that forces self-labeling before they are able to cope with irrational bias and feeling different. Some have access to positive role models or opportunities to form an affirming sexual identity among family, friends, the media, or through school programs such as gay–straight alliances. Urban environments or the Internet may give youth access to positive role models and experiences, but may also carry risks that require adult supervision.

Principle 6. Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful.

There is no established evidence that change in a predominant, enduring homosexual pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter homosexuality.[89] Psychiatric efforts to alter sexual orientation through "reparative therapy" in adults have found little or no change in sexual orientation, while causing significant risk of harm to self-esteem.[7] A study of efforts to do so in adults[71] has been criticized for failure to adequately consider risks such as increased anguish, self-loathing, depression, anxiety, sub-

stance abuse and suicidality, and for failure to support appropriate coping with prejudice and stigma.[90]

There is no empirical evidence that adult homosexuality can be prevented if gender nonconforming children are influenced to be more gender conforming. Indeed, there is no medically valid basis for attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may encourage family rejection and undermine self-esteem, connectedness, and caring, which are important protective factors against suicidal ideation and attempts.[82] As bullies typically identify their targets on the basis of adult attitudes and cues,[76] adult efforts to prevent homosexuality by discouraging gender variant traits in "pre-homosexual children" may risk fomenting bullying. Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial, or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated.[7,91]

Principle 7. Clinicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality.

A majority of children display gender role behavior that adult caregivers regard as departing from gender role norms in toy preferences at least some of the time (demonstrating a difference between that which is culturally expected and that which is actually statistically normal).[92] However, a smaller group of children demonstrate a consistent difference in gender role behavior from social norms. In different children, this may be true to varying degrees. In some, it may involve only a few areas—for example, an aversion to rough-and-tumble sports in boys, or tomboyishness in girls. In others, it may involve several areas, including dress, speech, and use of social styles and mannerisms. It is important to distinguish those who display only variation in gender role behavior (gender nonconformity, which is not a *DSM* diagnosis) from those who also display a gender identity discordant from their socially assigned birth gender and biological sex (gender discordance, reflected in the *DSM-IV* diagnosis Gender Identity Disorder when accompanied by marked gender nonconformity).[93]

A clinical interview using *DSM* criteria is the gold standard for making a *DSM* diagnosis. In some cases of gender role variance, there may be clinical difficulty distinguishing between gender nonconformity and gender discordance—for example, there may be clearly marked gender nonconforming behavior, but ambiguous cross-sex wishes. To assist clinicians in determining whether gender discordance is present, in addition to using clinical interviews, they can consider using structured instruments such as the Gender Identity Interview for Children,[94] the Gender Identity Questionnaire for Children,[95] and the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults.[96] In using such instruments, clinicians should bear in mind that the American Psychiatric Association's Gender Identity Disorder subworkgroup for *DSM-5* is currently debating areas of controversy in the diagnostic criteria for GID, including whether and how the explicit verbalization of gender discordant wishes should be included as a criterion, given the difficulty children may have expressing such wishes in nonaccepting environments.[93]

Disorders of sex development are an important differential diagnosis in gender discordant children and adolescents, for which endocrinological treatment may be indicated.[97] When the clinical history suggests that a somatic intersex condition may be present, clinicians should consider consultation with a pediatric endocrinologist or other specialist familiar with these conditions.

Children. Different clinical approaches have been advocated for childhood gender discordance. Proposed goals of treatment include reducing the desire to be the other sex, decreasing social ostracism, and reducing psychiatric comorbidity.[14] There have been no randomized controlled trials of any treatment. Early treatments for gender discordance developed in the 1970s included behavioral paradigms[98]; their long-term risks and benefits have not been followed up in controlled trials, and have been rejected on ethical grounds as having an inappropriately punitive and coercive basis.[99] Psychodynamically based psychotherapy for gender discordance in boys has been proposed based on a psychodynamic hypothesis that gender discordance is a defense in fantasy against profound, early separation anxiety[71]; like other treatment strategies, this has not been empirically tested in controlled trials.

Recent treatment strategies based upon uncontrolled case series have been described that focus on parent guidance and peer group interaction. One seeks to hasten desistence of gender discordance in boys through eclectic interventions such as behavioral and milieu techniques, parent guidance and school consultation aimed at encouraging positive relationships with father and male peers, gender-typical skills, and increased maternal support for male role-taking and independence.[100] Another approach encourages tolerance of gender discordance, while setting limits on expression of gender-discordant behavior that may place the child at risk for peer or community harassment.[101] Desistence of gender discordance has been described in both treatment approaches, as it is in untreated children.

As an ethical guide to treatment, "the clinician has an obligation to inform parents about the state of the empiric database,"[14] including information about both effectiveness and potential risks. As children may experience imperatives to shape their communications about gender discordant wishes in response to social norms, a true change in gender discordance must be distinguished from simply teaching children to hide or suppress their feelings. Similarly, the possible risk that children may be traumatized by disapproval of their gender discordance must be considered. Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth,[57] the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects.

Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed.

There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender-discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so. Social gender assignment appears to exert partial influence on the gender identity of infants with disorders of sex development.[69] At the same time, countervailing biological factors may override social gender assignment and contribute significantly to gender discordance in many cases. Therefore, the possibility that sending a child to school in his/her desired gender may consolidate gender discordance or expose the child to bullying should be weighed against risks of not doing so, such as distress, social isolation, depression, or suicide due to lack of social support. Further research is needed to guide clinical decision making in this area.

Adolescents. For some individuals, discordance between gender and phenotypic sex presents in adolescence or adulthood.[102] Sometimes it emerges in parallel with puberty and secondary sex characteristics, causing distress leading to a developmental crisis. Transgender adolescents and adults often wish to bring their biological sex into conformity with their gender identity through strategies that include hormones, gender correction surgery, or both, and may use illicitly obtained sex hormones or other medications with hormonal activity to this end. They may be at risk from side effects of unsupervised medication or sex hormone use.

One goal of treatment for adolescents in whom a desire to be the other sex is persistent is to help them make developmentally appropriate decisions about sex reassignment, with the aim of reducing risks of reassignment and managing associated comorbidity.[14] In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent. Transgender youth may face special risks associated with hormone misuse, such as short- and long-term side effects, improper dosing, impure or counterfeit medications, and infection from shared syringes.

For situations in which deferral of sex-reassignment decisions until adulthood is not clinically feasible, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues that reversibly delay the

development of secondary sexual characteristics.[102] The goals of such treatment are to avoid distress caused by unwanted secondary sexual characteristics, to minimize the later need for surgery to reverse them, and to delay the need for treatment decisions until maturity allows the adolescent to participate in providing informed consent regarding transition to living as the other sex. Prospective, case-controlled study of such treatment to delay puberty has shown some beneficial effects on behavioral and emotional problems, depressive symptoms, and general functioning (although not on anxiety or anger), and appears to be well tolerated acutely.[103] In addition, gender discordance is associated with lower rates of mental health problems when it is treated in adolescence than when it is treated in adulthood.[104] Therefore, such treatment may be in the best interest of the adolescent when all factors, including reducing psychiatric comorbidity and the risk of harm from illicit hormone abuse, are considered.

Treatment approaches for GID using guidelines based on the developmental trajectories of gender-discordant adolescents have been described.[105-107] In one approach, puberty suppression is considered beginning at age 12, cross-sex hormone treatment is considered beginning at age 16, and gender reassignment surgery at age 18.[105] Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and treatment of associated mental health problems. In another approach based on stage of physical development rather than age, pubertal suppression has been described at Tanner stage 2 in adolescents with persistent GID; risks requiring management include effects on growth, future fertility, uterine bleeding, and options for subsequent genital surgery and cross-sex hormone use.[107] For families of transgender adolescents, a therapeutic group approach has been described that encourages parental acceptance.[108] This approach may help to mitigate psychopathology and other deleterious effects of environmental nonacceptance. Further research is needed to definitively establish the effectiveness and acceptability of these treatment approaches.

Principle 8. Clinicians should be prepared to consult and act as a liaison with schools, community agencies, and other health care providers, advocating for the unique needs of sexual and gender minority youth and their families.

Evaluating youths' school, community, and culture—essential in any psychiatric evaluation—is particularly important for sexual and gender minority youth. Clinicians should seek information about the sexual beliefs, attitudes, and experiences of these social systems, and whether they are supportive or hostile in the patient's perception and in reality. Clinicians should not assume that all parties involved in a youth's social system know about his or her sexual identity. They should review with the youth what information can be shared with whom, and elicit concerns regarding specific caregivers. If appropriate, the clinician can consider interventions to enhance support, with the youth's knowledge and assent.

As consultants, mental health professionals can help to raise awareness of issues affecting sexual and gender minority youth in schools and communities, and advise programs that support them. Clinicians can consider advocating for policies and legislation supporting nondiscrimination against and equality for sexual and gender minority youth and families, and the inclusion of related information in school curricula and in libraries.

Principle 9. Mental health professionals should be aware of community and professional resources relevant to sexual and gender minority youth.

Many community-based organizations and programs provide sexual and gender minority students with supportive, empowering experiences safe from stigma and discrimination (e.g., the Harvey Milk School at the Hetrick Martin Institute, www.hmi.org; Gay Straight Alliances, www.gsanetwork.org).

There are many books and Internet resources for youth and families on issues such as discovering whether one is gay or lesbian. Clinicians should consider exploring what youth and families read, and help them to identify useful resources. Organizations such as Parents, Friends, and Families of Lesbians and Gays (PFLAG, www.pflag.org) and the Gay, Lesbian and Straight Education Network (GLSEN) provide support and resources for families, youth, and educators. These organizations have programs in a number of communities. Clinicians can obtain information through professional channels such

as the AACAP Sexual Orientation and Gender Identity Issues Committee (www.aacap.org), the American Psychiatric Association (www.psych.org), the Lesbian and Gay Child and Adolescent Psychiatric Association (www.lagcapa.org), and the Association for Gay and Lesbian Psychiatrists (www.aglp.org).

The Model Standards Project, published by the Child Welfare League of America, is a practice tool related to the needs of LGBT youth in foster care or juvenile justice systems available at www.cwla.org.[109] The *Standards of Care for Gender Identity Disorders*, including psychiatric and medical care, are published by the World Professional Association for Transgender Health (www.wpath.org).[110]

PARAMETER LIMITATIONS

AACAP Practice Parameters are developed to assist clinicians in psychiatric decision making. These Parameters are not intended to define the sole standard of care. As such, the Parameters should not be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and that patient's family, the diagnostic and treatment options available, and other available resources. &

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AACAP develops both patient-oriented and clinician-oriented Practice Parameters. Patient-oriented Parameters provide recommendations to guide clinicians toward best assessment and treatment practices. Recommendations are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not), and are graded according to the strength of the empirical and clinical support. Clinician-oriented Parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are based primarily on clinical consensus. This Parameter is a clinician-oriented Parameter.

The primary intended audience for the AACAP Practice Parameters is child and adolescent psychiatrists; however, the information contained therein may also be useful for other mental health clinicians.

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"Therapies" to change sexual orientation lack medical justification and threaten health

Washington, D.C., 17 May 2012 (PAHO/WHO) — Services that purport to "cure" people with non-heterosexual sexual orientation lack medical justification and represent a serious threat to the health and well-being of affected people, the Pan American Health Organization (PAHO) said in a position statement launched on 17 May, the International Day against Homophobia. The statement calls on governments, academic institutions, professional associations and the media to expose these practices and to promote respect for diversity.

Twenty two years ago, on May 17, the World Health Assembly removed homosexuality from the list of mental disorders when it approved a new version of the World Health Organization's International Classification of Diseases (ICD-10).

"Since homosexuality is not a disorder or a disease, it does not require a cure. There is no medical indication for changing sexual orientation," said PAHO Director Dr. Mirta Roses Periago. Practices known as "reparative therapy" or "conversion therapy" represent "a serious threat to the health and well-being—even the lives—of affected people."

The PAHO statement notes that there is a professional consensus that homosexuality is a natural variation of human sexuality and cannot be regarded as a pathological condition. However, several United Nations bodies have confirmed the existence of "therapists" and "clinics" that promote treatment intended to change the sexual orientation of non-heterosexual people.

The document notes that no rigorous scientific studies demonstrate any efficacy of efforts to change sexual orientation. However, there are many testimonies about the severe harm to mental and physical health that such "services" can cause. Repression of sexual orientation has been associated with feelings of guilt and shame, depression, anxiety, and even suicide.

As an aggravating factor, there have been a growing number of reports about degrading treatments, and physical and sexual harassment under the guise of such "therapies," which are often provided illicitly. In some cases, adolescents have been subjected to such interventions involuntarily and even deprived of their liberty, sometimes kept in isolation for several months.

"These practices are unjustifiable and should be denounced and subject to sanctions and penalties under national legislation," said Dr. Roses. "These supposed conversion therapies constitute a violation of the ethical principles of health care and violate human rights that are protected by international and regional

agreements."

To address the problem, PAHO makes a series of recommendations for governments, academic institutions, professional associations, the media, and civil society, including:

- "Conversion" or "reparative" therapies and the clinics offering them should be denounced and subject to adequate sanctions.
- Public institutions responsible for training health professionals should include courses on human sexuality and sexual health in their curricula, with a focus on respect for diversity and the elimination of attitudes of pathologization, rejection, and hate toward non-heterosexual persons.
- Professional associations should disseminate documents and resolutions by national and international institutions and agencies that call for the de-psychopathologization of sexual diversity and the prevention of interventions aimed at changing sexual orientation.
- In the media, homophobia in any of its manifestations and expressed by any person should be exposed as a public health problem and a threat to human dignity and human rights.
- Civil society organizations can develop mechanisms of civil vigilance to detect violations of the human rights of non-heterosexual persons and report them to the relevant authorities. They can also help to identify and report people and institutions involved in the administration of "reparative" or "conversion therapies."

PAHO, which celebrates its 110th anniversary this year, is the oldest public health organization in the world. It works with its member countries to improve the health and the quality of life of the people of the Americas. It also serves as the Regional Office for the Americas of WHO.

Links:

- PAHO Position Statement "Cures" for an illness that does not exist (/hq/index.php?option=com_docman&task=doc_download&gid=17703&Itemid=270&lang=en)
- PAHO/ Promotion of Sexual Health (/hq/index.php?option=com_content&task=blogcategory&id=2500&Itemid=2429&lang=en)
- www.paho.org/paho110/ (http://www.paho.org/paho110/)
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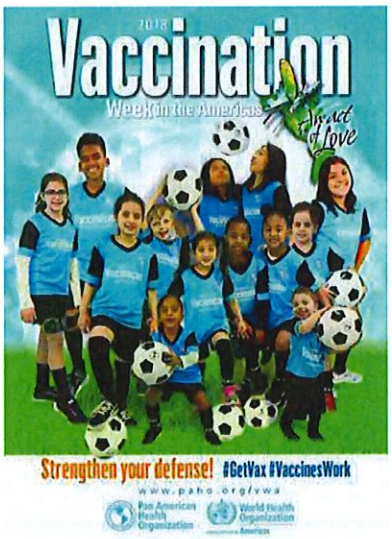

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Resources

- PAHO/WHO Collaborating Centers (http://www.paho.org/collaboratingcenters)
- IRIS Digital Library (http://iris.paho.org/xmlui)
- Virtual Health Library (http://bvsalud.org/en/)
- Virtual Campus for Public Health (http://www.campusvirtualsp.org/?q=en)
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Pan American Health Organization
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"CURES" FOR AN ILLNESS THAT DOES NOT EXIST

Purported therapies aimed at changing sexual orientation lack medical justification and are ethically unacceptable

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Introduction

Countless human beings live their lives surrounded by rejection, maltreatment, and violence for being perceived as "different." Among them, millions are victims of attitudes of mistrust, disdain and hatred because of their sexual orientation. These expressions of homophobia are based on intolerance resulting from blind fanaticism as well as pseudo-scientific views that regard non-heterosexual and non-procreative sexual behavior as "deviation" or the result of a "developmental defect."

Whatever its origins and manifestations, any form of homophobia has negative effects on the affected people, their families and friends, and society at large. There is an abundance of accounts and testimonies of suffering; feelings of guilt and shame; social exclusion; threats and injuries; and persons who have been brutalized and tortured to the point of causing injuries, permanent scars and even death. As a consequence, homphobia represents a public health problem that needs to be addressed energetically.

While every expression of homophobia is regrettable, harms caused by health professionals as a result of ignorance, prejudice, or intolerance are absolutely unacceptable and must be avoided by all means. Not only is it fundamentally important that every person who uses health services be treated with dignity and respect; it is also critical to prevent the application of theories and models that view homosexuality as a "deviation" or a choice that can be modified through "will power" or supposed "therapeutic support".

In several countries of the Americas, there has been evidence of the continued promotion, through supposed "clinics" or individual "therapists," of services aimed at "curing" non-heterosexual orientation, an approach known as "reparative" or "conversion therapy."[1] Worryingly, these services are often provided not just outside the sphere of public attention but in a clandestine manner. From the perspective of professional ethics and human rights protected by regional and universal treaties and conventions such as the American Convention on Human Rights and its Additional Protocol ("Protocol of San Salvador")[2], they represent unjustifiable practices that should be denounced and subject to corresponding sanctions.

Homosexuality as a natural and non-pathological variation

Efforts aimed at changing non-heterosexual sexual orientations lack medical justification since homosexuality cannot be considered a pathological condition.[3] There is a professional consensus that homosexuality represents a natural variation of human sexuality without any intrinsically harmful effect on the health of those concerned or those close to them. In none of its individual manifestations does homosexuality constitute a disorder or an illness, and therefore it requires no cure. For this reason homosexuality was removed

from the relevant systems of classification of diseases several decades ago.[4]

The ineffectiveness and harmfulness of "conversion therapies"

Besides the lack of medical indication, there is no scientific evidence for the effectiveness of sexual re-orientation efforts. While some persons manage to limit the expression of their sexual orientation in terms of conduct, the orientation itself generally appears as an integral personal characteristic that cannot be changed. At the same time, testimonies abound about harms to mental and physical health resulting from the repression of a person's sexual orientation. In 2009, the American Psychological Association conducted a review of 83 cases of people who had been subject to "conversion" interventions.[5] Not only was it impossible to demonstrate changes in subjects' sexual orientation, in addition the study found that the intention to change sexual orientation was linked to depression, anxiety, insomnia, feelings of guilt and shame, and even suicidal ideation and behaviors. In light of this evidence, suggesting to patients that they suffer from a "defect" and that they ought to change constitutes a violation of the first principle of medical ethics: "first, do no harm." It affects the right to personal integrity as well as the right to health, especially in its psychological and moral dimensions.

The long history of psychopathologization

For centuries, left-handed persons suffered because the use of the left hand ("sinister" in Latin) was thought to be associated with disaster. These people were regarded as carriers of misfortune and as having a "constitutional defect." Until relatively recently, there were attempts to "treat" and "correct" this supposed defect, causing suffering, humiliation, learning difficulties and difficulties in adapting to daily life in the affected persons.

Reported violations of personal integrity and other human rights

As an aggravating factor, "conversion therapies" have to be considered threats to the right to personal autonomy and to personal integrity. There are several testimonies from adolescents who have been subject to "reparative" interventions against their will, many times at their families' initiative. In some cases, the victims were interned and deprived of their liberty, sometimes to the extent of being kept in isolation during several months.[6] The testimonies provide accounts of degrading treatment, extreme humiliation, physical violence, aversive conditioning through electric shock or emetic substances, and even sexual harassment and attempts of "reparative rape," especially in the case of lesbian women. Such interventions violate the dignity and human rights of the affected persons, independently of the fact that their "therapeutic" effect is nil or even counterproductive. In these cases, the right to health has not been protected as demanded by the regional and international obligations established through the Protocol of San Salvador and the International Covenant on Economic, Social, and Cultural Rights.

Conclusion

Health professionals who offer "reparative therapies" align themselves with social prejudices and reflect a stark ignorance in matters of sexuality and sexual health. Contrary to what many people believe or assume, there is no reason – with the exception of the stigma resulting from those very prejudices – why homosexual persons should be unable to enjoy a full and satisfying life. The task of health professionals is to not cause harm and to offer support to patients to alleviate their complaints and problems, not to make these more severe. A therapist who classifies non-heterosexual patients as "deviant" not only offends them but also contributes to the aggravation of their problems. "Reparative" or "conversion therapies" have no medical indication and represent a severe threat to the health and human rights of the affected persons. They constitute unjustifiable practices that should be denounced and subject to adequate sanctions and penalties.

Recommendations

To governments:

- Homophobic ill-treatment on the part of health professionals or other members of health care teams violates human rights obligations established through universal and regional treaties. Such treatment is unacceptable and should not be tolerated.
- "Reparative" or "conversion therapies" and the clinics offering them should be reported and subject to adequate sanctions.
- Institutions offering such "treatment" at the margin of the health sector should be viewed as infringing the right to health by assuming a role properly pertaining to the health sector and by causing harm to individual and community well-being.[7]
- Victims of homophobic ill-treatment must be treated in accordance with protocols that support them in the recovery of their dignity and self-esteem. This includes providing them treatment for physical and emotional harm and protecting their human rights, especially the right to life, personal integrity, health, and equality before the law.

To academic institutions:

- Public institutions responsible for training health professionals should include courses on human sexuality and sexual health in their curricula, with a particular focus on respect for diversity and the elimination of attitudes of pathologization, rejection, and hate toward non-heterosexual persons. The participation of the latter in teaching activities contributes to the development of positive role models and to the elimination of common stereotypes about non-heterosexual communities and persons.
- The formation of support groups among faculty and within the student community contributes to reducing isolation and promoting solidarity and relationships of friendship and respect between members of these groups. Better still is the formation of sexual diversity alliances that include heterosexual persons.
- Homophobic harassment or maltreatment on the part of members of the faculty or students is unacceptable and should not be tolerated.

To professional associations:

- Professional associations should disseminate documents and resolutions by national and international institutions and agencies that call for the de-psychopathologization of sexual diversity and the prevention of interventions aimed at changing sexual orientation.
- Professional associations should adopt clear and defined positions regarding the protection of human dignity and should define necessary actions for the prevention and control of homophobia as a public health problem that negatively impacts the enjoyment of civil, political, economic, social, and cultural rights.
- The application of so-called "reparative" or "conversion therapies" should be considered fraudulent and as violating the basic principles of medical ethics. Individuals or institutions offering these treatments should be subject to adequate sanctions.

To the media:

- The representation of non-heterosexual groups, populations, or individuals in the media should be based on personal respect, avoiding stereotypes or humor based on mockery, ill-treatment, or violations of dignity or individual or collective well-being.
- Homophobia, in any of its manifestations and expressed by any person, should be exposed as a public health problem and a threat to human dignity and human rights.

- The use of positive images of non-heterosexual persons or groups, far from promoting homosexuality (in virtue of the fact that sexual orientation cannot be changed), contributes to creating a more humane and diversity-friendly outlook, dispelling unfounded fears and promoting feelings of solidarity.
- Publicity that incites homophobic intolerance should be denounced for contributing to the aggravation of a public health problem and threats to the right to life, particularly as it contributes to chronic emotional suffering, physical violence, and hate crimes.
- Advertising by "therapists," "care centers," or any other agent offering services aimed at changing sexual orientation should be considered illegal and should be reported to the relevant authorities.

To civil society organizations:

- Civil society organizations can develop mechanisms of civil vigilance to detect violations of the human rights of non-heterosexual persons and report them to the relevant authorities. They can also help to identify and report persons and institutions involved in the administration of so-called "reparative" or "conversion therapies."
- Existing or emerging self-help groups of relatives or friends of non-heterosexual persons can facilitate the connection to health and social services with the goal of protecting the physical and emotional integrity of ill-treated individuals, in addition to reporting abuse and violence.
- Fostering respectful daily interactions between persons of different sexual orientations is enriching for everyone and promotes harmonic, constructive, salutary, and peaceful ways of living together.

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[1] Human Rights Committee (2008). *Concluding Observations on Ecuador (CCPR/C/ECU/CO/5), paragraph 12.* <http://www2.ohchr.org/english/bodies/hrc/docs/co/CCPR.C.ECU.CO.5.doc>
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[2] The human rights that can be affected by these practices include, among others, the right to life, to personal integrity, to privacy, to equality before the law, to personal liberty, to health, and to benefit from scientific progress.

[3] American Psychiatric Association (2000). *Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies): Position Statement*. <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200001.aspx>
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[5] 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. <http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>

[6] Taller de Comunicación Mujer (2008). *Pacto Internacional de Derechos Civiles y Políticos: Informe Sombra*. <http://www.tcmujer.org/pdfs/Informe%20Sombra%202009%20LBT.pdf>
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[7] See General Comment No. 14 by the Committee on Economic, Social, and Cultural Rights with regards to the obligation to respect, protect and comply with human rights obligations on the part of States parties to the International Covenant on Economic, Social, and Cultural Rights.

AMERICAN SCHOOL COUNSELOR ASSOCIATION

The Professional School Counselor and LGBTQ Youth

(Adopted 1995, Revised 2000, 2005, 2007, 2013, 2014)

American School Counselor Association (ASCA) Position

Professional school counselors promote equal opportunity and respect for all individuals regardless of sexual orientation, gender identity or gender expression. Professional school counselors work to eliminate barriers that impede student development and achievement and are committed to the academic, personal/social and career development of all students.

The Rationale

Lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth often experience challenges to their academic and personal/social development related to a negative school climate. Students report feeling unsafe in school due to their sexual orientation, perceived orientation, gender identity or gender expression and report experiencing homophobic remarks, harassment and bullying (GLSEN, 2011). LGBTQ individuals often face multiple risk factors that may place them at greater risk for suicidal behavior (SPRC, 2008). Professional school counselors realize these issues impact healthy student development and psychological well-being.

The Professional School Counselor's Role

The professional school counselor works with all students through the stages of identity development and understands this may be more difficult for LGBTQ youth. It is not the role of the professional school counselor to attempt to change a student's sexual orientation or gender identity. Professional school counselors do not support efforts by licensed mental health professionals to change a student's sexual orientation or gender as these practices have been proven ineffective and harmful (APA, 2009). School counselors provide support to LGBTQ students to promote academic achievement and personal/social development. Professional school counselors are committed to the affirmation of all youth regardless of sexual orientation, gender identity and gender expression and work to create safe and affirming schools. School counselors:

- assist students with feelings about their sexual orientation and gender identity as well as the identity of others in an accepting and nonjudgmental manner
- advocate for equitable educational and extracurricular opportunities for all students regardless of sexual orientation, gender identity or gender expression
- promote policies that denounce the use of offensive language, harassment, and bullying that lead to a hostile school environment
- address absenteeism, lowered educational aspirations and academic achievement, and low psychological well-being as a result of victimization and feeling unsafe at school (GLSEN, 2012)
- provide a safe space for LGBTQ students and allies such as Gay and Straight Alliance Clubs
- promote sensitivity and acceptance of diversity among all students and staff to include LGBTQ students and diverse family systems
- advocate for the rights of families to access and participate in their student's education and school activities without discrimination (GLSEN, 2001)
- support an inclusive curriculum at all grade levels
- model language that is inclusive of sexual orientation and gender identity
- advocate for adoption of school policies that address discrimination and promote safe and supportive school environments (Robinson & Espelage, 2012)
- promote violence-prevention programs to create a safe school environment
- encourage staff training on inclusive practices, creating an affirming school environment, accurate information and risk factors for LGBTQ students (Russell, et.al. 2010)
- identify LGBTQ community resources for students and families

Summary

Professional school counselors promote affirmation, respect and equal opportunity for all individuals regardless of sexual orientation, gender identity, or gender expression. Professional school counselors promote awareness of and education on issues related to LGBTQ students and encourage a safe and affirming school environment. Professional school counselors work to eliminate barriers that impede student development and achievement and are committed to the academic, career and personal/social development of all students.

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