JUDITH M. GLASSGOLD, PSYD

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PROFESSIONAL EXPERIENCE

ACADEMIC EXPERIENCE

2017- PRESENT

RUTGERS—The State University. GRADUATE SCHOOL FOR APPLIED AND PROFESSIONAL PSYCHOLOGY,

- Part-time lecturer Masters Program in Appied Psychology.
- Teach Public Policy in Mental Health (18:544:512 Fall, 2018).
- Visiting Clinical Supervisor in doctoral program in clinical psychology.

1990-2009

RUTGERS—The State University. GRADUATE SCHOOL FOR APPLIED AND PROFESSIONAL PSYCHOLOGY, VISITING FACULTY 09/2007-09/2009. *CONTRIBUTING FACULTY* 09/1992-5/2007. VISITING LECTURER 09/1990-09/1992.

- Teaching, supervision of graduate student research, participation in scholarly activities, and psychotherapy supervision. Departmental governance, admissions, student evaluation,
- Courses: "Psychodynamic Psychotherapy with Diverse Clients", Community Psychology: Approaches to Diverse Populations", "Gender and Psychotherapy" and "Lesbian, Gay and Bisexual Issues in Psychology" and "Psychotherapy with Women".

DEPARTMENT OF PSYCHOLOGY RUTGERS UNIVERSITY, The State University. VISITING LECTURER. 1990. Responsible for teaching advanced undergraduate electives: "Systems of Psychotherapy" and "Psychology of Women".

WOMEN'S STUDIES PROGRAM RUTGERS UNIVERSITY The State University. VISITING LECTURER—01/86-06/89. Responsible for teaching undergraduate courses: "Psychology and Women" and "Women, Culture and Society".

HEALTH & PUBLIC POLICY

New Jersey Psychological Association
Director of Professional Affairs, *West Orange, NJ* *06/2017 - present*
West Orange, NJ

- Advise and consult with members on clinical, ethical, health programs, insurance, legal, and regulatory affairs relevant to professional practice.
- Advise Executive Board and committees of policy developments and delivery innovations in practice of psychology, federal and state programs (Medicare, Medicaid, TRICARE), legal and regulatory issues.
- Write regulatory comments and legislation relevant to state and federal initiatives.

Woodrow Wilson School of Public and International Policy
Princeton University, Princeton, NJ

Center for Health and Wellbeing *09/2019-06/2018*

- *Department Guest* *07/2017 - 06/2018*
- *Visiting Research Scholar* 09/2016 - 06/2017

Visiting Lecturer *01/2017-06/2017*

- Conduct research and scholarly activity related to mental health and substance use policies, LGBT health and civil rights policies
- Collaborate with other scholars and advise students
- Teach graduate level course: Mental Health and Substance use Policies in the US (**WWS 594A**)

Cabezon Group, Rockville, MD *04/2017-09/2017*
Project Lead

- Consultannt & Project lead for continuing education project on LGBT psychotherapy curiculum. Develop, coordinate multiple writers, edit and write. Logistical Support Services for Substance Abuse and Mental Health Servivces Administration: Office of Policy, Planning and Innovation (LHSS), U.S. Department of Health and Human Services.

Associate Executive Director *08/2013 - 08/2016*
Government Relations
Director, Congressional Fellowship Program
Public Interest Directorate
American Psychological Association, Washington, DC

- Advocate for innovative evidence-based approaches that apply psychology to improve human health, welfare, mental and physical health, specializing in issues relating to the behavioral health of the following topics: aging, children, youth and families, civil rights, ethnic minority concerns, health disparities, healthcare access reform, HIV/AIDS, individuals with disabilities, Lesbian, Gay, Bisexual and Transgender issues, poverty and women's issues.
- Efforts resulted in
  - Worked with US Substance Abuse and Mental Health Services Administration on public and professional education projects;
  - Successful changes to legislation health disparities among ethnic minorities and elements of integrated care, including S. 2680 Mental Health Reform Act of 2016 and HR 2646 Helping Families in Mental Health Crisis adopted in 21st Century Cures
  - Initiated association efforts on improving police/community relations and preventing gun violence
- Manage budget of close to $1 million
- Direct team of professional government relations, scientific staff, and graduate interns to achieve advocacy goals.
- Analyze legislation and regulations across entire portfolio, including mental and behavioral health and health disparities across federal agencies; appropriations and budget policies, including implementation of Affordable Care Act, Mental Health Parity and Addiction Equity Act, Medicare, and Medicaid for impact on mental and physical health disparities
- Provide testimony, public statements, public articles, presentations, legislative proposals and public comments on federal public policies.
- Represent association in meetings and briefings with members of Congress and their staff, Senior Executive Branch officials and other non-profit stakeholders to advocate for progressive mental and behavioral health, healthcare and civil rights policies.
- Advise Executive Management Team on federal policies.
- Ensure compliance with federal lobbying rules.

- Collaborate within association and with other external stakeholders, including community groups, stakeholders, and scientific and professional associations on areas of interest and other stakeholders in association on federal and state policy initiatives.
- Direct a Congressional Fellowship program for psychologists and internship program in public policy for graduate students.

Specialist in Health Policy (GS-15) *5/2012-8/2013*
Congressional Research Service, Library of Congress, Washington, DC

- Provide objective, expert public policy analysis and consultation related to Congressional Committees, Members, and staff. Areas of specialization included broad range of health care issues across Department of Health and Human Services, including the Affordable Care Act, care delivery, mental and behavioral health, health disparities and LGBT health, chronic health, aging, medical ethics, pharmaceutical product, and regulations.
- Prepare objective, non-partisan analytical written products, reports and confidential memoranda on health policy issues of national or international significance.
- Provide in-person briefings, personal assistance as an expert on public policy issues to Members of Congress and staff throughout the legislative process, including analyzing, appraising, and evaluating legislative proposals; and planning and leading multi-disciplinary team research projects and seminars.

Senior Policy Advisor, Health and Domestic Social Policy *8/2010-5/2012*
Office of Representative Sander Levin, (MI-12) US House of Representatives

Policy initiatives related personal office and Committee on Ways and Means (Chair 2010, Ranking Member 2011-2012)

- Legislative analysis and policy development related to health care and domestic social policies, including the implementation of the Affordable Care Act, Medicare, Medicaid, Social Security, Unemployment, TANF, public health, health appropriations, mental health, women's and children's health.
- Passed legislation – H.R.2941 - To reauthorize and enhance Johanna's Law to increase public awareness and knowledge with respect to gynecologic cancers; Unemployment provisions of: Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96); American Taxpayer Relief Act of 2012 (P.L. 112-240).
- Regulatory changes: successful effort to have breast feeding equipment become an eligible expense for FSA's, HSA's, and itemized tax deduction.

American Psychological Association *9/2009-8/2010*
American Association for the Advancement of Science
Washington, DC
Office of Representative Xavier Becerra (CA-31), US House of Representatives. Vice-Chair Democratic Caucus; Committees: Ways and Means, Budget.

- Performed duties of Health legislative aide and responsibilities included analyzing, writing, legislation and policy proposals, including Affordable Care Act (110th HR 3200 and HR 3590, and revising HR 977 (109th); Medicare, Medicaid, health disparities, mental health, childcare, and biomedical legislation. Met with stakeholders, analyzed legislation, briefed member of Congress.

CLINICAL EXPERIENCE

New Jersey State License in Psychology, # 35SI0028710 1991- present; New York State License in Psychology # 010469, 1991 (inactive)

Independent Practice *1991-2009*
Professional Psychology *Highland Park, NJ*

- Psychotherapy with individuals, families and couples.
- Completed evaluation and assessments as Court-appointed expert witness and evaluator for child custody and other family matters. Division of Youth and Family Services approved evaluator for termination of parental rights needs assessment, and case management.
- Specializations include serious mental illness, psychology of women, gender issues in psychotherapy, lesbian, gay, bisexual, and transgender issues depression and anxiety, substance abuse, assessment and treatment of trauma and sexual abuse in children, adolescents and adults. Licensed in New Jersey & New York.

Supervising Psychologist *1991-1993*
Community Mental Health Center *Flemington, NJ*
Hunterdon Medical Center

- Supervised psychological testing clinic, psychotherapy, and supervision of clinical staff on psychotherapy cases and evaluations.
- Provided expert testimony in areas of child custody and psychological evaluations. Coordinated and supervised psychological testing program providing forensic (child custody, probation and other assessments), as well as diagnostic evaluations, including cognitive, personality and projective measures.
- Provided individual and family psychotherapy to adults, children and adolescents.

Consulting Psychologist *1990-1991*
Institute for Evaluation and Planning *Freehold, NJ*

- Provided psychological services in three different residential programs for adolescents with serious emotional disturbance.
- Responsibilities included psychological assessment and evaluation, individual, group and family therapy, clinical consultation, staff supervision, and program evaluation and planning.
- Provided psychological assessment and therapy for sexual abuse (victims and perpetrators) on an outpatient basis for children, adolescents and families.
- Provided evaluations for Family Crisis Unit of Monmouth County Court and Division of Youth and Family Services.

Clinician *1987-1989*
The Community Mental Health Center *Piscataway, NJ*
University Of Medicine and Dentistry of New Jersey

- Provided individual psychotherapy with all ages, marital and family therapy, psychological assessment and crisis intervention.

EDUCATION

Graduate School of Applied and Professional Psychology *PsyD Clinical Psychology*
Rutgers University, The State University of New Jersey

Internship in Clinical/Community Psychology
Department of Psychiatry, Robert Wood Johnson Medical School

Harvard College BA - Cum Laude in Government
Cambridge, MA

Awards and Fellowships
Peterson Prize Rutgers University- Given to an alumna/alumnus who has made outstanding contributions to Professional Psychology
Alumni Association Award, Rutgers University – Outstanding accomplishment in professional psychology

Board of Trustees Fellowship for Graduate Study, Rutgers, The State University of New Jersey, 1983-1986
Radcliffe College Fellowship, Harvard University, 1976
National Parkinson's Disease Foundation Fellowship, 1975

NON-PROFIT LEADERSHIP

Friends of Hillsborough. President & Board Chair *1995-2000*

- Led successful grass roots, community advocacy group focused on environment and land use planning in New Jersey.
- Won major legal case protecting environmentally sensitive land.
- Developed policy, political and legal strategies, wrote grants, managed legal case, and collaborated with state and collaboration with local non-governmental groups.

American Psychological Association
Membership and Divisional Activities

- Chair, Task Force on the Appropriate Therapeutic Responses to Sexual Orientation (2007-2009)
- President (08/2003-08/2004), Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues. Member of the Executive Committee 2002-2005.
- Fellow of the American Psychological Association, Division 44 (Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues, 1997)
- Fellow of the American Psychological Association, Division 35 (Psychology of Women), 2003.
- Committee on Lesbian, Gay, and Bisexual Concerns. Chair & Member, 1/2002- 01/1999.

New Jersey Psychological Association

- President: 2008. Executive Board: 2007-2009.
- Ethics Committee, Member, 2001-2006. Chair, 7/2003-12/2006
- Committee on Legislative Affairs, Member, 1997-1999
- Member at Large, Executive Board 1994.
- Committee on Lesbian, Bisexual and Gay Concerns, Founding Chair, 1991. Chair, 1992-1996.

PUBLIC POLICY PUBLICATIONS (Congressional Research Service)

Corby-Edwards, Feder, J., Glassgold, J., Heisler, E., McCallion, G. (2013, July 9). *Federal Survey Data Collection of Sexual Orientation and Gender Identity Information*. Congressional Research Service Memorandum for Congress.

Glassgold, J. M. (2013, June 3). *Compounded Drugs*. Congressional Research Service Report for Congress.

Glassgold, J.M. & Salaam-Blyther, T. (2013, May 13*). Neglected Tropical Diseases: Definitions, Public Health, and Drug Treatments*. Congressional Research Service Memorandum for Congress.

Glassgold, J.M., Thaul, S. Kinzer, J. (2013, March 21). Selected Resources on Federal Oversight of Compounding Pharmacies. Congressional Research Service Report for Congress.

Bagalman, E. Corby-Edwards, A.K., & Glassgold, J. (2013, February 21). *Research on Violent Video Game Exposure and Gun Violence Perpetration, Interpersonal Physical Violence Perpetration, and Aggression*. Congressional Research Service Memorandum for Congress.

Thaul, S., Bagalman, E., Corby-Edwards, A.K, Glassgold, J.M., Johnson, J., Lister, S.A., Sarata, A.K, (2013, February 4).*The Food and Drug Administration Safety and Innovation Act (FDASIA, P.L. 112-144)*. Congressional Research Service Report for Congress.

Glassgold, J.M**.** (2013, January 22). *Living Organ Donors' Access to Health, Disability, and Life Insurance*. Congressional Research Service Memorandum for Congress.

Glassgold, J.M. and Napoli, A. (2013, January 9). *Literature Search: Symptom Validity Tests Used to Detect Malingering in Social Security Administration Disability Evaluations*. Congressional Research Service Memorandum for Congress.

Glassgold, J.M. and Liu, E. C. (2013, January 2). *Possible Effects of Flynn v. Holder on Hemapoietic Stem Cell Transplants*. Congressional Research Service Memorandum for Congress.

Glassgold, J. M. (2012, November 12). *International Issues in Diagnosis, Research, and Treatment of Dementia and Alzheimer's Disease***.** Congressional Research Service Memorandum for Congress.

Glassgold, J. M. (2012, October 26). *Federal Activities and Spending for Diabetes Prevention, Research, and Treatment*. Congressional Research Service Memorandum for Congress.

Thaul, S., Bagalman, E., Corby-Edwards, A.K, Glassgold, J.M., Johnson, J., Lister, S.A., Sarata, A.K, (2012, June 26). *FDA User Fees and the Regulation of Drugs, Biologics, and Devices: Comparative Analysis of S. 3187 and H.R. 5651*. Congressional Research Service Report for Congress.

Regulatory Comments

New Jersey Psychological Association (October, 2018). Letter to Attorney General Re: “Duty to Warn” legislation amendment to P.L. 2018, CHAPTER 34, approved June 13, 2018.

New Jersey Psychological Association (September 12, 2017). Letter to New Jersey Board of Psychological Examiners regarding, New Jersey P.L.2017.c117, authorizing health care providers to engage in telemedicine and telehealth.

American Psychological Association (March 24, 2016). Public comment on proposed rule of the Department of Labor for the Implementation of the Nondiscrimination and Equal Opportunity Provisions of the Workforce Innovation and Opportunity Act (WOIA) 29 CFR 28 RIN 1291-AA36.

American Psychological Association (December 31, 2015) Public Comment on National Coverage Analysis (NCA) Tracking Sheet for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N), Centers for Medicare and Medicaid Services, Department of Health and Human Services.

American Psychological Association (November 9, 2015). Public comment on proposed rule Nondiscrimination in Health Programs and Activities. A proposed rule by the Department of Health and Human Services (Section 1557 of the Affordable Care Act).

American Psychological Association (June 22, 2015) Public Comment on proposed rule Equal Employment Opportunity Commission 29 CFR Part 1630 RIN 3046–AB01 Amendments to Regulations Under the Americans With Disabilities Act.

American Psychological Association and American Psychological Association Practice Organization. (February 18, 2015). Public Comment on the draft criteria for Certified Community Behavioral Health Clinics.

Comments on behalf of the American Psychological Association. (April 24, 2014). RE: V. Other Topics for Consideration for the 2017 Edition Certification Criteria Rulemaking, 45 CFR Part 170, Voluntary 2015 Edition Electronic Health Record (EHR) Certification Criteria; Interoperability Updates and Regulatory Improve..

Comments on behalf of the American Psychological Association. (November 18, 2013). Request for Information (RFI): Inviting Comments and Suggestions on the Health and Health Research Needs. Specific Health Issues and Concerns for Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) Populations.

Testimony & Statements

American Psychological Association. (February 6, 2015). Written Statement for President's Task Force on 21st Century Policing. U.S. House of Representatives. Committee on Energy and Commerce, Subcommittee on Oversight and Investigations.

Written Statement of the American Psychological Association at a Hearing "The State of Civil and Human Rights in the United States". U.S. Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights. December. 9, 2014.

Statement of Joel A. Dvoskin, PhD, ABPP. On behalf of the American Psychological Association At a Hearing "Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis. September 18, 2014.

Testimony on behalf of the American Psychological Association at a hearing "Oversight of Federal Programs for Equipping State and Local Law Enforcement". U.S. Senate Committee on Homeland Security and Governmental Affairs. September, 9, 2014.

Statement of Arthur C. Evans, Jr. PhD. Commissioner, Department of Behavioral Health and Intellectual disAbility Services. Philadelphia, Pennsylvania at a Hearing “Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage" U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Oversight and Investigations. March 26, 2014.

Federal Reports

U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). (October, 2015). Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. HHS Publication No. (SMA) 15-4928. Rockville, MD: Substance Abuse and Mental Health Services Administration. Roles: Project development, coordination, editing and writing.

Selected Presentations and Trainings – Psychology and Public Policy

Glassgold, J.M. (2018, November). Invited Lecture: “LGBTQ Mental Health Issues”. Psi Chi Chapter and PRIDE of College of St. Elizabeth, Madison, NJ.

Glassgold, J.M. (2018, August) Invited presentation: “Legislative Advocacy” in all-day pre-convention workshop sponsored by Division 44 of the American Psychological Association.

Glassgold, J.M. (2018, August). Discussant in Accepted program “When Faith Matters More Than Sexual Orientation---Challenges in Ethics, Training, and Psychotherapy”.

Glassgold, J.M. (2017, December). Understanding the New Jersey Telehealth Law. Presented at New Jersey Psychological Association Symposium

Glassgold, J.M. (2016, October 13). Invited Talk: *Mental Health and Substance Abuse Policies Post the Affordable Care Act*, Woodrow Wilson School, Princeton University.

Glassgold, J.M. (2016, August). *Social Justice Issues Approaches to Advocacy*. Annual Convention of the American Psychological Association, Denver, CO.

Glassgold, J.M. (2016, June 26). “*Giving” Psychology Away to Public Policies* in Symposium entitled: Psychology and Public Policy: Connections, Barriers, Opportunities. Presented as part of the Annual Conference of the Society for the Psychological Study of Social Issues, *Giving Psychology Away*, Minneapolis, MN.

Glassgold, J.M. (2016, June 16). *Supportive and Affirming Services for LGBTQ Youth*. Webinar presented by Child Welfare Capacity Building Collaborative funded by the Children’s Bureau, Department of Health and Human Services.

Glassgold, J.M. (2016, June 15). *LGBT Youth: Ensuring Supportive & Affirmative Approaches to Behavioral Health Services*. Webinar sponsored by the National Council on Behavioral Health, Washington DC.

Glassgold, J.M. (2016, March 30). *Legislative Advocacy Training for Women’s Leadership Institute of the American Psychological Association* -- American Psychological Association, Washington, DC

Glassgold, J.M. (2016, February 28). *Mobile Apps and Health Disparities*. Workshop presented at the 33rd Annual Winter Roundtable at Teacher’ College, Columbia University, New York City.

Kennedy, E.K, Glassgold, J. M., & Ryan, C. (2016, February 13). *Alternatives to Conversion Therapy: Supporting & Affirming LGBT Youth.* Workshop presented at *Time to Thrive, Human Rights Coalition,* Dallas, TX.

Kennedy, E.K & Glassgold, J. M. (2016, February 1). *Alternatives to Conversion Therapy: Supporting & Affirming LGBT Youth. 26th National Leadership Forum & SAMHSA's 12th Prevention Day. National Harbor, Maryland.*

Glassgold, J.M. & Kennedy, E. K. (2015, November 20). *Ending Conversion Therapy and Supporting LGBTQ Children & Youth: Affirming Models of Intervention*. Podcast created by Mormon Mental Health. Available at: http://www.mormonmentalhealth.org/082-ending-conversion-therapy.

Glassgold, J.M. (2015, November 17). *Legislative Advocacy Training for Public Interest Leadership Conference- Mental Health Reform*. American Psychological Association, Washington, DC.

Glassgold, J. M. (2015, November 13). Invited panelist to address disparities in mental and behavioral health in a session entitled*: Advancing the March Toward Health Equity- HEAA Legislation* presented at the 2015 Congressional Tri-Caucus Health Equity and Accountability Act Summit of the Congressional Black Caucus Braintrust. Charleston, SC.

Glassgold, J. M & Kennedy, E.K. (2015, November 9). *Ending Conversion Therapy and Supporting LGBTQ Children & Youth: Affirming Models of Intervention*. Webinar presented to Culture Consortium of the National Child Traumatic Stress Network.

Glassgold, J. M. (2015, October). Participant on panel: *Ending conversion therapy in America*". White House and Department of Agriculture Utah LGBT Rural Summit Series, Weber State University, Ogden, UT.

Glassgold, J.M. (2015, August). *Legislative Advocacy Training for Minority Fellowship Program*. Held at the Annual Meeting of the American Psychological Association, Toronto, Canada.

Glassgold, J.M. (2015, January). "Access to Behavioral Health Care in Communities of Color: Role of ACA and MHPAEA", presented at the FAMILIESUSA Washington, DC conference "Health Action 2015: Building Real Progress.

Glassgold, J.M. (2014, December) *Addressing LGBT Behavioral Health Disparities by Improving Access to Care.* Presentation/Webinar jointed sponsored by the American Psychological Association and the US Substance Abuse and Mental Health Services Administration.

Publications - Professional Journals - Psychology

Glassgold, J. M. (2010). A Process without End: Seeking the Unrealized Yet Irrepressible Aspects of Self. *Women & Therapy*. *33* (3-4), 246-263. In Special Issue: A Minyan of Women: Family Dynamics, Jewish Identity and Psychotherapy Practice.

Glassgold, J. M. (2009). The Case of Felix: An Example of Gay-Affirmative, Cognitive-Behavioral Therapy. *Pragmatic Case Studies in Psychotherapy,* www2.scc.rutgers.edu/journals/index.php/pcsp/article/.../995/2398

Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Annual Conference of the American Psychological Association.

Glassgold, J. M. (2008). Bridging the Divide: Integrating Lesbian Identity and Orthodox Judaism. *Women & Therapy, 31*(1), 59-72.

Glassgold, J. M. & Knapp, S (2008). Ethical issues in screening clergy or candidates for religious professions for denominations that exclude homosexual clergy. *Professional Psychology, 39*(3), 346-352.

Glassgold, J. M. (2007). In dreams begin responsibilities: Psychology, agency and activism. *Journal of Gay and Lesbian Psychotherapy, 11*(3/4), 37-57.

Glassgold, J. M. (2007, Summer). Ethical issues when addressing diversity in psychological practice. *New Jersey Psychologist, 57(2), 28-30.*

Glassgold, J. M. (2007). Religious issues in psychological practice: ethical considerations. *New Jersey Psychologist, 57*(1), 16-18.

Glassgold, J. M. (2006). Ethics Column: Legal and Ethical issues and impairment in colleagues. *New Jersey Psychologist.*

Glassgold, J. M. (2005). Bullying and harassment of Lesbian, Gay, Bisexual, and Transgender youth. In Special Section: Violence in the Schools: The issue of bullying. *New Jersey Psychologist,* 55(3), 28-30.

Berson, J. & Glassgold, J. M. (2005). Ethics Column: Ethics in family therapy. *New Jersey Psychologist*, 55(3), 14-15.

Glassgold, J. M. and Wahler L. (2005). Ethics Column: Termination of cases when endangered or threatened by a patient: Protection of Providers. *New Jersey Psychologist*, *55(1*), 14-15.

Glassgold, J. M. and Iasenza, S. (Eds.). (2004). The second wave: Lesbians, feminism, & psychoanalysis. *Journal of Lesbian Studies Special Issue*, 8(1/2). Jointly published by Harrington Park Press.

Glassgold, J. M. (2003). Ethics in brief: Insider trading. *New Jersey Psychologist,* 53(3), 29.

Glassgold, J. M., Fitzgerald, J., Haldeman, D. (2003). Letter to the editor: Response to Yarhouse & Throckmorton. *Psychotherapy: Research & Practice*, *40(1)*, 376-378.

Glassgold, J. M. (2002). Ethical issues in psychotherapy with lesbian, gay, and bisexual clients. *New Jersey Psychologist*, 52(4), 10-12.

Schneider, M. S, Brown, L. S. & Glassgold, J. M. (2002). Implementing the resolution on appropriate therapeutic responses to sexual orientation: A guide for the perplexed. *Professional Psychology*, *33*(3), 265-276.

Glassgold, J. M. (2002). Individual and systems concerns in therapy with same-sex couples. *New Jersey Psychologist*, 52 (1), 15-18.

Glassgold, J. M., Fitzgerald, J., Haldeman, D. (2002). Letter to the Editor. *Psychotherapy: Theory, Research, Practice, Training*, 39(4), 376-378.

Glassgold, J. M. (Ed.). (1993, Summer). Special Issue: Psychotherapy with Lesbians, Gay Men, and Bisexuals. New Jersey Psychologist, 43(3).

Glassgold, J. M. (1992, Spring). What's in a name? Reflections on sexual orientation. *Psychology of Women: Newsletter of Division 35, American Psychological Association*, 19(2), 3-4.

Tellerman, K., Astrow, A., Fahn, S., Snider, S.R., Snider, R.S. and Glassgold, J.M. (1979). Cerebellar control of catecholaminergic activities: Implications for drug therapy of movement disorders. *International Journal of Neurology*, 13,135-155.

Jackson, V., Glassgold, J.M., Miller, R., and Snider, S.R. (1977). Hypersensitivity of rats with chronic cerebellar lesions to abnormal behavior induced by apomorphine. *Neuroscience Abstracts*, 6(20), 205.4.

Levandowsky, M., Hauser, D.C.R. & Glassgold, J. (1975). Chemosensory responses of a protozoan are modified by antitubulins. *Journal of Bacteriology*, 124(2), 1037-1038.

Hauser, D.C.R., Levandowsky, M. and Glassgold, J. (1975). Ultrasensitive responses of protozoa to epinephrine and other neurochemicals. *Science*, 190(4211), 285-286.

Professional Books and Book Chapters

Glassgold, J.M. (in progress). Research On Sexual Orientation Change Efforts. In Sexual Orientation Change Efforts, D. Haldeman & M. Hendricks (Eds). Harrington Park Press.

Glassgold, J.M. & Ryan, C. (in progress). The Role of Families in Efforts to Change, Support, and Affirm Sexual Orientation, Gender Identity and Expression in Children and Youth. In Sexual Orientation Change Efforts, D. Haldeman & M. Hendricks (Eds). Harrington Park Press.

Glassgold, J.M. (2017). *Conversion Therapy* in Nadal, K. L., Mazzula, S. L., & Rivera, D. P. (Eds.). The Sage Encyclopedia on Psychology and Gender. Thousand Oaks: Sage.

Glassgold, J. M. (2010). A Process without End: Seeking the Unrealized Yet Irrepressible Aspects of Self. In B. Greene & D. Brodbar (Eds). *A Minyan of Women: Family Dynamics, Jewish Identity and Psychotherapy Practice*. NY: Routledge.

Glassgold, J. M. (2008). Bridging the Divide: Integrating Lesbian Identity and Orthodox Judaism. In A. Mahoney & O. Espin (Eds.), *Sin or Salvation: The relationship between sexuality and spirituality in psychotherapy*. Harrington Park Press. Jointly published as Women & Therapy, 31(1).

Glassgold, J. M and Drescher, J. (Eds.). (2007). *Activism in LGBT Psychology*. NY: Harrington Park Press. Jointly published as Journal of Gay and Lesbian Psychotherapy 11 (3/4).

Glassgold, J. M. and Iasenza, S. (Eds.). (2004). *The second wave: Lesbians, feminism, & psychoanalysis*. Harrington Park Press. Jointly published as *Journal of Lesbian Studies,* 8 (1/2).

Glassgold, J. M. (2000). Incest. In Bonnie Zimmerman (Ed.), *Lesbian Histories and Cultures: An Encyclopedia,* (p. 389-390). Encyclopedia of Lesbian and Gay Histories and Cultures (Vol. 1). NY: Garland Press.

Glassgold, J. M. & Iasenza S. (Eds.). (1995). *Lesbians and Psychoanalysis: Revolutions in Theory and Practice.* New York: The Free Press.

Glassgold, J. M. (1995). Psychoanalysis with lesbians: Agency and Subjectivity. In J. M. Glassgold & S. Iasenza (Eds.), *Lesbians and Psychoanalysis: Revolutions in Theory and Practice*, (pp. 203-228). New York: The Free Press

Glassgold, J. M. (1992). New directions in dynamic theories of lesbianism: From psychoanalysis to social constructionism. In J. Chrisler & D. Howard (Eds.). *New Directions in Feminist Psychology*, pp. 154-164. New York: Springer.

Glassgold, J. M. (1990). The construction of feminist psychoanalysis: An analysis of Nancy Chodorow's "The Reproduction of Mothering." [Dissertation Abstract] *Dissertation Abstracts International. 51*(2-B), Aug 1990, 984.

Selected Presentations and Trainings – Professional Psychology

Glassgold, J.M. (2017, February) Invited Speaker: "*The Psychology of Sexual Orientations and Gender Identities*" at a Conference entitled: Sexuality, Gender and the Jewish Family. Arizona State University, Phoenix, AZ.

Glassgold, J.M. & Crowder, R. III. (2016, June 25). Interactive discussion and film presentation: *Understanding Race Post Ferguson.* Presented as part of the Annual Conference of the Society for the Psychological Study of Social Issues, *Giving Psychology Away*, Minneapolis, MN.

Glassgold, J. M. (2015, August). Spiritually Sensitive and Affirmative Therapeutic Responses to Sexual and Gender Minorities. Paper presented at symposium entitled A Dialogue on the Intersection of Religion/Spirituality, Sexual Orientation, and Gender Identity at the annual meeting of the American Psychological Association, Toronto, Canada.

Glassgold, J.M. (2015, August). Appropriate Therapeutic Responses to Sexual Orientation: Affirmative Practices. Continuing Education Training presented with K. Ritter and C. Ryan at APA Annual Conference, Washington, DC

Glassgold, J.M. (2015, August). APA's Congressional Fellowship Program. . Co-Chair of Symposium and presenter: APA Policy Fellowship Opportunities. Held at the annual meeting of the American Psychological Association, Toronto Canada.

Glassgold, J.M. (2014, August). A dialogue on the intersection of religion/spirituality, sexual orientation, and gender identity. Presented as part of a Symposium of the Annual Conference of the American Psychological Association, Washington, DC.

Glassgold, J.M. (2014, August). APA's Congressional Fellowship Program: Psychology's Key to Policy. Co-Chair of Symposium on 40th Anniversary of Congressional Fellowship Program.

Glassgold, J.M. (2014, August). APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation: Affirmative Practices. Continuing Education Training presented with K. Ritter and C. Ryan at APA Annual Conference, Washington, DC.

Glassgold, J.M. (2013, August). A Framework for Affirmative Therapy for Those Distressed by their Same-Sexual Orientation. Presentation at Symposium entitled Responding to Sexual Orientation Change Efforts: Affirmative Policy and Treatment presented at the APA Annual Conference, Honolulu, HI.

Glassgold, J.M. (2013, August). "Issues for Children and Adolescents." In APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation: Affirmative Practices. Continuing Education Training presented with K. Ritter and T. Moragne at APA Annual Conference, Honolulu, HI.

Glassgold, J. M. (2012, April). Invited Lecture: "Coming Out Religious and LGBTQ," and Invited Seminar: "Activism and the Psychology of Women and Gender." Women's Studies Department, Northern Illinois University.

Glassgold, J. M. (2012, March). The Unethical Life of Reparative Therapy: The History and Ethics of Attempts to Cure Homosexuality. Lecture at Baltimore Country Community College. Part of the Community Connection Book Series. Awarded Outstanding Program of the Year.

Glassgold, J. M. (2009, August). Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Annual Conference of the American Psychological Association, Toronto, CA.

Glassgold, J. M. (2009, January). Sexual orientation and religion: A difficult dialogue. Colloquium Long Island University, New York.

Glassgold, J. M. (2009, January). Transcending conflicts: Integrating religion and sexual orientation. In Colloquium: When aspects of client diversity collide: Ethical considerations. National Multicultural Conference and Summit, New Orleans, LA.

Glassgold, J. M. (2007, January). Steps for Creating a Transgender-Sensitive Climate & Positive Mental Health on College Campuses. Annual Conference of Rutgers University Health Services. New Brunswick, NJ.

Glassgold, J. M. (2006, April). Department of Child Psychiatry, Grand Rounds: Non-traditional sexual orientation and suicidality: Case reports and discussion. Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey, Piscataway, NJ

Glassgold, J. M. (2005, October). Ethical Issues in Treating the Treater. Symposium at the Fall Meeting of the New Jersey Psychological Association. Woodbridge, NJ.

Glassgold, J.M. (2005, August). A Process without End: Seeking the Unrealized and Irrepressible Aspects of Self. Paper presented in symposium: Minyan of Women: Family dynamics, Jewish identities, & Psychotherapy practice. Annual Conference of the American Psychological Association, Washington, DC.

Glassgold, J. M. (2005, April). Psychoanalysis: Toward a liberatory practice/praxis. Paper Presented in Symposium: Lesbians, Feminism & Psychoanalysis: Toward the Second Wave. Midwinter Conference of Division 39, Psychoanalysis, of the American Psychological Association. NY, NY

Glassgold, J. M. (2004, August) Perceptions of the Other by the Other. Paper presented in symposium: Minyan of Women: Family dynamics, Jewish identities, & Psychotherapy practice. Annual Conference of the American Psychological Association, Honolulu, Hawaii.

Glassgold, J. M. (2004, July). Presidential Address, Society for the Psychological Study of Lesbian, Gay, & Bisexual Issues (Division 44 of the American Psychological Association). In Dreams begin Responsibilities: Psychology, Agency & Activism. Annual Conference of the American Psychological Association, Honolulu, Hawaii.

Glassgold, J. M. (2004, July). Lesbians, Feminism & Psychoanalysis: Affirming Integrations. Chair, Invited Symposium. Annual Conference of the American Psychological Association, Honolulu, Hawaii.

Glassgold, J. M. (2004, July). Supporting scientific integrity and freedom in behavioral health research. Chair, Invited Symposium. Annual Conference of the American Psychological Association, Honolulu, Hawaii. See related article, Monitor on Psychology, 35(9), October 2004, p. 38.

Glassgold, J. M. (2004, July). Discussant. Voices of heterosexual allies: Public discourse, activism, & research. Annual Conference of the American Psychological Association, Honolulu, Hawaii.

Glassgold, J. M. (2004, February). Perceptions of the Other by the Other. Paper presented in symposium: Minyan of Women: Family dynamics, Jewish identities, & Psychotherapy practice. Annual Meeting of the Association of Women in Psychology, Philadelphia, PA.

Glassgold, J. M. (2004, February). Lesbians, Feminism, and Psychoanalysis: Structured Discussion. Annual Conference of the Association of Women in Psychology. Philadelphia. PA.

Glassgold, J. M. (2003, November). Chair, Panel: Understanding Changes to the American Psychological Association Code of Ethics-2202. Bi-Annual Meeting New Jersey Psychological Association, Woodbridge, NJ.

Glassgold, J. M. (2003, August). Co-Chair: Symposium: Skeletons out of our Closet: Psychoanalytic and GLBT explorations. Annual Conference of the American Psychological Association, Toronto, CA.

Glassgold, J. M. (2003, August). Chair and Discussant: Film: Trembling Before G-D. Annual Conference of the American Psychological Association, Toronto, CA.

Glassgold, J. M. (2003, August). Juggling diverse practices: Psychodynamic, child & forensic. Paper presented as part of a symposium “Privately out of the closet: Lives and work of LGB therapists.” Annual Conference of the American Psychological Association, Toronto, CA.

Glassgold, J. M. (2003, August). Getting into APA leadership. Paper presented at Mentoring Workshop for LGBT Students. Annual Conference the American Psychological Association, Toronto, CA.

Glassgold, J. M. (2001, February 19). Gay and lesbian teenagers. Appearance on “Family Talk”, CN8, Comcast Cable Network.

Glassgold, J.M. (August, 2000). Discussant. Public Interest Miniconvention Valuing Diversity. Presented at the Annual Conference of the American Psychological Association, Washington, DC.

Glassgold, J. M. (April, 2000). Identity and a sense of belonging in adolescents. Invited Address at the 4th Annual Sarah van Alen Lecture Series. Collier School, Marlborough Twp, NJ.

Glassgold, J. M. (August, 1999). Conversation Hour: Lesbian, Gay, and Bisexual Therapists working with Bisexual Clients. Presented at the Annual Conference of the American Psychological Association, Boston, MA.

Glassgold, J. M. (August, 1999). Discussion: Promoting Research in Lesbian, Gay and Bisexual Issues. Presented at the Annual Conference of the American Psychological Association, Boston, MA.

Glassgold, J. M. (February, 1997). Expressing Desire: Subjectivity and Agency in Female Desire. Paper presented at a conference of Division 39, Psychoanalysis, of The American Psychological Association. Denver, CO.

Glassgold, J. M. (November, 1996). Lesbian Identity Development: Theoretical Views from Psychoanalysis to Lesbian Affirmative Therapy. Presented at a Conference: The Treatment of Lesbians and Gay Men in Psychiatric Practice. American Psychiatric Association, 48th Institute on Psychiatric Services, Chicago, IL.

Glassgold, J. M. & Iasenza, S. (October, 1996). Psychoanalysis with Lesbians: Modern Approaches to Individual and Couples Therapy. Workshop Presented at the Fall Meeting of the New Jersey Psychological Asso-

ciation.

Glassgold, J. M. (March 1996). Increasing agency in lesbian women. Symposium: Lesbians and Psychoanalysis. .Paper presented at the annual meeting of the Association of Women in Psychology. Portland OR.

Glassgold, J. M. (March, 1996). Dynamic psychotherapy with bisexual women. Symposium: Treatment issues with Bisexual Women. Presented at the annual meeting of the Association of Women in Psychology. Portland, OR.

Glassgold, J. M. (March, 1996). Addressing bisexuality in therapy. Presentation at Plenary Panel at the Conference: Psychotherapy with the Gay and Lesbian Community. Sponsored by the Institute for Human Identity, New York.

Glassgold, J. M. (August, 1995). Co-Chair, Lesbians and Psychoanalysis: New Directions in Theory and Practice. Critical Issues in Psychoanalysis with Lesbians. Paper presented at the Annual Conference of the American Psychological Association. New York, NY.

Glassgold, J. M. (August, 1995). Organizing a Gay and Lesbian Committee in a Tolerant State. Paper presented
at Symposium: Confronting Sexual Orientation Concerns within and outside State Psychological Associations. Presented at the Annual Conference of the American Psychological Association, New York, NY.

Glassgold, J. M. & Iasenza, S. (March, 1995). Psychoanalysis and Lesbians. Workshop presented at the Annual Conference of the Association of Women in Psychology, Indianapolis, IN.

Glassgold, J. M. (November, 1993). Homophobia in the Therapist: Improving clinical services to the gay and Lesbian community. Workshop presented at Jewish Family Services of North Middlesex County, NJ.

Glassgold, J. M. (November, 1993). Reaching the sexual minority youth: Working with gay, lesbian and bisexual Youth. Part of training team sponsored by The Human Resource Development Institute & the Division of Youth and Family Services of New Jersey. Rider College, Lawrenceville, NJ.

Glassgold, J. M. (November, 1993). Psychological Perspectives on Homophobia. Invited Address at Plenary Panel: Perspectives on Diversity. Seton Hall University, West Orange, NJ.

Glassgold, J. M. (December, 1993). Sexual abuse as a risk factor in HIV transmission in women. Workshop presented at the annual conference of the Women and AIDS Coalition, Newark, NJ.

Glassgold, J. M. (August, 1993). Similarity and Difference in Psychotherapy. Paper presented at the annual meeting of the American Psychological Association. Chair of Symposium: Addressing Difference in Therapist-Patient Sexual Orientation. Toronto, Canada.

Glassgold, J. M. (February, 1993). New directions in dynamic theories of lesbianism: From psychoanalysis to contextualism. Conference on Psychotherapy in the Gay and Lesbian Community. Sponsored by the Institute for Human Identity. New York, NY.

Glassgold, J. M. (December, 1992). LGBT Adolescents and the role of the school psychologist. Workshop presented at the Annual meeting of the National Association of School Psychologists—New Jersey Chapter. Clark, NJ.

Glassgold, J. M. (December, 1992). The social construction of family norms. Presentation at the Family Institute of New Jersey. Metuchen, NJ.

Glassgold, J. M. (May, 1992). Lesbian youth: Survival through resistance. Presentation at conference: “One in Ten III: Invisible Youth. Lesbian and Gay Adolescents in School, Community and Family. Newark, NJ.

Glassgold, J. M. (March, 1992). Models of Feminist Therapy: Applications for college students. Training presented at Rutgers College Counseling Center. New Brunswick, NJ.

Glassgold, J. M. (February, 1992). Plenary Panel: Living and Working in the same community. Conference on Psychotherapy in the Gay and Lesbian Community. Sponsored by the Institute for Human Identity: Exploring our many roles and relationships. New York, NY.

Glassgold, J. M. (February, 1992). Psychotherapy with lesbians and gay men. Presentation at the meeting of the Morris County Psychological Association. Morristown, NJ.

Glassgold, J. M. (January, 1992). The development of sexual orientation: Issues in the psychotherapy of women. Presentation at meeting of the New Jersey Association of Women Therapists. Berkeley Heights, NJ.

Glassgold, J. M. (November, 1991). Focal Issues in the treatment of lesbians and gay men. Chair of symposium and presenter. New Jersey Psychological Association Fall Meeting. Somerset, New Jersey.

Glassgold, J. M. (February, 1991). The development of sexual orientation: Issues for psychotherapists. Training presented at Rutgers College Counseling Center. New Brunswick, NJ.

Glassgold, J. M. (September, 1990). The role of support groups in graduate school training in professional psychology. Paper presented at the Colloquium series of the Department of Psychology, C.W. Post Campus, Long Island University.

Glassgold, J. M. (August, 1990). The role of peer support groups in fostering professional development. Paper presented at the annual meeting of the American Psychological Association. Symposium entitled What they didn't teach you in clinical psychology graduate school: Making the transition from graduate student to full-fledged professional.

Glassgold, J. M. (August, 1989). The Construction of Lesbian Identity and Sexuality. Paper presented at the annual meeting of the American Psychological Association. Symposium co-chair and presenter. Symposium entitled: Social Constructionism and the Psychology of Sexuality and Identity.

Glassgold, J. M. (August, 1989). An appraisal of feminist object-relations theory. Paper accepted for presentation at the annual meeting of the American Psychological Association.

Glassgold, J. M. (March, 1989). Exploring Theoretical Models of Lesbianism. Paper presented at the annual conference of the Association of Women in Psychology: "The Many Faces of Feminist Psychology", Newport, Rhode Island.

Glassgold, J. M. (March, 1988). Lesbianism and Psychoanalysis. Paper presented and discussion session facilitated at the annual conference of the Association of Women in Psychology: "New Directions in Feminist Psychology", Bethesda, MD.

Glassgold, J. M. (August, 1987). Lesbianism and Psychoanalysis. Paper presented at the annual meeting of the Association of Lesbian and Gay Psychologists held concurrently with the American Psychological Association, New York, NY.

Glassgold, J. M. (April, 1987). Developmental Issues for Lesbians from a Family Systems Perspective. Paper presented at the University of Medicine and Dentistry of New Jersey, Family Therapy Training Program, Piscataway, NJ. `

Glassgold, J. M. (April, 1987). Psychoanalysis and Lesbianism: A Critique of Theory. Paper presented at conference: "Therapy for the Lesbian and Gay Community", sponsored by the Institute for Human Identity, New York City, NY.

AMERICAN PSYCHOLOGICAL ASSOCIATION

Report of the American Psychological Association Task Force on

Appropriate Therapeutic Responses to Sexual Orientation

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

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

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August 2009
Printed in the USA

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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.

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.

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.

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 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 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.

Increasing Other-Sex Sexual Behavior

Studies on whether interventions can lead to other-sex sexual activity show limited results. These studies show more success for those who had some other-sex sexual orientation (e.g., sexual arousal) and were sexually experienced with members of the other sex prior to intervention than for those who had no other-sex sexual orientation and no history of other-sex sexual behavior. The results for this outcome suggest that some people can initiate other-sex sexual behavior whether or not they have any observed other-sex sexual orientation.

As previously noted, in the early studies many people were described as heterosexually experienced. From the data provided by H.E. Adam and Sturgis in their 1977 review, 61%–80% of male research participants appeared to have histories of dating women, and 33%–63% had sexual intercourse with women prior to intervention. Additionally, some of the men were married at the time of intervention. Because so many of the research participants in these studies had other-sex sexual attractions or intimate relationships at the outset, it is unclear how to interpret changes in their levels of other-sex sexual activity.

EARLY STUDIES

Experimental studies

According to H. E. Adams and Sturgis (1977), only 8% of participants in controlled studies are reported to have engaged in other-sex sexual behavior following SOCE. Among those studies we reviewed, only 2 participants showed a significant increase in other-sex sexual activity (McConaghy & Barr, 1973; Tanner, 1974). In Tanner's randomized controlled trial, men increased the frequency of intercourse with females but maintained the frequency of intercourse with males.

Quasi-experimental studies

McConaghy et al. (1981) found no difference in the frequency of other-sex sexual behavior following SOCE.

Nonexperimental studies

Among within-subject patient studies in which aversion techniques were used, some studies reported that a subset of 12%–40% of people in the multiple-subject studies and all people in single-patient studies engaged in other-sex sexual behavior following intervention (e.g., Bancroft, 1969; Fookes, 1960; Hallam & Rachman, 1972; Hanson & Adesso, 1972; Kendrick & McCullough, 1972; Larson, 1970). Regarding other techniques

studied in early intervention research, Barlow et al. (1975) reported that 1 of 3 research participants began to date women after biofeedback. Huff's (1970) research participant also began to date women after desensitization training. LoPiccolo (1971) used orgasmic reconditioning to treat a male–female couple. The male could not achieve an erection with his female partner and found sex with women dissatisfying. At 6 months, he was able to develop and maintain an erection and ejaculate intravaginally.

RECENT STUDIES

As previously noted, recent studies provide no sound basis for attributing individual reports of their current sexual behavior to SOCE. No results are reported for these studies.

SUMMARY

In general, the results from studies indicate that while some people who undergo SOCE do engage in other-sex sexual behavior afterward, the balance of the evidence suggests that SOCE is unlikely to increase other-sex sexual behavior. Findings show that the likelihood of having sex with other-sex partners for those research participants who possess no other-sex sexual orientation prior to the intervention is low.

Marriage

One outcome that some proponents of efforts to change sexual orientation are reported to value is entry into heterosexual marriage. Few early studies reported on whether people became heterosexually married after intervention. In a quasi-experimental study, Birk et al. (1971) found that 2 of 18 respondents (11%) were married at 36 months. Two uncontrolled studies (Birk, 1974; Larson, 1970) indicated that a minority of research participants ultimately married, though it is not clear what role, if any, intervention played in this outcome. Recent research provides more information on marriage, though research designs do not permit any attribution of marital outcomes to SOCE.

Improving Mental Health

The relationship between mental health, psychological well-being, sexual orientation, sexual orientation identity, and sexual behavior is important. Few studies report health and mental health outcomes, and those that do report outcomes tend to use psychometrically weak measures of these constructs and weak study designs. Among the early studies that report on mental health, three nonexperimental single-patient case studies report that clients were more self-assured (Blitch & Haynes, 1972) or less fearful and distressed (Hanson & Adesso, 1972; Huff, 1970).

Overall, the lack of high-quality data on mental health outcomes of efforts to change sexual orientation provide no sound basis for claims that people's mental health and quality of life improve. Indeed, these studies add little to understanding how SOCE affects people's long-term mental health.

Reports of Harm

Determining the efficacy of any intervention includes examination of its side effects and evidence of its harm (Flay et al., 2005; Lilienfeld, 2007). A central issue in the debates regarding efforts to change same-sex sexual attractions concerns the risk of harm to people that may result from attempts to change their sexual orientation. Here we consider evidence of harm in early and recent research.

EARLY STUDIES

Early research on efforts to change sexual orientation focused heavily on interventions that include aversion techniques. Many of these studies did not set out to investigate harm. Nonetheless, these studies provide some suggestion that harm can occur from aversive efforts to change sexual orientation.

EXPERIMENTAL STUDIES

In McConaghy and Barr's (1973) experiment, 1 respondent of 46 subjects is reported to have lost all sexual feeling and to have dropped out of the treatment as a result. Two participants reported experiencing severe depression, and 4 others experienced milder depression during treatment. No other experimental studies reported on iatrogenic effects.

QUASI-EXPERIMENTAL STUDIES

None reported on adverse events.

NONEXPERIMENTAL STUDIES

A majority of the reports on iatrogenic effects are provided in the nonexperimental studies. In the study conducted by Bancroft (1969), the negative outcomes reported include treatment-related anxiety (20% of 16

participants), suicidal ideation (10% of 16 participants), depression (40% of 16 participants), impotence (10% of 16 participants), and relationship dysfunction (10% of 16 participants). Overall, Bancroft reported the intervention had harmful effects on 50% of the 16 research subjects who were exposed to it. Quinn, Harbison, and McAllister (1970) and Thorpe et al. (1964) also reported cases of debilitating depression, gastric distress, nightmares, and anxiety. Herman and Prewett (1974) reported that following treatment, their research participant began to engage in abusive use of alcohol that required his rehospitalization. It is unclear to what extent and how his treatment failure may have contributed to his abusive drinking. B. James (1962) reported symptoms of severe dehydration (acetonuria), which forced treatment to be suspended.

Overall, although most early research provides little information on how research participants fared over the longer term and whether interventions were associated with long-term negative effects, negative effects of treatment are reported to have occurred for some people during and immediately following treatment.

High dropout rates characterize early treatment studies and may be an indicator that research participants experience these treatments as harmful. Lilienfeld's (2007) review of harm in psychotherapy identified dropout as not only an indicator of direct harm but also of treatment ineffectiveness.

RECENT STUDIES

Although the recent studies do not provide valid causal evidence of the efficacy of SOCE or of its harm, some recent studies document that there are people who perceive that they have been harmed through SOCE (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; G. Smith et al., 2004), just as other recent studies document that there are people who perceive that they have benefited from it (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Pattison & Pattison, 1980; Schaeffer et al., 2000; Spitzer, 2003). Among those studies reporting on the perceptions of harm, the reported negative social and emotional consequences include self-reports of anger, anxiety, confusion, depression, grief, guilt, hopelessness, deteriorated relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation, self-hatred, and sexual dysfunction. These reports of perceptions of harm are countered by accounts of perceptions of relief, happiness, improved relationships with God, and perceived improvement in mental health status, among other reported benefits. Many participants in studies by Beckstead and Morrow (2004) and Shidlo and Schroeder (2002) described experiencing first the positive effects and then experiencing or acknowledging the negative effects later.

Overall, the recent studies do not give an indication of the client characteristics that would lead to perceptions of harm or benefit. Although the nature of these studies precludes causal attributions for harm or benefit to SOCE, these studies underscore the diversity of and range in participants' perceptions and evaluations of their SOCE experiences.

Summary

We conclude that there is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the 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).

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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.

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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).

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.

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.

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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).

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.

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).

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.

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).

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.

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 (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).

Reducing parental rejection, hostility, and violence (verbal or physical) may contribute to the mental health and safety of the adolescent.

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.

. . . therapy that increases the client's ability to cope, understand, acknowledge, and integrate sexual orientation concerns into a self-chosen life is the measured approach.

Education, Training, and Research

We were asked to provide recommendations for education, training, and research as they pertain to such affirmative interventions. We examine these areas separately.

EDUCATION AND TRAINING

Professional education and training

Training of LMHP to provide affirmative, evidence-based, and multicultural interventions with individuals distressed by their same-sex sexual attractions is critical. Research on LMHP behaviors indicates a range of interventions, some of which are based on attitudes and beliefs rather than evidence, especially as some LMHP may have been educated during the period when homosexuality was pathologized (cf. Bartlett et al., 2001; Beutler, 2000; M. King et al., 2004; Liszcz & Yarhouse, 2005). We recommend that LMHP increase their awareness of their own assumptions and attitudes toward sexual minorities (APA, 2000; R. L. Worthington et al., 2005). This occurs by increasing knowledge about the diversity of sexual minorities (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status), as well as the management of the LMHP's own biases in order to avoid colluding with clients' internalized stigma and with the negating environments in which clients and LMHP live (APA, 2000; Dillon et al., 2004; Israel & Hackett, 2004; R. L. Worthington et al., 2005). We recommend that training in affirmative, evidence-based, and multiculturally informed interventions for sexual minorities be offered at all graduate schools and postgraduate training programs.

An important resource for LMHP is the APA (2000) *Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients*,[70] which advises LMHP to be competent in a variety of domains, including knowledge of the impact of stigma on mental health, the unique issues facing same-sex relationships and families, and the range of diversity concerns for sexual minority individuals. We recommend that several areas in which LMHP working with clients seeking SOCE obtain additional knowledge and skills include: (a) sexuality, sexual orientation, and sexual identity development; (b) the psychology of religion and spirituality, including models of faith development, religious coping, and the positive psychology of religion; (c) identity development models, including those that integrate multiple identities and facilitate identity conflict resolution; and (d) adaptive ways to manage stigma, minority stress, and multiple aspects of identity. We also recommend that practitioners review publications that explicate the above-mentioned topics and evidence-based, LGB-affirmative, and multicultural approaches to psychological interventions (APA, 2000, 2002a, 2002c, 2004, 2005b, 2006, 2007b, 2008a; Bartoli & Gillem, 2008; Brown, 2006; Fowers & Davidov, 2006; Schneider et al., 2002).

[70] These guidelines are being revised, and a new version will be available in 2010.

Those less familiar with religious perspectives can broaden their views on religion and religious individuals and reduce their potential biases by seeking relevant information on religious faith and the psychology of religion (e.g., Ano & Vasconcelles, 2005; Exline, 2002; Emmons, 1999; Emmons & Paloutzian, 2003; Fowler, 2001; Goldstein, 2007; Pargament & Mahoney, 2005; Pargament et al., 1998, 2005). Training programs for practitioners can increase competencies in these areas by including comprehensive material on religion and spirituality (Bartoli, 2007; Hage, 2006; Hathaway et al., 2004; Yarhouse & Fisher, 2002; Yarhouse & VanOrman, 1999) and on ways to incorporate religious approaches into psychotherapy (see, e.g., Richards & Bergin, 2000, 2004; Sperry & Shafranske, 2004). Additionally, publications that illustrate affirmative integration and resolution of religious and sexual minority identity are helpful (Astramovich, 2003; Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Ritter & O'Neil, 1989, 1995).

Conservative religious practitioners can increase their compassionate and understanding responses to sexual minorities. Some focus on increasing compassionate responses toward sexual minorities by conservative religious students or individuals (Bassett et al., 2005; Benoit, 2005; Fischer & DeBord, 2007; McMinn, 2005; Yarhouse, Burkett, & Kreeft, 2001; Zahniser & Boyd, 2008; Zahniser & Cagle, 2007). One study found an evolution of positive attitudes toward sexual minorities among LMHP who hold conservative religious values (E. Adams, Longoria, Hitter, & Savage, 2009). These perspectives are based on established social psychology research, such as the contact hypothesis, where increasing personal contact with members of minority groups of equal status reduces bias, including attitudes toward sexual minorities (e.g., Herek & Capitanio, 1996; Herek & Glunt, 1993; Pew Forum on Religion and Public Life, 2003).

Finally, although this report has limited information regarding sexual minorities in other countries, the research review and practice recommendations may be helpful to professionals. We recommend dissemination of this report to international mental health organizations and LGBT advocacy groups.

We recommend the following steps be taken by the APA to educate LMHP and support training programs in providing education:

1. Disseminate this report to accredited doctoral programs, internships, and other postdoctoral programs in psychology both in the United States and other countries to encourage the incorporation of this report and other relevant material on LGBT issues into graduate school training programs and internship sites.
2. Disseminate information to faculty in psychology departments in community colleges, colleges, and university programs as information and for use in curriculum development.
3. Maintain the currently high standards for APA approval of continuing professional education providers and programs.
4. Offer symposia and continuing professional education workshops at APA's annual convention that focus on treatment of individuals distressed by their same-sex sexual attractions, especially those who struggle to integrate religious and spiritual beliefs with sexual orientation identity.
5. Pursue the publication of a version of this report in an appropriate journal or other publication.

Public education

The information available to the public about SOCE and sexual orientation is highly variable and can be confusing. In those information sources that encourage SOCE, the portrayals of homosexuality and sexual minorities tend to be negative and at times to emphasize inaccurate and misleading stereotypes (Kennedy & Cianciotto, 2006; SPLC, 2005). Sexual minorities, individuals aware of same-sex sexual attractions, families, parents, caregivers, policymakers, religious leaders, and society at large can benefit from accurate scientific information about sexual orientation and about appropriate interventions for individuals distressed by their same-sex sexual attractions both in the United States and internationally. We recommend that APA:

1. Create informational materials for sexual minority individuals, families, parents, and other stakeholders on appropriate multiculturally competent and client-centered interventions for those distressed by their sexual orientation who may seek SOCE.
2. Create informational materials on sexual orientation, sexual orientation identity, and religion for all stakeholders, including the public and institutions of faith.
3. Create informational materials focused on the integration of ethnic, racial, national origin and

cultural issues, and sexual orientation and sexual orientation identity.

4. Integrate the conclusions of this report into existing APA public information resources, including print, media, and the Internet.

5. Collaborate with other relevant organizations, especially religious organizations, to disseminate this information.

RESEARCH

Our systematic review of research has highlighted the methodological problems pervasive in recent research on SOCE. This raises two issues: (a) the publication of poorly designed research and (b) whether more research on SOCE should be conducted to pursue questions of benefit, harm, and safety. These two issues are addressed separately.

Much of the recent research on SOCE has had serious methodological problems. Although this research area presents serious challenges (e.g., obtaining a representative sample, finding appropriate measures, and using evidence-based constructs), many of the problems were avoidable. Problems included (a) inappropriate use of statistical tests, (b) poor measurement, and (c) designs that did not permit valid causal conclusions to be drawn.

Hunt and Carlson (2007) have argued that studies with immediate social relevance that have an impact on social policy or social issues should be held to a higher standard because this literature has the potential to influence policymakers and the public, and incomplete or misleading information has serious costs. Research published on SOCE needs to meet current best-practice research standards. Many of the problems in published SOCE research indicate the need for improvement in the journal review process. It is recommended that professional and scientific journals retain reviewers and editors with expertise in this area to maintain the standards of published research.

We concluded that research on SOCE (psychotherapy, mutual self-help groups, religious techniques) has not answered basic questions of whether it is safe or effective and for whom. Any future research should conform to best-practice standards for the design of efficacy research. Additionally, research into harm and safety is essential. Certain key issues are worth highlighting. Future research must use methods that are prospective and longitudinal, allow for conclusions about cause and effect to be confidently drawn, and employ sampling methods that allow proper generalization.[71]

Future research should also include appropriate measures in terms of specificity of measurement of sexual orientation, sexual orientation identity and outcomes, and psychometric adequacy. Mixed-method research, in which methods and measures with offsetting weaknesses are simultaneously employed, may be especially advantageous. Alternative physiological means of measuring sexual orientation objectively may also be helpful. Recent research has used alternatives to genital gauges for the assessment of sexual orientation in men and women, such as functional magnetic resonance imaging (Ponseti et al., 2006). Physiological measures often use visual portrayals of nude individuals that some religious individuals may find morally unacceptable. Jlang, Costello, Fang, Huang, and He (2006) have explored the use of invisible images and have measured selective inattention/attention as an alternative to assess sexual arousal. Such methods or the development of methods that are less intrusive and are more consistent with religious values would be helpful to develop for this population.

Additionally, preexisting and co-occurring conditions, mental health problems, participants' need for monitoring self-impression, other interventions, and life histories would have to be given appropriate consideration so that research can better account for and test competing explanations for any changes observed in study participants over time. Specific conceptual and methodological challenges exist in research related to sexual minority populations, such as the conceptualization of sexual orientation and sexual orientation identity and obtaining representative samples. Researchers would be advised to consider and compensate for the unique conceptual and

[71] A published study that appeared in the grey literature in 2007 (S. L. Jones & Yarhouse, 2007) has been described by SOCE advocates and its authors as having successfully addressed many of the methodological problems that affect other recent studies, specifically the lack of prospective research. The study is a convenience sample of self-referred populations from religious self-help groups. The authors claim to have found a positive effect for some study respondents in different goals such as decreasing same-sex sexual attractions, increasing other-sex attractions, and maintaining celibacy. However, upon close examination, the methodological problems described in Chapter 3 (our critique of recent studies) are characteristic of this work, most notably the absence of a control or comparison group and the threats to internal, external, construct, and statistical validity. Best-practice analytical techniques were not performed in the study, and there are significant deficiencies in the analysis of longitudinal data, use of statistical measures, and choice of assessment measures. The authors' claim of finding change in sexual orientation is unpersuasive due to their study's methodological problems.

methodological challenges in this area (Meyer & Wilson, 2009; Moradi, Mohr, Worthington, Fassinger, 2009).

Safety issues continue to be important areas of study. As noted previously, early research indicates that aversive techniques have been found to have very limited benefits as well as potentially harmful effects. These documented harms were serious. An additional finding is that these treatments had extremely high dropout rates, which has been linked to adverse effects. Some individuals report harm from recent nonaversive techniques, and some individuals report benefits.

Some authors have stated that SOCE should not be investigated or practiced until safety issues have been resolved (Davison, 1976, 1991; Herek, 2003), as it is still unclear which techniques or methods may or may not be harmful. Assessing the safety of recent practices is a high priority given that this research is the least rigorous. Given that types of harm can be multiple, outcome studies with measures capable of assessing deterioration in mental health, appearance of new symptoms, heightened concern regarding existing symptoms, excessive dependency on the LMHP, and reluctance to seek out new treatment are important to include in future research (Lilienfeld, 2007). Other areas to assess are types of harm to others (e.g., some individuals have noted that advocating other-sex marriage or promising sexual orientation change may negatively affect spouses, potential spouses, and children) (Buxton, 1994, 2007; Wolkomir, 2006).

Finally, LMHP must be mindful of the indirect harms of SOCE, such as the "opportunity costs" (Lilienfeld, 2007) and the time, energy, effort, and expense of interventions that offer limited benefit and have the potential to cause disillusionment in psychotherapy. However, as concerns regarding harm have been raised, addressing risks to research participants and concerns regarding voluntary participation (see Standard 8.02 in APA, 2002b) must be carefully considered in any future research.

Research that meets these scientific standards and addresses efficacy and safety might help to clarify the issues. Even so, scientific research may not help to resolve the issues unless it can better account for the complexity of the concerns of the current population. The results of current research are complicated by the belief system of many of the participants whose religious faith and beliefs may be intricately tied to the possibility of change. Future research will have to better account for the motivations and beliefs of participants in SOCE.

Emerging research reveals that affirmative interventions show promise for alleviating the distress of children, adolescents, and families around sexual orientation and identity concerns (D'Augelli, 2002, 2003; Goodenow et al., 2006; Perrin, 2002; C. Ryan et al., 2009). However, sexual minority adolescents are underrepresented in research on evidence-based approaches, and sexual orientation issues in children are virtually unexamined (APA, 2008d). Specific research on sexual minority adolescents and children has identified that stigma can be reduced through community interventions, supportive client-centered approaches, and family reconciliation techniques that focus on strengthening the emotional ties of family members to each other, reducing rejection, and increasing acceptance (D'Augelli, 2003; Goodenow et al., 2006; C. Ryan et al., 2009). This line of research should be continued and expanded to include conservatively religious youth and their families.

Finally, we presented a framework for therapy with this population. Although this model is based on accepted principles of psychotherapy and is consistent with evidence-based approaches to psychotherapy, it has not been evaluated for safety and efficacy. Such studies would have to be conducted in the same manner as research on SOCE and in ways that are consistent with current standards (see, e.g., Flay et al., 2005).

Recommendations for basic research

To advance knowledge in the field and improve the lives of individuals distressed by same-sex sexual attractions who seek SOCE, it is recommended that researchers, research-funding organizations, and other stakeholders, including those who establish funding priorities, work together to improve our knowledge of sexuality, sexual orientation, and sexual orientation identity in the following areas:

1. The nature and development of sexuality, sexual orientation, sexual orientation identity across the life span and the correlates to these variables, incorporating differences across age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status.

2. Religious identity and faith development (inclusive of all world religions) and their intersection with other aspects of human life and identity, such as sexual orientation, sexual orientation identity, and the multiple social identity statuses related to privilege and stigma.

3. Identity integration, reduction in distress, and positive mental health for populations of religious sexual minorities and ethnic minority populations.
4. Culture, gender, religion, and race/ethnicity in the experience and construction of sexual orientation and sexual orientation identity.
5. Mental health outcomes of those who choose not to act on their sexual orientation by living celibately or in relationships with other-sex partners.

Recommendations for research in psychotherapy

We recommend that researchers and practitioners rigorously investigate multiculturally competent and affirmative evidence-based treatments for sexual minorities and those distressed by their sexual orientation that do not aim to alter sexual orientation but rather focus on sexual orientation identity exploration, development, and integration without prioritizing one outcome over another, for the following populations:

1. Sexual minorities who have traditional religious beliefs
2. Sexual minorities who are members of ethnic minority and culturally diverse communities both in the United States and internationally
3. Children and adolescents who are sexual minorities or questioning their sexual orientation
4. Parents who are distressed by their children's perceived future sexual orientation
5. Populations with any combination of the above demographics

Policy

We were asked to make recommendations to APA to inform the association's response to groups that promote treatments to change sexual orientation or its behavioral expression and to support public policy that furthers affirmative therapeutic interventions.

The debate surrounding SOCE has become mired in ideological disputes and competing political agendas (Drescher, 2003; Drescher & Zucker, 2006). Some organizations opposing civil rights for LGBT individuals advocate SOCE (SPLC, 2005). Other policy concerns involve religious or socially conservative agendas where issues of religious morality conflict with scientific-based conceptions of positive and healthy development. We encourage APA to continue its advocacy for lesbian, gay, bisexual, and transgender individuals and families and to oppose prejudice against sexual minorities (APA, 2003, 2005, 2006, 2008b). We encourage collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles. These collaborative relationships can be designed to integrate humanitarian perspectives and professional expertise (Tyler, Pargament, & Gatz, 1983).

Thus, the task force urges APA to:

1. Actively oppose the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion and take a leadership role in responding to such distortions.
2. Support the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based on lack of scientific knowledge about sexual orientation.
3. Encourage advocacy groups, elected officials, policymakers, religious leaders, and other organizations to seek accurate information and avoid promulgating inaccurate information about sexual minorities.
4. Seek areas where collaboration with religious leaders, institutions, and organizations can promote the well-being of sexual minorities through the use of accurate scientific data regarding sexual orientation and sexual orientation identity.
5. Encourage the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns to prioritize initiatives that address religious and spiritual concerns and the concerns of sexual minorities from conservative faiths.
6. Adopt a new resolution: the Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts (see Appendix A).[72]

[72] The resolution was adopted by the APA Council of Representatives in August 2009.

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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

Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth

October 2015

Substance Abuse and Mental Health Services Administration
SAMHSA

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Acknowledgements

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

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

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

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

Contents

Executive Summary

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

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

The purpose of this report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ outh*, is to provide mental health professionals and families with accurate information about effective and ineffective therapeutic practices related to children's and adolescent's sexual orientation and gender identity. Specifically, this report addresses the issue of conversion therapy for minors. The conclusions in this report are based on professional consensus statements arrived at by experts in the field. Specifically, conversion therapy—efforts to change an individual's sexual orientation, gender identity, or gender expression[2]—is a practice that is not supported by credible evidence and has been disavowed by behavioral health experts and associations. Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm.

Key Findings

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

- Same-gender[3] sexual orientation (including identity, behavior, and attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
- There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
- Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment. (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

Understanding Sexual Orientation and Gender Identity in Children and Youth

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

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

There is not a single developmental trajectory for either sexual minority or gender minority youth. Compared to the 20th century, in the 21st century, youth started realizing and disclosing a minority sexual orientation and/or identifying as lesbian, gay, or bisexual at younger ages than in previous generations (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, Bimbi, Nanín, & Parsons, 2006; R. C. Savin-Williams, 2001). Though aspects of sexuality are displayed beginning in infancy, little is known about sexual orientation among pre-pubertal children (Adelson & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI), 2012). Children are rarely if ever distressed about their current or future sexual orientation; more commonly, parents and guardians are distressed about a child's perceived current or future sexual orientation and seek the assistance of behavioral health providers (American Psychological Association, 2009). Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual orientation identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. In comparison with their heterosexual counterparts, sexual minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Corliss et al., 2010; Friedman et al., 2011; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann et al., 2011; Marshal et al., 2011; Russell, 2003). Supportive families, peers, and school and community environments are associated with improved psychosocial outcomes for sexual minority youth (Bouris et al., 2010; Kosciw, Greytak, Palmer, & Boesen, 2014; Lease, Horne, & Noffsinger-Frazier, 2005).

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

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

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

Therapeutic Efforts with Sexual and Gender Minority Youth[4]

Given the professional consensus that conversion therapy efforts are inappropriate, the following behavioral health approaches are consistent with the expert consensus statements and current research, and are recommended by professional associations (American Psychological Association, 2015a; APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Byne, et al., 2012). When providing services to children, adolescents, and families, appropriate therapeutic approaches include: providing accurate information on the development of sexual orientation and gender identity and expression; increasing family and school support; and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Approaches should be client-centered and developmentally-appropriate with the goal of treatment being the best possible level of psychological functioning, rather than any specific gender identity, gender expression, or sexual orientation. Appropriate therapeutic approaches with sexual and gender minority youth should include a comprehensive evaluation and focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support. It is important to identify the sources of any distress experienced by sexual and gender minority youth and their families, and work to reduce this distress. Working with parents and guardians is important as parental behaviors and attitudes have a significant effect on the mental health and well-being of sexual and gender minority children and adolescents. School and community interventions may also be necessary and appropriate.

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

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

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

Ending the Use of Conversion Therapy for Minors

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

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Introduction

This report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ outh*, provides an overview of the current state of scientific understanding of the development of sexual orientation and gender identity in children and adolescents as well as the professional consensus on clinical best practices with these populations. Specifically, this report addresses the issue of conversion therapy for minors. Conversion therapy—efforts to change an individual's sexual orientation, gender identity, or gender expression[5]—is a practice that is not supported by credible evidence, and has been disavowed by behavioral health experts and associations. Importantly, this report also provides a nuanced overview of appropriate supportive interventions to assist families in exploring the sometimes difficult issues associated with sexual orientation, gender identity, and gender expression.

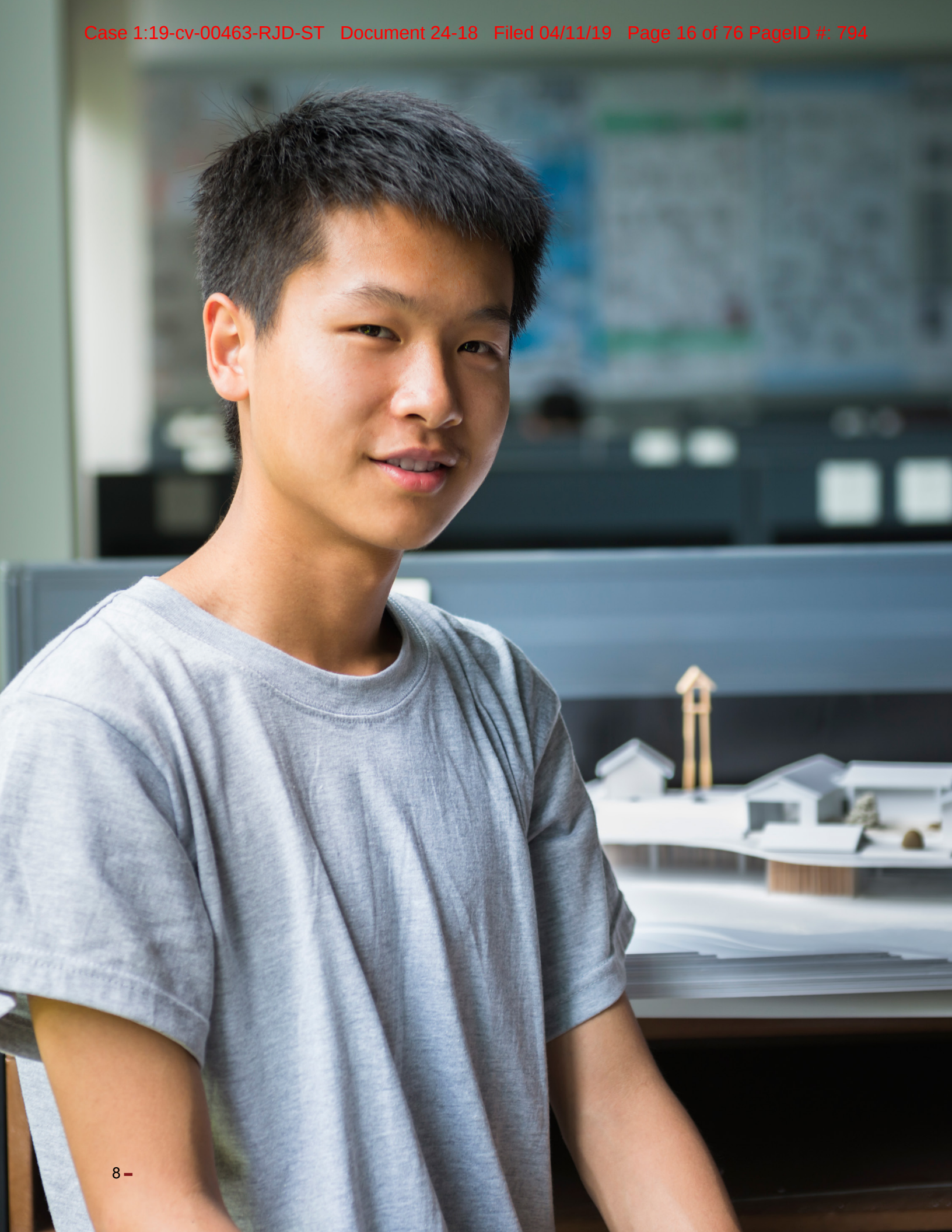
This work is the result of a collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Psychological Association (APA), which convened a panel of behavioral health professionals (e.g., psychologists, researchers and clinicians from psychology, social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

In addition, this report highlights areas of opportunity for future research, and provides an overview of mechanisms to eliminate the use of harmful therapies. In an effort to provide useful tools for families, practitioners, and educators, the report also provides resources on several topics, including: *Family and Community Acceptance*, *School-Based Issues*, *Pediatric Considerations*, and *Affirmative Exploratory Therap* . In addressing these four topics, SAMHSA aims to enable families, providers, educators, and community members to take actions that will reduce the health risks and disparities facing this vulnerable population.

> "Being gay is not a disorder. Being transgender is not a malady that requires a cure."
>
> **—Vice Admiral Vivek H. Murthy, 19th U.S. Surgeon General**

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

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



Professional Consensus Process

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

APA initially developed a list of the areas of expertise to be used in identifying potential experts to participate in the consensus panel based on existing professional guidelines and resolutions related to sexual orientation, gender identity, and gender expression, as well as published research. APA solicited nominations from specialists in the field with expertise in gender, sexuality and sexual orientation, child and adolescent development and mental health, and the psychology of religion. Additionally, APA solicited nominations from professional associations representing the major mental health and health professions. Using the input received from these sources, APA extended invitations to a short list of highly recommended group of experts. This initial expert pool nominated additional experts based on their assessment of the expertise needed to achieve the goals of the meeting. The final panel of 13 experts consisted of ten psychologists, two social workers, and one psychiatrist. These individuals included researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel also included experts with a background in family therapy, ethics, and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B. Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and Mark Yarhouse, PsyD. APA activities were coordinated by Clinton W. Anderson, PhD and Judith Glassgold, PsyD.

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

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

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

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

Sue Thau

Statements of Professional Consensus

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

Guiding Principles

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

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

Professional Consensus on Conversion Therapy with Minors

1. Same-gender[7]sexual orientation (including identity, behavior, and/or attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
2. There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
3. Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatments. Directing the child to be conforming to any gender expression or sexual orientation, or directing the parents to place pressure for specific gender expressions, gender identities, and sexual orientations are inappropriate and reinforce harmful gender and sexual orientation stereotypes.

Professional Consensus on Sexual Orientation in Youth

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

Professional Consensus on Gender Identity and Gender Expression in Youth

Consensus on the Overall Phenomena of Gender Identity and Gender Expression

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

Consensus on Efforts to Change Gender Identity

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

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

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

Pre-Pubertal Children

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

Peri-Pubertal Adolescents

9. For peri-pubertal adolescents, the purpose of pubertal suppression is to provide time to support identity exploration, to alleviate or avoid potential distress associated with physical maturation and secondary sex characteristics[8], and to improve future healthy adjustment. If pubertal suppression is being considered, it is strongly recommended that parents or guardians and medical providers obtain an assessment by a licensed behavioral health provider to understand the present status of a peri-pubertal adolescent's gender identity or gender expression and associated distress, as well as to provide developmentally-appropriate information to the peri-pubertal adolescent, parents or guardians, and other health care professionals involved in the peri-pubertal adolescent's care. The purpose of the assessment is to advise and inform treatment decisions regarding pubertal suppression after sharing details of the potential risks, benefits, and implications of pubertal suppression, including the effects of pubertal suppression on behavioral health disorders, cognitive and emotional development, and future physical and sexual health.

Pubertal and Post-Pubertal Adolescents

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

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

Research Overview

Sexual Orientation

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

Gender

Gender is a ubiquitous and multi-faceted social category. When discussing the concept of gender, scientists distinguish between biological sex, gender identity, and gender expression. Biological sex refers to one's physical sex characteristics (Hughes, Houk, Ahmed, & Lee, 2006). Infants' biological sex is labeled at birth, almost always based solely on external genital appearance; this is referred to as one's assigned sex at birth[10]. Gender identity refers to a person's deeply felt, inherent sense of being a girl, woman or female; a boy, a man or male; a blend of male or female; or an alternative gender (Bethea, 2013; Institute of Medicine, 2011). Gender expression refers to the ways a person communicates their gender within a given culture, including clothing, communication patterns, and interests; a person's gender expression may or may not be consistent with socially prescribed gender roles or assigned sex at birth, and may or may not reflect his or her gender identity (American Psychological Association, 2008).

Similar to sexual orientation, significant changes have occurred over time in the scientific understanding of gender. Though one's biological sex, gender identity, and gender expression are distinct constructs, society expects that they will align, and for most individuals this is true – that is, most individuals who are assigned female at birth identify as girls or women and adopt a feminine gender expression, while most individuals who are assigned male at birth identify as boys or men and adopt a masculine gender expression[11](American Psychological Association, 2015a). However, for some individuals, these constructs do not align. The term transgender refers to individuals whose gender identity is not consistent with their sex assigned at birth. The term gender diverse (or gender nonconforming) refers to individuals whose gender expression does not conform to the stereotypical norms in their culture for their assigned sex at birth. Research in recent decades has also challenged the perception of gender as a binary construct with mutually exclusive categories of male or female, boy or girl, man or woman (American Psychological Association, 2015a; Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). It has also often been assumed that one's gender identity – that is, the deeply felt, inherent sense of one's gender – always aligns with sex assigned as birth (American Psychological Association, 2015a). Scientists now recognize that a wide spectrum of gender identities and gender expressions exist (and have always existed), including people who identify as either man or woman, neither man nor woman,

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

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

Sexual Orientation and Gender in Childhood

Sexual Orientation in Childhood

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

Gender Identity and Gender Expression in Childhood

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

It is important to note that research on gender identity issues among children is largely clinical in nature and focuses on the treatment and intervention of Gender Dysphoria and, previously, Gender Identity Disorder[12](APA Task Force on Gender Identity and Gender Variance, 2009). Though there

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

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

The fact that a large proportion of gender minority children do eventually develop a gender identity consistent with their sex assigned at birth has been viewed as evidence of the malleability of gender identity (Zucker, 2004; Zucker & Bradley, 1995). However, this conclusion has been challenged in recent years by some scholars. These researchers and clinicians have pointed out that the diagnostic criteria for Gender Dysphoria (and, previously, Gender Identity Disorder) in Childhood includes indicators that might denote gender dysphoria or gender identity, but might also simply be markers of diverse gender expression (for example, children's play preferences; Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013). These scholars have suggested that the inclusion in study samples of many children with diverse gender expressions who may not have gender dysphoria could explain the large proportion of gender minority children who eventually do not meet the diagnostic criteria in adolescence (Hidalgo et al., 2013; Wallien & Cohen-Kettenis, 2008).

One of gender's greatest complexities is that some people never identify with the sex they were assigned at birth, some people consistently identify with the sex they were assigned at birth, and still others vary over time. Gender minority children follow two trajectories[13]: On the first, children will experience gender dysphoria through adolescence and adulthood (unless dysphoria is mitigated through social or medical transition) and will identify as transgender or as a gender different from that assigned at birth. On the other trajectory, gender minority children will develop to be cisgender individuals, i.e., they will eventually identify with a gender consistent with their sex assigned at birth (Simons, et al., 2014). Gender minority children who eventually develop a cisgender identity are more likely to identify as lesbian, gay, or bisexual in adolescence and young adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). It is unknown whether gender minority children who develop a cisgender identity continue to express their gender in ways that do not conform to stereotypical gender norms, as this has not been studied. No prospective data exist on factors that might predict for any particular child which trajectory they will follow. There is, however, recent retrospective evidence identifying factors that are more common among children who eventually identify as transgender: early cognitive ("I am a girl") rather than affective ("I feel like a girl") assertion of gender; consistent and firm gender-

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

Clinical Issues in Childhood

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

Gender minority children are not a monolithic group: some gender diverse children are distressed; while others are not distressed, but may be referred for mental health care because of parental concerns related to their gender or perceived future sexual orientation. Among those who are distressed, the source of distress varies. Some gender diverse children are distressed by their primary sex characteristics or by the anticipation of future sex characteristics, while others are not (Coleman, et al., 2012; Vance, et al., 2014). In addition to anatomical dysphoria, children's feelings of gender typicality, gender contentedness, and pressure to conform to stereotypical gender norms also appear related to children's psychosocial adjustment. Researchers have reported on the relationships between these various components of gender identity and indicators of children's psychosocial adjustment, such as self-esteem, internalizing and externalizing problems, and social competence with peers (Carver, Yunger, & Perry, 2003; Egan & Perry, 2001; Yunger, Carver, & Perry, 2004).

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

Sexual Orientation and Gender in Adolescence

Sexual Orientation in Adolescence

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

Gender Identity in Adolescence

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

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

Clinical Issues in Adolescence

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

Pubertal development can be especially distressing for transgender adolescents and can set off a cascade of mental health problems during adolescence (Byne, et al., 2012; Coleman, et al., 2012). Mental health challenges are more common among adolescents with gender dysphoria than among children with gender dysphoria (Byne et al., 2012), which may be due to peer ostracism that increases with age (APA Task Force on Gender Identity and Gender Variance, 2009). Additionally, as with children, the prevalence of autism spectrum disorders appears to be higher among clinical samples of adolescents with gender dysphoria than among the general population of adolescents (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012). Adolescents with autism spectrum disorders (ASD) would benefit from careful assessment distinguishing between symptomatology related to gender dysphoria and symptoms related to ASD. de Vries, et al. (2010) reported a rate of autism spectrum disorders 10 times higher among children and adolescents referred to their gender clinic in Amsterdam, Netherlands as compared to the general population. This research only examined cases of severe autism and not milder versions such as Asperger's disorder, which Edwards-Leeper and Spack (2012) reported being more commonly seen among patients in the GeMS clinic in Boston, especially among those with a late-onset of gender dysphoria. The question of whether gender dysphoria is simply a symptom of autism spectrum disorder among youth with ASD has been raised by behavioral health providers; Edwards-Leeper and Spack (2012) suggest that it is also worth questioning validity of the autism diagnosis among transgender youth, particularly those with Asperger's disorder, as it is possible that social awkwardness and lack of peer relationships are the result of feeling isolated and rejected due to gender identity and expression (Edwards-Leeper & Spack, 2012). More research is needed into appropriate treatment for sexual and gender minority children and adolescents with developmental disabilities as well; behavioral health providers should not presume that young people with developmental disabilities cannot also be sexual and gender minorities.

Influences on Health and Well-Being

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

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

Family

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

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

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

Religion & Spirituality

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

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

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

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

It is important not to reify categories within faiths such as “traditional”, “liberal”, “affirming” and “non-affirming”; religion and spirituality are complex, nuanced aspects of human diversity. Parents from faith backgrounds have reactions that are similar in essential ways to all parents (e.g., sense of loss, desire for information, coming to terms with difference between hopes and reality; Maslowe and Yarhouse, 2015). Research indicates that families who identify superordinate goals such as unconditional love, mercy, forgiveness, and respect for all human beings can remain connected to their children in positive ways (Ryan et al, 2009; Maslowe & Yarhouse, 2015).

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

School

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

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

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

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

Identity Development

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

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

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

Intersecting Identities

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

Therapeutic Efforts with Sexual and Gender Minority Youth

Introduction[16]

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

In providing services to children, adolescents, and families experiencing distress related to sexual orientation or gender, behavioral health providers should consider the following as the scientific basis of treatment[17]:

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

Conversion Therapy

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

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

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

The discussion surrounding conversion therapy with gender minority youth is complicated by the fact that though diverse gender expressions and transgender identities are now understood to be part of the normal spectrum of human gender (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuypere, & Bockting, 2010), there remains a related psychiatric diagnosis: Gender Dysphoria (formerly Gender Identity Disorder (American Psychiatric Association, 2013a). Although there is much debate over whether Gender Dysphoria should remain a psychiatric diagnosis (for example, see Bockting & Ehrbar (2005)), such a discussion is beyond the scope of this report. However, the shift from Gender Identity Disorder to Gender Dysphoria in version five of the Diagnostic and Statistical Manual of Mental Disorders does reflect a shift away from a pathological view of gender diversity towards a focus on the distress experienced as a result of the incongruence between one's physical body and gender identity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014). Thus, the distress remains the target of intervention, rather than gender identity. There is also scientific consensus that for many people, medical intervention in the form of hormone therapy or gender affirming surgeries may be medically necessary to alleviate gender dysphoria (American Medical Association, 2008; American Psychological Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

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

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

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

In conclusion, given the lack of evidence for the efficacy conversion therapy and the fact that conversion therapy efforts are based on a view of gender diversity that runs counter to scientific consensus, in addition to evidence that rejecting behaviors and a lack of support have adverse effects on the psychological well-being of gender minority youth – conversion therapy, as well as any therapeutic intervention with an *a priori* goal for a child's or adolescent's gender expression, gender identity, or sexual orientation, is inappropriate. Given the potential for harm associated with conversion therapy efforts, other affirmative behavioral health interventions are recommended for individual or family distress associated with sexual orientation and gender identity.

Appropriate Interventions for Distress in Children, Adolescents, and Families[18]

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

Client-Centered Individual Approaches

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

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

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

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

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

Behavioral health providers should strive to incorporate multicultural awareness into their treatment, considering age, ethnicity and race, gender and gender identity, sexual orientation and attraction, ability and disability issues, religion and spirituality, generation, geographic issues and other notable factors. A key aim is to dispel negative stereotypes and to provide accurate information in developmentally-appropriate terms for children and adolescents. Identity development is multifaceted and may include multiple and intersecting identities, such as ethnic and racial and religious and spiritual identities. Sexual orientation, gender identity and expression are fluid concepts and in flux, requiring the consideration of generational changes and norms. Supporting youth in age-appropriate tasks such as developing positive peer relationships, positive parent and family relations, dating, exploring gender expression, sexuality, multiple identity development and disclosure as appropriate is a critical consideration. Behavioral health providers should take into consideration potential sources of social support and community resources. Client-centered and exploratory approaches specific to gender minority youth have been discussed in numerous publications (Edwards-Leeper, et al., in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, et al., 2005; Yarhouse, 2015c).

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

Family Approaches

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

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

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

Ryan, et al. (2010) recommended that behavioral health providers assess family reactions to LGBTQ children and adolescents, specifically the presence of family rejection. Further, behavioral health providers should attempt to modify highly rejecting behaviors, providing anticipatory guidance to families that include recommendations for support on the part of the family, and explaining the link between family rejection and negative health problems in children and adolescents. Behavioral health providers should seek ways to ameliorate parents' distress about their children's sexual orientation and/or gender, such as exploring parental attributions and values regarding minority sexual orientations and gender diversity. Family therapy may be helpful in facilitating dialogues, increasing acceptance and support, reducing rejection, and improving management of conflicts or misinformation that may exacerbate a child or adolescent's distress (Mattison & McWhirter, 1995; Ryan, et al., 2009; Salzburg, 2004, 2007). Such therapy can include family psychoeducation to provide accurate information and teach coping skills and problem-solving strategies for dealing more effectively with the challenges sexual and gender minority youth may face and the concerns the families and caretakers may have (Ben-Ari, 1995; Perrin, 2002; Ryan & Diaz, 2005; Ryan & Futterman, 1998; Ryan, et al., 2009; Salzburg, 2004, 2007; Yarhouse, 1998).

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

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

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

Many families may feel they have to choose between competence (in a provider) and deeply held beliefs. It is ideal when a family can work with competent providers who also share their deeply held beliefs and who are affirming of sexual orientation and gender diversity. However, when such providers are not available, it is important for families to work with competent providers who will be sensitive to the family's deeply held beliefs and values while offering competent, appropriate services for sexual and gender minority minors (Yarhouse, 2015b). Thus, behavioral health providers may wish to increase their own competence in working with certain communities with deeply held beliefs and focus on viewing these beliefs through the imperative of multicultural competence and mutual respect (Bartoli & Gillem, 2008). This is includes understanding how to translate between psychology and deeply held beliefs rather than judging those beliefs. Certain language, such as acceptance, might not resonate with communities that have strongly held beliefs, whereas the concept of unconditional love might (Yarhouse, 2015a).

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

School and Community Interventions

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

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

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

Additional Appropriate Approaches with Gender Minority Youth

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

Social Transition

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

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

Medical Intervention

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

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

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

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

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

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

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

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

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

Future Directions for Research

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

Development of sexual orientation and gender identity

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

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

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

Addressing the needs of disconnected LGBTQ youth

LGBTQ youth experiencing homelessness, in juvenile justice facilities, or otherwise in out-of-home care may lack permanent and stable family connections in part because of family distress around issues relating to their LGBTQ identity. These vulnerable populations, as well as low-income and racial and ethnic minority LGBTQ youth, are often neglected in research studies that most often recruit youth who are already connected to clinics or providers. This need for more representative sampling and better recruitment efforts should be addressed by future researchers interested in sexual orientation and gender identify among youth.

Long-term Outcomes

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

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

Integration, Collaboration, and Dissemination

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

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

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

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

> *"When assessing the validity of conversion therapy, or other practices that seek to change an individual's gender identity or sexual orientation, it is as imperative to seek guidance from certified medical experts. The overwhelming scientific evidence demonstrates that conversion therapy, especially when it is practiced on young people, is neither medically nor ethically appropriate and can cause substantial harm.*
>
> *As part of our dedication to protecting America's youth, this Administration supports efforts to ban the use of conversion therapy for minors."* (Jarrett, 2015)

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

Sue Thau

Approaches to Ending the Use of Conversion Therapy

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

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

Reducing discrimination and negative social attitudes towards LGBT identities and individuals

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

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

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

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

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

Dissemination of information, training and education for behavioral health providers

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

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

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

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

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

Legislative, regulatory, and legal efforts

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

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

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

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

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

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

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

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

Guidance for Families, Providers, and Educators

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

Promoting Family and Community Acceptance and Support

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

Over the past decade, the concept of "connectedness" has been seen by researchers and clinicians as an essential aspect in helping to protect against risk and promote wellness for individuals in families and communities. For LGBTQ youth, family, peer and community support have been shown to be important sources of support, and among these, family support and acceptance during adolescence were found to have the strongest influence on overall adjustment and well-being in young adulthood. Because most young people are nurtured through diverse family, caregiver and kinship systems, LGBTQ and gender diverse children and adolescents need support in the context of their families, cultures and faith communities. Access to accurate information about sexual orientation and gender identity development is critical for families and caregivers who often have limited and inaccurate information about these core aspects of human development. This is particularly important for families and caregivers who believe that LGBTQ identities and gender diversity may be at odds with or disavowed by their religious and cultural values and beliefs.

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

Key Points:

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

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

Resources

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

Gender Spectrum: www.genderspectrum.org

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

PFLAG : www.pflag.org

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

Bullying, Harassment, and Other School-Based Issues

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

Key points:

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

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

- School-based mental health professionals may often be one of the few trusted adults with whom young people can be open about who they are and what barriers they are facing as a result. Some LGBTQ young people may not be in a position to discuss their sexual orientation or gender identity with their families, whether because their family has already made it clear that such conversations are not welcome, or because of fears of family rejection if they come out. In addition to providing a safe and welcoming atmosphere, school-based mental health professionals can equip themselves with LGBTQ-related resources, know the warning signs for identity-based mistreatment, and be prepared to serve as one of the primary adults with whom LGBTQ youth can discuss these issues.
- It is important to understand that confidentiality is essential; students should not be outed to their parents or to their peers, and professionals should not assume that the name, pronouns, or manner of dress that a student uses in school is the same at home; often times, school may be the only place where a young person feels comfortable being out or expressing their gender in a certain way. Students should be asked how they would like to be addressed and in which context. Safety and support should be of paramount concern.
- Students should never be asked to change gender non-conforming behavior as a means of resolving issues arising in school. Beyond the potential for increasing psychological distress, such requests occur within the context of a system that already frequently penalizes LGBTQ youth. This population is disproportionately disciplined in schools, and is over-represented in the juvenile justice system. While five to seven percent of youth are estimated to be LGBTQ, they represent 15 percent of the juvenile justice population, and up to 40 percent of homeless youth. Helping to ensure that LGBTQ youth can be who they are *and* stay in school is a life-changing and potentially life-saving intervention.
- One of the most important steps that families and schools can take is to ensure that schools have inclusive and supportive policies for LGBTQ youth that are implemented effectively. Numerous resources have been developed (several are listed below) that walk through all of the ways in which a school can make system-wide changes that benefit all students, including LGBTQ students. Beyond simply being in the best interest of LGBTQ students and their behavioral health, Title IX of the Education Amendments of 1972 protects transgender and gender nonconforming students from discrimination. Proactive adoption of inclusive policies can prevent costly and time-consuming efforts to remedy issues after damage has already occurred.

Resources:

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

GLSEN: www.glsen.org

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

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

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

PFLAG : www.pflag.org

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

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

Pediatric Care Considerations for LGBTQ Children and Adolescents

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

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

Key points:

- *Families need accurate information about LGBTQ identities as being normal variants of the human experience.* Specifically, this is important in helping pediatricians respond to family and parent questions about the healthiness or normality of their child's or adolescent's behavior or identity is inherently pathological and whether these behaviors or identities can or should be changed. This can be particularly important for transgender and gender nonconforming youth, who may be seeking medical interventions to help mitigate the effects of untreated gender dysphoria, as some parents might hold the belief that their youth's gender identity is inherently pathological. In fact, it is the associated gender identity-sex anatomy discrepancy that characterizes gender dysphoria, and which is the treatable phenomena, not the gender identity itself. This information is readily available (several resources are listed below), and sharing it may be the most important way a pediatrician can support the healthy development of sexual and gender minority youth.
- *Practices should provide office climates that allow all youth to feel comfortable disclosing their gender identity or sexual orientation, whether it differs from societal expectations and cultural norms or not.* Steps to do so can include a number of things, ranging from changing intake forms to include both gender identity and sex assigned at birth, routinely asking about pronoun preferences when with youth alone, training frontline staff to use youths' preferred name and pronoun (and when it is safe and appropriate to do so), to forming partnerships with local LGBTQ organizations and building relationships with LGBTQ community providers to whom they can refer youth and families to when appropriate.
- *Family dynamics are particularly important to address as they pertain to attitudes and beliefs about gender identity and sexual orientation.* Research has shown that LGBTQ youth who come from highly rejecting families are nearly nine times more likely to engage in suicidal behavior when compared to their LGBTQ youth counterparts who come from accepting families (Ryan, et al., 2009). Pediatricians should be aware of the various types of

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

- *Pediatricians should be careful not to reinforce gender stereotypes when working with LGBTQ and gender nonconforming youth and their families.* This can require recognizing your own implicit biases and working to change ingrained patterns, such as giving certain stereotypically masculine toys to boys and others to girls, or asking adolescents specifically whether they have a boyfriend or a girlfriend instead of determining the information in a manner that does not presuppose the gender of their romantic or sexual interest or attraction.
- *Pediatricians should be aware of the situations when it is necessary to enlist an interdisciplinary team of providers to address the health of some LGBTQ youth.* While some issues may be resolved through the simple provision of information, it may be necessary to establish an interdisciplinary team that includes qualified behavioral health professionals and ongoing collaboration. For all LGBTQ youth, recognizing and detecting signs of emotional distress and psychiatric co-occurring diagnoses (such as depression, anxiety, substance abuse), requires astute screening (particularly in the case of suicide), detection of psychiatric conditions, and prompt referral to a behavioral health provider. As is addressed in depth in the *Affirmative Care* section, for adolescents with gender dysphoria, it is important to coordinate the care with a qualified behavioral health provider and endocrinologist in determining eligibility and readiness for physical interventions such as pubertal suppression or cross-gender hormone therapy. In some situations, coordination of care with the behavioral health provider and surgeon may be necessary as well when considering surgical interventions for eligible adolescents with gender dysphoria as described in the WPATH standards of care (Coleman et al., 2012).

Resources:

American Academy of Pediatrics. (2013). Policy Statement: Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics, 132*(1), 198 -203 doi: 10.1542/peds.2013-1282

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

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Affirmative Care for Gender Minority Youth

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

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

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

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

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

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

Resources

TransYouth Family Allies: www.imatyfa.org/

Trans Youth Equality Foundation: www.transyouthequality.org

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

Gender Spectrum: www.genderspectrum.org

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

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

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

Summary and Conclusion

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

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

The research, clinical expertise, and expert consensus make it clear that conversion therapy efforts to change a child's or adolescent's gender identity, gender expression, or sexual orientation are not an appropriate therapeutic intervention. No evidence supports the efficacy of such interventions to change sexual orientation or gender identity, and such interventions are potentially harmful. Appropriate therapeutic approaches to working with sexual and gender minority youth include: providing accurate information on the development of sexual orientation and gender identity and expression, increasing family and school support, and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Social transition and medical interventions, including pubertal suppression and hormone therapy, are additional therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation, developmentally-appropriate informed consent of youth and their families, and a weighing of potential risks and benefits are vital when considering interventions with gender minority youth.

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

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

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Appendix A: Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Acknowledgments

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

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

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

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

Endnotes

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

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

Substance Abuse and Mental Health Services Administration
SAMHSA
HHS Publication No. (SMA) 15-4928

Position Statement on Issues Related to Homosexuality

Approved by the Board of Trustees, December 2013
Approved by the Assembly, November 2013

"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*.

While recognizing that the scientific understanding is incomplete and often distorted because of societal stigma, the American Psychiatric Association holds the following positions regarding same-sex attraction and associated issues. It is the American Psychiatric Association's position that same-sex attraction, whether expressed in action, fantasy, or identity, implies no impairment per se in judgment, stability, reliability, or general social or vocational capabilities. The American Psychiatric Association believes that the causes of sexual orientation (whether homosexual or heterosexual) are not known at this time and likely are multifactorial including biological and behavioral roots which may vary between different individuals and may even vary over time. The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective does sexual orientation need to be changed.

The American Psychiatric Association opposes discrimination against individuals with same-sex attraction whether it be in education, employment, military service, immigration and naturalization status, housing, income, government services, retirement benefits, ability to inherit property, rights of survivorship, spousal rights, family status, and access to health services. The American Psychiatric Association recognizes that such discriminations, as well as societal, religious, and family stigma, may adversely affect the mental health of individuals with same-sex attraction necessitating intervention by mental health professionals, for which, the American Psychiatric Association supports the provision of adequate mental health resources to provide that intervention. The American Psychiatric Association supports same-sex marriage as being advantageous to the mental health of same-sex couples and supports legal recognition of the right for same-sex couples to marry, adopt and co-parent.

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NOTE: This statement combines into one document APA policies previously expressed in twelve separate position statements adopted between 1973 and 2011.

Journal of Counseling Psychology

0022-0167/14/$12.00 DOI: 10.1037/cou0000011

Sexual Orientation Change Efforts Among Current or Former LDS Church Members

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This study examined sexual orientation change efforts (SOCE) by 1,612 individuals who are current or former members of the Church of Jesus Christ of Latter-day Saints (LDS). Data were obtained through a comprehensive online survey from both quantitative items and open-ended written responses. A minimum of 73% of men and 43% of women in this sample attempted sexual orientation change, usually through multiple methods and across many years (on average). Developmental factors associated with attempts at sexual orientation change included higher levels of early religious orthodoxy (for all) and less supportive families and communities (for men only). Among women, those who identified as lesbian and who reported higher Kinsey attraction scores were more likely to have sought change. Of the 9 different methods surveyed, private and religious change methods (compared with therapist-led or group-based efforts) were the most common, started earlier, exercised for longer periods, and reported to be the most damaging and least effective. When sexual orientation change was identified as a goal, reported effectiveness was lower for almost all of the methods. While some beneficial SOCE outcomes (such as acceptance of same-sex attractions and reduction in depression and anxiety) were reported, the overall results support the conclusion that sexual orientation is highly resistant to explicit attempts at change and that SOCE are overwhelmingly reported to be either ineffective or damaging by participants.

Keywords: LGBTQ, SOCE, psychotherapy, religion, Mormon

Many twenty-first-century, traditional world religions continue to denounce both same-sex attractions (SSA) and same-sex sexual activity as immoral, despite a growing social and professional consensus that views both as positive variants of human sexuality (Fontenot, 2013). As a result of this conflict, many traditional religious individuals who experience SSA engage in sexual orientation change efforts (SOCE) in an attempt to conform to religious teachings and social pressure (Beckstead, 2012; Jones & Yarhouse, 2011; Maccio, 2010). Despite a recent increase in public discourse regarding SSA, SOCE studies have been limited in quantity, scope, and methodology, and ultimately have failed to demonstrate either the effectiveness or benefit/harm of SOCE (American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation [APA], 2009). Even with the APA's (2009) extensive report and recommendations regarding SOCE, considerable questions remain regarding SOCE demographics, prevalence, and intervention types. Consequently, the purpose of this study was to document and evaluate the prevalence, variety, duration, demographics, effectiveness, benefits, and harm of SOCE within one particular faith tradition—the Church of Jesus Christ of Latter-day Saints (LDS, Mormon). We built upon the APA (2009) recommendations for improving SOCE research by using (a) more representative sampling methods, (b) more precise measures of sexual orientation and identity, (c) references to life histories and mental health concerns, and (d) increased inquiry regarding efficacy and safety.

Brief History of SOCE Research

Some early studies purported to demonstrate SOCE effectiveness (e.g., Birk, Huddleston, Miller, & Cohler, 1971; James, 1978; McConaghy, Armstrong, & Blaszczynski, 1981; Tanner, 1975). While not claiming the elimination of a same-sex orientation, some of these authors reported limited success in decreasing same-sex attraction and behavior, usually without a reciprocal increase in opposite-sex attraction or sexual behavior (cf. APA, 2009). However, this work suffered from major methodological flaws, including the absence of control groups, biased samples, very small treatment groups (< 15 subjects per treatment group), and internally inconsistent methods of data collection. In many recent

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We would like to thank Lee Beckstead for his valuable contributions in reviewing and revising this article, and Natasha Clark for her valued support as a research assistant.

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studies, researchers have attempted to gain a deeper understanding of SOCE through surveys, case studies, clinical observations, and descriptive reports with convenience-sampled populations from religiously affiliated organizations, where conflict and distress remain high despite increasing social acceptance of LGBTQ individuals (e.g., Nicolosi, Byrd, & Potts, 2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Silverstein, 2003; Spitzer, 2003). A recent review of this literature by an APA (2009) task force on SOCE efforts showed that individuals reported varied rationale for SOCE (also see Morrow & Beckstead, 2004). For example, telephone interviews with 200 self-selected individuals claiming success in sexual orientation change cited personal, emotional, religious, and/or marriage-related issues as reasons for seeking change (Spitzer, 2003).

The APA (2009) also reported widely varied SOCE strategies. A survey of 206 licensed mental health professionals who practice sexual orientation change therapy reported providing individual psychotherapy, psychiatry, group therapy, or a combination of individual and group therapies to address clients' reported desire to change sexual orientation (Nicolosi et al., 2000). Many individuals have attempted sexual orientation change with the help of nonprofessional individuals or organizations, which are often religiously or politically motivated (e.g., Evergreen International, Exodus International, Focus on the Family, Jews Offering New Alternatives for Healing; cf. Besen, 2012; Drescher, 2009). Such efforts range from one-on-one pastoral counseling to group conferences or retreats and can include such practices as confession, repentance, and self-control, as well as cognitive behavioral approaches (Ponticelli, 1999). Individuals may also engage in personal efforts to change sexual orientation. One recent qualitative study of sexual and religious identity conflict among late adolescents and young adults reported heightened efforts to be faithful, bargains with God, prayer, fasting, and increased church involvement as commonly self-reported individual efforts to "overcome" SSA (Dahl & Galliher, 2012). The outcomes of these private and religious efforts, however, remain almost completely unstudied.

Finally, qualitative reports have suggested that individuals who engaged in SOCE reported a variety of perceived benefits and harms (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Shidlo & Schroeder, 2002). Based on a comprehensive review of this work, the APA (2009) SOCE task force concluded that no study to date has demonstrated adequate scientific rigor to provide a clear picture of the prevalence or frequency of either beneficial or harmful outcomes. More recent studies claiming benefits and/or harm have done little to ameliorate this concern (e.g., Jones & Yarhouse, 2011; Karten & Wade, 2010).

Limitations of Previous Work

Experimental, quasi-experimental, correlational, and qualitative SOCE studies are limited in scope, methodological rigor, and comprehensiveness (APA, 2009). Previous studies have employed problematic sampling procedures, including biased subjects, small samples sizes, and a lack of female participants (e.g., McCrady, 1973; Mintz, 1966; Nicolosi et al., 2000; Spitzer, 2003). Virtually all studies to date have relied on convenience sampling, without any attempt to draw from nonbiased sources (Silverstein, 2003). Many researchers have drawn directly from those who were previously enrolled in therapeutic religious programs intended to change sexual orientation—participants who may be under cultural, religious, or personal pressure to make a positive self-report (e.g., Maccio, 2011; Nicolosi et al., 2000; Spitzer, 2003). Furthermore, previous studies have lacked consistency in the definitions of sexual orientation and sexual orientation change, making it difficult to compare across studies (Savin-Williams, 2006).

The frequency and rate of SOCE in SSA populations remain unknown (see Morrow & Beckstead, 2004, for a discussion). No known study to date has drawn from a representative sample of sufficient size to draw conclusions about the experience of those who have attempted SOCE. Furthermore, no known study to date has provided a comprehensive assessment of basic demographic information, psychosocial well-being, and religiosity, which would be required to understand the effectiveness, benefits, and/or harm caused by SOCE. Most studies have focused on the outcome of interventions led by licensed mental health professionals, while neglecting to directly assess the effectiveness or potential harm of self-help, religious, or nonlicensed efforts to change, understand, or accept sexual orientation. Finally, in spite of the APA's 2009 report on SOCE, considerable debate continues about the meaning of the report (cf. Hancock, Gock, & Haldeman, 2012; Rosik, Jones, & Byrd, 2012), focusing specifically around the lack of more conclusive SOCE-related outcome research.

The LDS Church and Same-Sex Attraction

The Church of Jesus Christ of Latter-day Saints is a U.S.-based Christian religious denomination claiming more than 14 million members worldwide (Church of Jesus Christ of Latter-day Saints, 2013). The LDS church claims the Holy Bible as scripture and, through traditional Biblical interpretations, has historically both condemned same-sex sexuality as sinful (cf. Kimball, 1969; O'Donovan, 1994) and explicitly encouraged its lesbian, gay, bisexual, transgender, and queer (LGBTQ) members to attempt sexual orientation change (Byrd, 1999; Faust, 1995; Packer, 2003; Pyrah, 2010). While the LDS church has somewhat softened its stance toward LGBTQ individuals in recent years (Church of Jesus Christ of Latter-day Saints Church, 2012), it continues to communicate to its LGBTQ members that sexual orientation change is possible through various means including prayer, personal righteousness, faith in Jesus Christ, psychotherapy, group therapy, and group retreats (e.g., Holland, 2007; Mansfield, 2011). In these respects, the LDS church's approach to SSA has closely paralleled other religious traditions including Orthodox Judaism, evangelical Christianity, and Roman Catholicism (Michaelson, 2012).

The Present Study

In the current study, we aimed to build on previous work to present a comprehensive analysis of the (a) prevalence of SOCE in a sample of SSA Mormons, (b) most commonly pursued SOCE methods, (c) demographic and developmental factors associated with increased likelihood to engage in SOCE, (d) effectiveness of SOCE, and (e) extent to which SOCE treatments have led to reported positive or iatrogenic effects. Our sample included sufficient numbers of men and women so that gender can be included as a factor in analyses, allowing for a more nuanced assessment of gendered SOCE processes. We sought to overcome many of the limitations of previous work by reporting from a large, interna-

tional, demographically diverse sample and by employing a large battery of qualitative and quantitative measures of demographic information, psychosocial well-being, mental health, sexuality, and religiosity. We also believed that the LDS church's long-standing opposition to same-sex sexuality, along with its continued support of SOCE in various forms, made the LDS SSA population ideal for a deeper study of these issues—one that could also inform our understanding of SOCE within other religious traditions.

Method

Research Team

Given the controversial nature of SOCE research, we feel it is important to engage transparently in our research dissemination. All authors self-identify as LGBTQ allies and also affirm the position of the American Psychological Association on the importance of affirming and supporting religious beliefs and practices (American Psychological Association, 2010). All authors have been active in supporting the LGBTQ community through campus, community, online, and national/international engagement. Four of the five authors were raised LDS, and two remain active LDS church participants. All authors work closely with LGBTQ Mormons in their professional and/or personal roles.

Participants

Participants were recruited for a web-based survey entitled "Exploration of Experiences of and Resources for Same-Sex-Attracted Latter-day Saints." Inclusion criteria were as follows: Participants had to (a) be 18 years of age or older, (b) have experienced SSA at some point in their life, (c) have been baptized a member of the LDS church, and (d) have completed at least a majority of survey items (i.e., the basic demographics, relevant sexual history, and psychosocial measures sections).

Data management. The LimeSurvey online survey software (Schmitz & LimeSurvey Project Team, 2011) marked 1,588 responses as "completed." Of these responses, 40 were excluded because the respondents failed to meeting participation criteria in the following ways: underage ($n = 8$), no indication of LDS membership ($n = 3$), no indication of ever experiencing same-sex attraction ($n = 17$), and leaving the majority of the survey blank (i.e., nothing beyond the demographic information, $n = 12$). Data for one participant was lost during downloading and data cleaning. Of the records designated as "not completed" by Limesurvey, 65 were included because they met the aforementioned inclusion criteria. This process left 1,612 respondents in the final data set.

Demographic information. Seventy-six percent of the sample reported to be biologically male and 24% reported to be biologically female. Regarding gender, the following responses were reported: "male" (74.5%), "female" (22.2%), "female to male" (0.3%), "male to female" (0.6%), "neither male nor female" (0.5%), and "both male and female" (1.9%). The mean sample age was 36.9 years ($SD = 12.58$). Approximately 94% reported residing in the United States, with 6% residing in one of 22 other countries (Canada being the next most common, at 2.8%). Of those residing in the United States, 44.7% reported residing in Utah, with the remainder residing across 47 other states and the District of Columbia. Regarding race/ethnicity, 91.1% identified as exclusively White, 4.5% as multiracial, 2.2% as Latino/a, and the remainder as either Asian, Black, Native American, Pacific Islander, or other.

Regarding educational status, 97.2% reported at least some college education, with 63.7% reporting to be college graduates. Sexual orientation self-labeling indicated that 75.5% identified as gay or lesbian, 14.5% as bisexual, and 4.9% as heterosexual, with the remaining 5.1% identifying as queer, pansexual, asexual, same-sex or same-gender attracted, or other. Relationship status was reported as 40.8% single, 22.7% unmarried but committed to a same-sex partner, 16.9% married or committed to heterosexual relationships, 12.6% in a marriage, civil union, or domestic partnership with a same-sex partner, and 5.8% divorced, separated, or widowed. Regarding LDS church affiliation, participants described themselves as follows: 28.8% as active (i.e., attending the LDS church at least once per month), 36.3% as inactive (i.e., attending the LDS church less than once per month), 25.2% as having resigned their LDS church membership, 6.7% as having been excommunicated from the LDS church, and 3.0% as having been disfellowshipped (i.e., placed on probationary status) from the LDS church.

Measures

The survey included items developed specifically for this study and a number of pre-existing measures assessing psychosocial health and sexual identity development. Major survey sections included demographics; sexual identity development history; measures of psychosocial functioning; an exploration of various methods to accept, cope with, or change sexual orientation; and religiosity. The larger study yielded data for a number of research questions; only measures relevant for the current study are described in the following sections. Specifically, measures for this study focus on methods related to SOCE and on a number of outcome variables related to sexual identity development (i.e., sexual identity distress) and positive psychosocial functioning (self-esteem and quality of life) that allowed us to assess SOCE correlates related to general well-being.

Sexual orientation identity, history, and religiosity. Participants answered several questions about their sexual orientation identity, history, sexual development milestones, disclosure experiences, and religiosity. Participants rated levels of family and community support for LGBTQ identities via a 6-point Likert-type scale from 0 (*closed or nonsupportive*) to 5 (*very open or supportive*). Participants rated their sexual behavior/experience, feelings of sexual attraction, and self-declared sexual identity on a 7-point Likert-type scale (modeled after the one-item Kinsey scale), ranging from 0 (*exclusively opposite sex*) to 6 (*exclusively same sex*), with the additional option of asexual also provided (Kinsey, Pomeroy, & Martin, 1948). Participants rated early and current religious orthodoxy on a 6-point Likert-type scale from 0 (*orthodox*—a traditional, conservative believer) to 5 (*unorthodox*—more liberal and questioning).

Attempts to cope with same-sex attraction. Participants were asked which of several activities they had engaged in to "understand, cope with, or change" their sexual orientation. Options included: (a) individual effort (e.g., introspection, private study, mental suppression, dating the opposite sex, viewing

opposite-sex pornography), (b) personal righteousness (e.g., fasting, prayer, scripture study), (c) psychotherapy, (d) psychiatry (medication for depression, anxiety, sleep problems, somatic complaints, and so forth), (e) group therapy, (f) group retreats, (g) support groups, (h) church counseling (e.g., LDS bishops), and (i) family therapy. These options were developed by the research team based on several sources, including direct clinical practice with LDS LGBTQ individuals, familiarity with LDS culture/practice and doctrine (Holland, 2007; Mansfield, 2011), and the psychology LGBTQ literature (APA, 2009). For each option, participants were asked to provide their ages when the effort began, the duration (in years), and a rating of the perceived effectiveness of each method (effort: 1 = *highly effective*, 2 = *moderately effective*, 3 = *not effective*, 4 = *moderately harmful*, 5 = *severely harmful*). These variables were later reversed scored to ease interpretation, such that 1 = *severely harmful*, 2 = *moderately harmful*, 3 = *not effective*, 4 = *moderately effective*, and 5 = *highly effective*. Participants were also provided an open-ended field to describe each effort in their own words.

Participants were asked to indicate their original goals for each effort, along with what was actually worked on (e.g., "desire to change same-sex attraction," "desire to accept same-sex attraction"). Participants were grouped into two categories: "SOCE reported" and "SOCE not reported." The participants in the SOCE-reported group consisted of those who checked the "desire to change same-sex attraction" box for at least one method or who responded affirmatively to one of the following two questions: (a) "My therapist(s) actively worked with me to reconsider my same-sex sexual behavior and thought patterns in order to alter or change my same-sex attraction," and/or (b) "My therapist(s) used aversive conditioning approaches (i.e., exposure to same-sex romantic or sexual material while simultaneously being subjected to some form of discomfort) in attempts to alter my attraction to members of my same-sex." All other participants were categorized as SOCE not reported.

Sexual Identity Distress Scale. The Sexual Identity Distress Scale (SID; Wright & Perry, 2006) is a seven-item measure assessing sexual-orientation-related identity distress. SID scores are obtained by reverse scoring the negative items and summing the scores. Higher scores indicate greater identity distress. According to its authors, the SID has demonstrated high internal consistency (α = .83), test–retest reliability, and strong criterion validity (Wright & Perry, 2006). Cronbach's alpha for the current sample was .91.

Rosenberg Self-Esteem Scale. The Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) is a 10-item measure of self-esteem developed for adolescents but used with samples across the developmental spectrum. The RSES uses a Likert-type scale (1–4), with higher scores indicating higher self-esteem (reverse scoring required). The RSES demonstrated test–retest reliability of .85 and has demonstrated good validity. Cronbach's alpha for the current sample was .92. Total scores are calculated as the average across items.

Quality of Life Scale (QOLS). The QOLS (Burckhardt, Woods, Schultz, & Ziebarth, 1989) is a 16-item instrument measuring six domains of quality of life: material and physical well-being; relationships with other people; social, community and civic activities; personal development and fulfillment; recreation; and independence. The average total score for "healthy populations" is about 90. Average scores for various less-healthy groups range between Israeli patients with posttraumatic stress disorder (61) and young adults with juvenile rheumatoid arthritis (92). Evaluations from various studies indicate that the QOLS has demonstrated internal consistency (αs = from .82 to .92) and high test–retest reliability (rs = from .78 to .84; Anderson, 1995; Wahl, Burckhardt, Wiklund, & Hanestad, 1998). Cronbach's alpha for the current sample was .90.

Procedures

Data collection and recruitment. This study was approved by the institutional review board at Utah State University. It was released as an online web survey from July 12 through September 29, 2011, and required both informed consent and confirmation that the respondents had only completed the survey once. Participants were given the option of providing their names, e-mail addresses, and phone numbers in order to receive study results and/or be contacted for future studies; approximately 70% of the respondents voluntarily provided this information.

Since past SOCE outcome studies have been criticized for either small or biased samples, considerable efforts were made to obtain a large and diverse sample, especially with regard to ideological positions toward SOCE. Journalists in the online and print media were contacted about this study as it was released. Because of feature coverage by the Associated Press, articles about this study appeared in over 100 online and print publications worldwide, including the Huffington Post, ReligionDispatches.org, *Salt Lake Tribune*, *San Francisco Chronicle*, *Houston Chronicle*, *Q-Salt Lake*, and KSL.com. In all, 21% of respondents indicated that they heard about the study directly through one of these sources or through direct Internet search.

Leaders of major LDS-affiliated LGBTQ support groups were also contacted and asked to advertise this study within their respective organizations (e.g., Affirmation, Cor Invictus, Disciples, Evergreen International, LDS Family Fellowship, Gay Mormon Fathers, North Star, and Understanding Same-Gender Attraction). In total, 21% of respondents indicated learning about the survey from one of these groups. Careful attention was paid to include all known groups and to ensure inclusion across the spectrum of varying LDS belief and orthodoxy (to avoid claims of selection/recruitment bias). Special emphasis was made to reach out directly and in multiple ways to conservative LDS LGBTQ support groups such as Evergreen and North Star. Only Evergreen International refused to advertise, although many among our respondents acknowledged either current or past Evergreen affiliation.

Nonreligiously affiliated LGBTQ support organizations (e.g., Equality Utah, Salt Lake City Pride Center) were also helpful in promoting awareness about this survey. In total, 5% of respondents indicated learning about the survey from one of these sources. Once the survey was promoted through the previously described venues, a sizable portion of survey respondents (47%) indicated learning about the survey through word of mouth, including e-mail, Facebook, blogs, online forums, or other web sites.

Missing data. An analysis of missing data for the variables hypothesized to be associated with SOCE (family and community support, early religious orthodoxy, Kinsey scores, and the SID, RSES, and QOLS measures) revealed that 373 of the 1,612 cases (23.1%) contained at least some missing data across these vari-

ables, with 693 of the 62,175 fields overall (1.1%) being left blank. To account for potential bias in our statistical analyses arising from these missing data, we conducted a multiple imputation analysis using SPSS Statistics Version 20 to test the robustness of our findings with respect to the group comparisons using these measures. In SPSS, the imputation method was set to "automatic," and the number of imputations was set to five. When comparing the pooled imputed results with the original analyses, we found significance levels remained unchanged (with one exception noted in a later discussion), and *t* values changed minimally. Consequently, all statistical analyses reported are based on the original, nonimputed data.

Results

SOCE Prevalence, Methods, and Effectiveness

SOCE prevalence. Overall, 73% of men ($n = 894$) and 43% of women ($n = 166$) reported engaging in at least one form of SOCE, $\chi^2(1, n = 1{,}610) = 120.81$, $\Phi = .274$, $p < .001$. Of those who did attempt sexual orientation change, participants averaged 2.62 ($SD = 1.60$) different SOCE methods (maximum of eight, and minimum of one). Men reported utilizing a higher number of different SOCE types ($M = 2.76$, $SD = 1.63$) than did women ($M = 1.93$, $SD = 1.22$), t (adjusted $df = 286$) $= -7.58$, $p < .001$, $d = 0.58$.

Most common SOCE methods. Personal righteousness was reported by both men and women as the most commonly used SOCE method with the longest average duration, followed by individual effort, church counseling, and psychotherapy. Some of the most common personal righteousness methods mentioned included increased prayer, fasting, scripture study, focus on improving relationship with Jesus Christ, and temple attendance. Some of the most common individual effort methods mentioned included cognitive efforts (e.g., introspection, personal study, journaling), avoidance (e.g., suppression, self-punishment), seeking advice from others, seeking to eliminate or reverse same-sex erotic feelings (e.g., date the opposite sex, view opposite-sex pornography, emphasize gender-conforming appearance or behavior), and exploration in the LGBTQ community. A full list of prevalence rates, average durations, and effectiveness ratings for the nine SOCE methods is provided in Table 1. As a group, religious and private efforts (personal righteousness, ecclesiastical counseling, and individual efforts) were by far the most commonly used change methods (use exceeding 85% by those attempting change), with

Table 1
Sexual Orientation Change Efforts (SOCE) Method Prevalence, Starting Age, Duration, and Effectiveness Ratings by Sex

SOCE method	Count/%		Age began SOCE method (yrs.)		Method duration (yrs.)		SOCE method effectiveness		Method effectiveness w/out SOCE			Effect size
	n	%	*M*	*SD*	*M*	*SD*	*M*	*SD*	*n*	*M*	*SD*	*d*
Personal righteousness												
Men	688	77	16.65	6.91	12.40	9.73	2.57	1.21	218	3.39	1.26	−0.66
Women	114	68.7	17.55	6.75	8.18	8.14	2.37	1.09	91	3.33	1.15	−0.86
Individual effort												
Men	520	58.2	17.45	6.78	11.24	9.25	2.88	1.18	376	3.93	0.98	−0.97
Women	62	37.3	19.28	6.33	8.07	6.88	2.97	1.12	176	4.09	0.93	−1.09
Church counseling												
Men	448	50.1	21.10	7.86	7.34	8.65	2.58	1.15	161	3.06	1.22	−0.41
Women	54	32.5	21.61	7.25	6.34	6.89	2.59	1.11	33	2.45	1.20	0.12
Psychotherapy												
Men	330	36.9	24.29	9.06	4.70	5.76	3.23	1.20	335	3.96	0.91	−0.68
Women	37	22.3	23.11	6.75	6.27	6.79	3.22	1.16	155	4.11	0.82	−0.89
Support Groups												
Men	138	15.4	28.34	10.16	3.61	4.65	3.24	1.06	202	4.22	0.81	−1.04
Women	7	4.2	26.29	6.55	4.86	6.50	3.71	0.95	50	4.14	0.97	−0.45
Group therapy												
Men	126	14.1	27.93	10.44	2.71	3.38	3.16	1.18	111	4.04	0.85	−0.85
Women	6	3.6	32.00	9.10	1.58	0.80	3.00	1.79	31	3.90	0.98	−0.62
Group Retreats												
Males	56	6.3	29.88	11.18	2.45	3.84	3.45	1.24	53	4.36	0.83	−0.86
Females	3	1.8	26.33	3.51	0.70	0.52	2.67	1.53	4	4.50	1.00	−1.42
Psychiatry												
Men	33	3.7	25.52	10.73	8.38	9.42	3.06	1.30	276	3.91	0.90	−0.76
Women	2	1.2	25.50	3.54	17.00	5.66	4.50	0.71	115	3.95	0.98	0.64
Family therapy												
Men	34	3.8	24.42	9.21	4.37	6.40	2.88	1.07	65	3.65	1.02	−0.74
Women	1	0.6	21.00	N/A	0.25	N/A	N/A	N/A	12	3.58	0.67	N/A

Note. The % column indicates, out of the total number (by sex) who attempted to change, the percentage who used each method. Method effectiveness: ratings: 1 = *severely harmful,* 2 = *moderately harmful,* 3 = *not effective,* 4 = *moderately effective*, 5 = *highly effective*. The "method effectiveness w/out SOCE" columns represent those who engaged in the respective method without attempting to change their sexual orientation. Regarding comparisons of method effectiveness with and without SOCE, *t* values ranged from −0.5 to 14.5; *p* values ranged from .59 to < .001. Effect size (*d*) reflects differences between SOCE-focused methods and non-SOCE-focused methods.

therapist-led (40.4%) and group-involved (20.8%) change efforts trailing significantly in prevalence. Finally, 31.1% of participants reported engaging exclusively in private forms of SOCE, not indicating any effort that involved external support.

Method effectiveness/harm ratings. As detailed in Table 1, when sexual orientation change was not reported as a method objective, participants rated all but one of the methods as at least moderately effective (scores between 3.0 and 4.0), with a few methods (support groups, group therapy, group retreats, psychotherapy, psychiatry, individual effort) approaching or exceeding highly effective status (4.0 and above). Conversely, when sexual orientation change was reported as a method objective, in almost all cases reported method effectiveness was significantly lower (i.e., more harmful), with medium to large Cohen's *d* effect sizes (see Table 1 for exact effect sizes). Several SOCE methods including personal righteousness, individual effort, church counseling, and family therapy received average effectiveness ratings below 3.0 (more harmful than helpful). As shown in Figure 1, the SOCE methods most frequently rated as either ineffective or harmful were individual effort, church counseling, personal righteousness, and family therapy. The SOCE methods most frequently rated as effective were support groups, group retreats, psychotherapy, psychiatry, and group therapy. Ironically, methods most frequently rated as "effective" tended to be used the least and for the shortest duration, while methods rated most often as "ineffective" or "harmful" tended to be used most frequently and for the longest duration.

Developmental Factors Linked to SOCE

As reported in Table 2, some developmental factors that appear to be associated with SOCE included less family and community support for LGBTQ identities (for men only) and high levels of religious orthodoxy prior to acknowledging SSA (for both men and women; highly significant with a Bonferroni corrected $\alpha = .008$). Those who reported growing up in a rural community were more likely to engage in SOCE (71.0%) than those who reported growing up in an urban (63.0%) or a suburban (64.4%) community, $\chi^2(2, n = 1{,}565) = 6.95, \Phi = .067, p = .03$.

Effectiveness of Change Efforts

Reported changes in sexual identity. With regard to self-reported sexual attraction and identity ratings, only one participant out of 1,019 (.1%) who engaged in SOCE reported both a heterosexual identity label and a Kinsey attraction score of zero (exclusively attracted to the opposite sex). As shown in Table 2, the mean Kinsey attraction, behavior, and identity scores of those reporting SOCE attempts were not statistically different from those who did not indicate an SOCE attempt. Multiple imputation procedures to account for missing data yielded only one significant change in outcome; the statistical difference in Kinsey attraction scores between women who reported engaging in SOCE versus those who did not was found to be significant for the pooled imputation results at $t = -2.0, p = .045$ (vs. $t = -1.75, p = .08$ in the original analysis)—indicating that women who reported

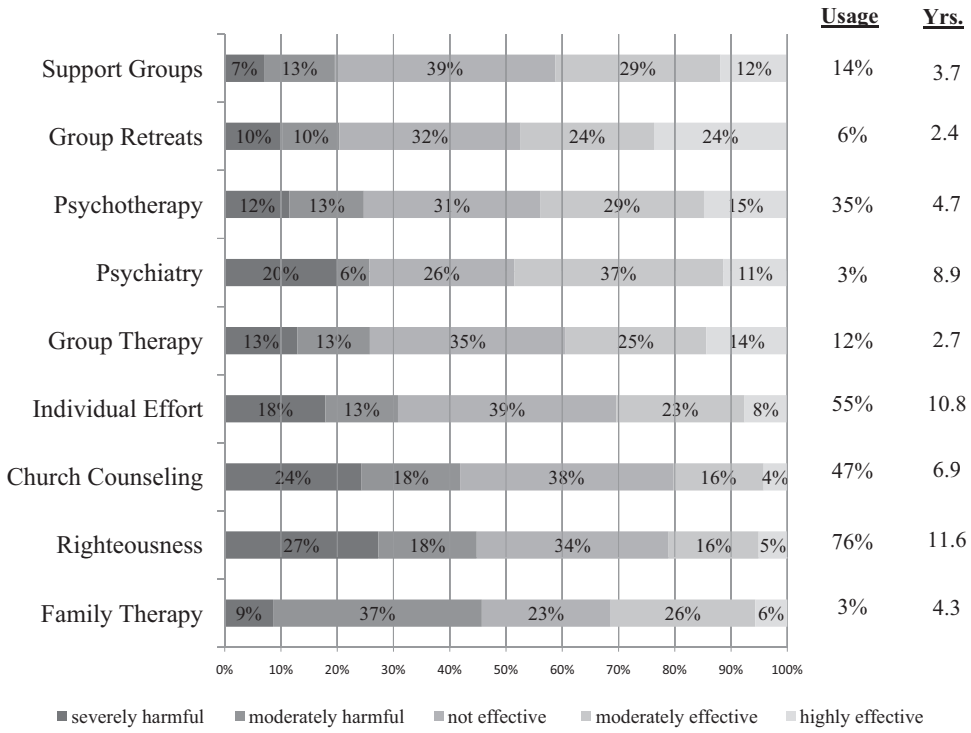

Figure 1. Graph displaying nine sexual orientation change effort (SOCE) methods, participant ratings of each method's effectiveness or harmfulness, percentages of participants who used each method, and the average number of years each method was employed.

Table 2
Developmental Factors, Kinsey Scores, and Psychosocial Health by Sexual Orientation Change Efforts (SOCE) Involvement

Variable	SOCE reported			SOCE not reported						
	n	*M*	*SD*	*n*	*M*	*SD*	*t*	*df*	*p*	*d*
Developmental factors by sex										
Men										
Family LGBTQ support	879	0.89	1.31	323	1.33	1.63	4.4	483[a]	<.001	0.30
Community LGBTQ support	881	0.96	1.32	325	1.33	1.6	3.73	495[a]	<.001	0.25
Religious orthodoxy before acknowledging SSA	874	1.22	1.61	293	2.46	1.94	9.89	435[a]	<.001	0.70
Women										
Family supportive growing up	165	0.84	1.23	218	1.00	1.42	1.11	381	.268	0.12
Community supportive growing up	164	1.09	1.41	221	1.23	1.43	0.95	383	.343	0.10
Religious orthodoxy before acknowledging SSA	165	1.51	1.73	213	2.77	1.95	6.66	369[a]	<.001	0.68
Kinsey scores by sex										
Men										
Feelings of sexual attraction	858	5.12	1.28	315	4.93	1.62	−1.88	466[a]	.061	0.13
Sexual behavior/experience	849	4.49	2.00	306	4.72	1.89	1.71	1153	.088	0.12
Sexual identity	845	4.82	1.98	308	4.87	1.98	0.37	1151	.709	0.03
Women										
Feelings of sexual attraction[b]	161	4.45	1.57	209	4.15	1.62	−1.75	368	.08	0.19
Sexual behavior/experience	157	3.76	2.09	206	3.32	2.15	−1.97	361	.05	0.21
Sexual identity	154	4.47	2.02	204	4.09	2.04	−1.76	356	.08	0.19
Psychosocial health by sex										
Men										
Quality of life	894	82.28	14.3	326	82.48	14.74	0.21	1218	0.834	0.01
Sexual identity distress	894	10.16	7.61	325	7.01	6.23	−7.35	697[a]	<.001	0.45
Self-esteem	894	3.15	0.64	328	3.29	0.61	3.38	1220	0.001	0.22
Women										
Quality of life	166	81.9	13.2	222	83.01	13.81	0.79	386	0.428	0.08
Sexual identity distress	166	9.49	7	221	7.04	5.91	−3.65	320[a]	<.001	0.38
Self-esteem	166	3.13	0.64	222	3.21	0.66	1.22	386	0.220	0.12

Note. LGBTQ = lesbian, gay, bisexual, transgender, and queer; SSA = same-sex-attracted.
[a] Corrected degrees of freedom. [b] Multiple imputation analyses conducted to account for missing data found a statistical difference in Kinsey attraction scores (from 0, *exclusively opposite sex* to 6, *exclusively same sex*) between women who reported engaging in SOCE vs. those who did not at $t = -2.0$, $p = .045$. Also, those who self-rated as "asexual" (i.e., rating of 7) were not included in the Kinsey analyses so as to not alter the commonly accepted interpretations of Kinsey scores.

engaging in SOCE reported significantly higher Kinsey attraction scores than women who did not report engaging in SOCE.

With regard to sexual identity (Table 3), more than 95% of both men and women who engaged in some form of SOCE identified as nonheterosexual. Men who did and did not report engaging in SOCE did not differ from each other statistically in terms of current sexual identity labels. Women who reported engaging in SOCE were significantly more likely to self-identify as lesbian than were those who did not engage in SOCE. SOCE participants currently self-identifying as heterosexual reported a mean Kinsey attraction score of 3.02 ($SD = 1.42$), which is commonly associated with bisexuality.

Reports and explanations of successful change. Participants were provided the option to describe their various change efforts in their own words. A review of these narratives yielded 32 participants (3.1% of those attempting change) who indicated some type of SSA change. Of these 32 participants, 15 described a decrease in the frequency and/or intensity of their SSA, without mentioning a cessation of SSA. As an example, one participant wrote, "While the same-sex attraction is still stronger than heterosexual attractions, the frequency and intensity and duration of those attractions have lessened." Twelve of the 32 narratives did not mention attraction at all but instead mentioned either a decrease or a cessation of same-sex sexual behavior, as exemplified in this narrative: "I feel like I have been forgiven for my sexual behavior. I think of a same-sex relationship every day, but I don't act on it." Five of the narratives reported an increase in other-sex attractions, two of the narratives reported a reduction in anxiety about the SSA, and five indicated some sort of change that was unclear or vague (e.g., "I have felt so much strength from God to control myself"). Finally, it should be noted that some participants fit into more than one of these categories and that none of the 32 participants indicated an elimination of SSA.

Perceived Benefits and Harm Associated With SOCE

Perceived benefits. Open-ended narratives were also reviewed to provide further insight into the perceived effectiveness summarized in Table 1 and Figure 1. Based on this review, methods rated as effective did not appear to generally reflect any changes in sexual orientation but instead referred to several other benefits, such as ultimate acceptance of sexual orientation, a decrease in depressive or anxiety symptoms, and improved family relationships. One such example from the personal righteousness narratives illustrates this point: "Instead of meeting original goals, the direction of the goals changed as I learned to accept and love myself as I am—as God created me." Another participant who attempted SOCE through a psychotherapist added,

> My therapist wanted to treat what he called the "underlying factors" that could lead to my same-gender attraction. He wanted to help with

Table 3
Current Sexual Identity Status Differences by Sex and by Sexual Orientation Change Efforts (SOCE) Involvement

Variable	SOCE reported		SOCE not reported	
	n	%	*n*	%
Men[a]				
Gay	717	80.30	267	81.40
Bisexual	96	10.80	37	11.30
Heterosexual	41	4.60	14	4.30
Same-sex- or gender-attracted	20	2.20	0	0.00
Other	19	2.10	10	3.00
Subtotal	893		328	
Women[b]				
Lesbian	109	65.70	109	49.10
Bisexual	32	19.30	69	31.10
Heterosexual	7	4.20	17	7.70
Other	18	10.80	27	12.20
Subtotal	166		222	

[a] Male differences are not statistically significant. [b] Female differences are significant at $\chi^2(3, n = 388) = 11.68, \phi = .174, p < .01$.

> depression and other things he was qualified to do. It did help, and the therapy helped with coping but did not really treat the underlying cause. In fact, because of talking, I resolved to accept it.

Perceived harm. As shown in Table 2, comparisons of psychosocial health were made between those who reported SOCE attempts and those who did not. Overall, no significant difference (Bonferroni corrected $\alpha = .008$) in quality of life for men or women was found between the two groups, though participants who reported engaging in SOCE had significantly higher sexual identity distress (men and women) and lower self-esteem (men only).

A similar review of the open-ended narratives also provides additional insight into the harmful ratings assigned to the various methods. Reportedly damaging aspects of SOCE included decreased self-esteem, increased self-shame, increased depression and anxiety, the wasting of time and money, increased distance from God and the church, worsening of family relationships, and increased suicidality. One example from the personal righteousness narratives illustrates: "Therapy, meeting with the bishop, meeting with stake president, praying, fasting, etc. Nothing worked. I felt that God wasn't listening, or wanted me to suffer. I felt horrible until I changed my outlook."

A narrative from the ecclesiastical counseling narratives further illustrates:

> After first being told to go on a mission to be cleansed of these feelings (resulting in relationships that intensified my same-sex activity) and then being told to get married and have children, and the feelings would go away—I buried myself emotionally and spiritually.

Another participant wrote, "My Bishop gave me a blessing promising me that I could change. Every day I didn't change, I thought I was more a failure, more of a monster."

Discussion

The purpose of this study was to better understand the demographics, prevalence, variety, perceived effectiveness, and potential benefit/harm of sexual orientation change efforts (SOCE) among current and former LDS church members through the recruitment of a large, demographically diverse sample. Our findings suggest that the majority of participants engaged in SOCE via multiple avenues for over a decade (on average). Almost no evidence of SSA being eliminated via SOCE could be found in this sample, and minimal evidence supported successful change in sexual orientation. SOCE participants in this sample showed no differences in quality of life from those who had not engaged in SOCE, but psychosocial function was lower in those who had engaged in SOCE. Participants reported a number of positive and negative outcomes of change efforts; perceived effectiveness ratings varied substantially, depending on the particular method and the reported goals.

The Nature of SOCE

LDS SOCE demographics. Highly religious LDS men from unsupportive families and communities were most likely to report having engaged in SOCE, while LDS women were somewhat less likely to do so. These findings confirm previous research that SOCE efforts most often arise from religious and/or social pressure (APA, 2009). The finding that same-sex-attracted LDS women were less likely to engage in SOCE seems noteworthy, though the exact reasons for this are still unknown. Same-sex-attracted LDS women may feel less pressure to engage in SOCE because of the greater sexual fluidity afforded women within the constraints of socialized gender roles (Diamond, 2009); U.S. male culture tends to stigmatize male homosexuality more than female homosexuality or bisexuality (Herek, 2002). The role of LDS cultural factors, such as the church's historical emphasis on missionary service for 19-year-old men with an accompanying requirement for sexual worthiness also warrants investigation.

Prevalence of SOCE types. Although the psychology literature to date has focused almost exclusively on therapist-led SOCE (APA, 2009), religious and private forms of SOCE were far more prevalent in our sample. To illustrate, while more than 85% of SOCE participants reported engaging in either religious or individual SOCE efforts, only 44% reported some form of therapist or group-led SOCE. Personal righteousness (e.g., prayer, fasting, scripture study, improved relationship with Jesus Christ) as a form of SOCE was reported by our sample to be (a) by far the most prevalent method used to change sexual orientation (more than twice as common as psychotherapy), (b) initiated at the earliest average ages (16–18 years), and (c) utilized for the longest average duration of any SOCE method (more than12 years on average for men and eight years for women). Church counseling (e.g., with LDS bishops) and individual efforts also yielded significantly higher prevalence and duration rates than most other SOCE forms. These findings generally held true for both men and women, though LDS women reported engaging in church counseling, individual-based, and group-based SOCE at considerably lower rates than LDS men.

We recognize, from the age of onset and duration of effort data, that many of our participants were still actively engaged in efforts to understand, cope with, or change their orientation and that the efforts have been carried out across varying developmental stages and historical contexts (i.e., our participants ranged in age from 18–70 years). Thus, while our "snapshot in time" yields important information about the experiences of SOCE at a broad and com-

prehensive level, we look forward to more detailed assessment of the ways that SOCE are developmentally, historically, and culturally contextualized.

Effectiveness/Harm Rates of SOCE

The evidence from this study—based on multiple criteria including Kinsey-style self-ratings of attraction, sexual identity self-labels, method effectiveness ratings, and open-ended responses—suggests that for this sample, sexual orientation was minimally amenable to explicit change attempts. The literature supports these findings (APA, 2009; Beckstead, 2012). It is notable that zero open-ended narratives could be found indicating complete elimination of SSA via SOCE and that only a small percentage of our sample (3.2%) indicated even slight changes in sexual orientation. When survey participants did report experiencing sexual orientation change, the most common descriptions involved slight to moderate decreases in SSA, slight to moderate increases in other-sex attraction, and/or a reduction in same-sex sexual activity. As Beckstead (2012) noted, it is unclear if the decreased frequency and intensity of SSA are due to a reduction of sexual attraction or due to avoidance behaviors and/or a decrease of intense feelings, such as anxiety and shame, associated with SSA. Instead of fundamental changes in core sexual orientation, accommodation and acceptance of one's SSA were the most common themes. While these findings seem consistent with the larger literature and broad professional consensus, we are compelled by the fact that we have observed these patterns within a population that may be among the most likely to embrace and support change efforts.

We note that all nine methods utilized by participants to understand, cope with, or change SSA (with the exception of church counseling for women) were rated as effective (on average) when sexual orientation change was not listed as a goal. However, when sexual orientation change was listed as a goal, a majority of methods decreased in reported effectiveness—often with large effect sizes. Personal righteousness was rated as the most "severely harmful" of all SOCE methods for our sample, particularly noteworthy given that it was also rated as the most commonly used SOCE method (76%) for the longest average duration (12 years for men, eight years for women). Church counseling and individual efforts were rated as the next most "severely damaging" SOCE methods for our sample, with church counseling being rated as only slightly less damaging than personal righteousness. Significantly higher sexual identity distress (in men and women) and lower self-esteem (in men) were associated with prior participation in SOCE, although we do not know distress and self-esteem levels prior to SOCE participation, and thus cannot determine causality.

Additional study is warranted to provide better understanding of why religious methods were simultaneously used so frequently, yet rated as most ineffective/harmful. We theorize that the high prevalence of religious SOCE is due in large part to the LDS church's continued emphasis on prayer, fasting, scripture study, improved relationship with Jesus Christ, and consulting with church leaders (e.g., bishops) as primary ways to deal with SSA (Holland, 2007; Kimball, 1969; Mansfield, 2011). We also speculate that highly religious individuals in our sample were more likely keep their SSA private due to social stigma and thus more likely to favor/trust religious or private efforts over secular ones. In addition, most licensed therapists are likely to refuse to engage in SOCE—all of which could explain the increased prevalence of private and religious forms of SOCE in this sample.

Based on our review of the open-ended responses, we also speculate that when religious SOCE did not result in the desired outcomes, it may have damaged many of our participants' faith and confidence in God, prayer, the church, and its leaders. Consequently, failed SOCE often led to high levels of self-shame, feelings of unworthiness, rejection and abandonment by God, and self-loathing, as well as "spiritual struggles" for many of our respondents (Bradshaw, Dehlin, Galliher, Crowell, & Bradshaw, 2013; Dahl & Galliher, 2012; McConnell, Pargament, Ellison, & Flannelly, 2006). This pattern of findings does emphasize the importance of ensuring that LDS church leaders are adequately trained to deal with LGBTQ issues and addressing culturally inherited leadership beliefs and practices that might be contributing to these deleterious effects.

Effectiveness. In terms of effectiveness, group-related and therapist-led methods tended to be rated by participants as the most effective and least damaging. While therapist-led SOCE were reportedly used less frequently than individual and religious methods, they were surprisingly common, given the general denunciation of SOCE by all of the major mental health professional organizations. A review of the open-ended descriptions for the various methods indicated that for the majority of participants, a rating of "effective" for therapist-led methods did not signify successful change in sexual orientation but instead indicated other outcomes such as acceptance of sexual orientation (even when change was an original goal), a decrease in anxiety or depression, and/or improvements in family relationships. These findings appear to align with APA (2009) conclusions that the secondary benefits found in SOCE can be found in other approaches that do not attempt to change sexual orientation.

Implications for Counseling

Our results present several possible implications for therapist-led and church-affiliated LGBTQ counseling. First and most obvious, these findings lend additional support to the strong positions already taken by most mental health professional organizations that therapist-led SOCE treatments are not likely to be successful—although our data indicate that such interventions are ongoing among the LDS population. Consequently, LDS-affiliated therapists, support group/retreat leaders, and ecclesiastical leaders who encourage or facilitate SOCE (whether therapist-led, religious, or group-based) might consider amending their approaches in light of these findings. LDS therapists, group, and ecclesiastical leaders might also consider providing evidence-based psychoeducation about reported SOCE effectiveness rates to their LDS LGBTQ clients, family, and fellow congregants.

Given the high prevalence and reported ineffectiveness/harm rates of religious SOCE in particular, counselors and church leaders who work with LDS LGBTQ populations might consider explicitly assessing for and exploring histories of religious SOCE with LDS LGBTQ clients. In addition, group-based methods such as support groups, group therapy, and group retreats (that do not encourage SOCE) should potentially be recommended with increased frequency, along with psychiatry (where depression/anxiety is particularly notable)—based on their reported relative effectiveness compared with other methods. Finally, as noted in Bradshaw et al. (2013), LDS-affiliated

therapists should duly consider the finding that acceptance-based forms of therapy are likely to be rated as significantly more effective and less harmful by LDS LGBTQ individuals than are change-based forms of therapy. Ultimately, these suggestions align well with the therapeutic recommendations offered by the APA (2009).

Summary and Limitations

The major findings from this study are as follows: (a) the majority of same-sex-attracted current and former LDS church members reported engaging in SOCE for mean durations as long as 10–15 years, (b) religious and private SOCE were reported to be by far the most commonly used SOCE methods for the longest average durations and were rated as the most ineffective/damaging of all SOCE methods, and (c) most LDS SOCE participants reported little to no sexual orientation change as a result of these efforts and instead reported considerable harm.

Our reliance on convenience sampling limits our ability to generalize our findings to the entire population of same-sex-attracted current and former LDS church members. For example, our sample almost certainly overrepresents men, Whites, and U. S. residents, along with those who are more highly educated and affluent, and who either read the newspaper or are Internet-connected. Because of the highly distressing, stigmatizing, and/or controversial nature of being both same-sex-attracted and LDS, it is probable that a significant number of both highly devout and highly disaffected current and former LDS church members did not become aware of or feel comfortable participating in this study.

The extent to which these findings generalize to the broader, non-LDS LGBTQ religious population is uncertain. While we acknowledge that the LDS church is distinctive in many ways from other more LGBTQ-affirming religious institutions (e.g., Reform and Reconstructionist Judaism, Unitarian Universalism, and Episcopalian), there is some evidence to suggest that the societal and theological pressures experienced by LDS LGBTQ individuals are similar to those in other conservative religious traditions (e.g., Orthodox Judaism, Catholicism, evangelical Christianity, and Islam; APA, 2009; Michaelson, 2012). Though no known research has been conducted to compare SOCE experiences across religious denominations, the APA's report on SOCE seems to acknowledge several commonalities in LGBTQ/SOCE experiences between LDS church members and those of other religious traditions, which include (a) church-based doctrinal and administrative opposition toward same-sex sexuality, (b) no known role for same-sex relationships within church structure, (c) the possible threat of expulsion for assuming an open LGBTQ identity, (d) considerable church-related familial and social pressure to eschew an LGBTQ identity and to engage in SOCE, (e) ostracizing of LGBTQ individuals at church/temple/synagogue/mosque, and (f) considerable psychological distress for religious LGBTQ individuals due to identity conflict. In addition, several studies with samples drawn from Christian reparative therapy conferences (e.g., Exodus International) have explicitly noted the participation of LDS church members, suggesting possible similarities between LDS LGBTQ experiences and those of other religious traditions (Beckstead & Morrow, 2004; Morrow & Beckstead, 2004). We are hopeful that additional research will be conducted to further assess similarities and differences in SOCE experiences between religious traditions.

Because our survey relied heavily on both self-report and participant memory, responses are likely to be impacted accordingly. Also, while we are able to provide some correlational data relative to findings such as factors associated with the likelihood of SOCE participation, average Kinsey scores of those who did and did not engage in SOCE, and a relationship between SOCE and well-being, it is not possible to determine causality and directionality of these relationships without the use of methodologies such as randomized clinical trials or longitudinal studies. For example, regarding our finding that women who have engaged in SOCE were more likely to identify as lesbian than those who did not engage in SOCE, it is difficult to ascertain from our data whether women who are more likely to identify as lesbian are also more likely to engage in SOCE, or if the process of engaging in SOCE might make one's nonheterosexual identity more salient. Finally, it should be noted that participants were not always consistent and coherent in their reports. For example, a number of participants described SOCE in their open-ended responses, even though they had not indicated "change" as either a goal or as something worked on during the methods earlier in the survey. In order to retain a more parsimonious set of classification criteria, we elected to use more conservative inclusion criteria and did not include participants in the SOCE-reported group based on open-ended responses only. Consequently, it is likely that SOCE rates are underreported in our sample.

In summary, this study contributes to the literature by demonstrating significantly greater prevalence of religious and private SOCE versus therapist-led SOCE, no meaningful evidence of reported SOCE effectiveness, and considerable evidence of SOCE-related harm—all via a large, diverse sample. Despite our results being limited to one particular faith tradition, the observed motivations, correlates, and outcomes of SOCE are likely relevant in other conservative religious contexts, and we look forward to additional research on this topic.

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Received August 21, 2013
Revision received October 25, 2013
Accepted November 5, 2013 ■

JOURNAL OF SEX & MARITAL THERAPY, *41*(4), 391–412, 2015

ISSN: 0092-623X print / 1521-0715 online
DOI: 10.1080/0092623X.2014.915907

Routledge
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Sexual Orientation Change Efforts Through Psychotherapy for LGBQ Individuals Affiliated With the Church of Jesus Christ of Latter-day Saints

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This study reports the results of a comprehensive online survey of 1,612 current or former members of the Church of Jesus Christ of Latter-day Saints, many of whom engaged in psychotherapy to cope with (i.e., understand, accept, or change) their same-sex attractions. Data obtained from written and quantitative responses showed that therapy was initiated over a very wide age range and continued for many years. However, counseling was largely ineffective; less than 4% reported any modification of core same-sex erotic attraction. Moreover, 42% reported that their change-oriented therapy was not at all effective, and 37% found it to be moderately to severely harmful. In contrast, affirming psychotherapeutic strategies were often found to be beneficial in reducing depression, increasing self-esteem, and improving family and other relationships. Results suggest that the very low likelihood of a modification of sexual orientation and the ambiguous nature of any such change should be important considerations for highly religious sexual minority individuals considering reorientation therapy.

Affirmative psychotherapy is the predominant modern stance in serving lesbian, gay, bisexual, or questioning (LGBQ) individuals (Chung, Szymanski, & Markle, 2012), an approach that is

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based on increasing awareness in psychology and the broader culture of the substantial strains such individuals experience in their heteronormative contexts. Psychotherapy that focuses on fostering self-acceptance and increasing a sense of empowerment for such persons (e.g., Butler, 2010; Ross, Doctor, Dimito, Kuehl, & Armstrong, 2007) is strongly supported by most major mental health organizations (e.g., American Medical Association, 2011; American Psychological Association, 2011; National Association of Social Workers, 2012).

An older, more controversial approach promoted sexual orientation change. A recent review outlines the challenge of verifying change and provides recommendations for offering beneficial therapeutic assistance when it is not forthcoming (Beckstead, 2012). Evidence suggests that programs aimed at altering orientation lack evidence for effectiveness and may produce harmful outcomes (e.g., American Psychological Association, 2012; Just the Facts Coalition, 2008). The Pan American Health Organization (2012) recently issued a position statement (*"Cures" For An Illness That Does Not Exist*) concluding that "purported therapies aimed at changing sexual orientation lack medical justification and are ethically unacceptable" (p. 1). Nevertheless, reparative therapy advocates continue to promote its use (National Association for Research and Therapy of Homosexuality, 2009, 2012a), tout claims of success (Dahle et al., 2009; Nicolosi, Byrd, & Potts, 2000), and repudiate evidence to the contrary (Jones, Rosik, Williams, & Byrd, 2010).

In a recent defense of reorientation therapy, Jones (2012) identified what he described as "false beliefs" (p. 3) espoused by opponents of reparative or conversion therapies: the assumption that same-sex relationships are equivalent to heterosexual marriages in all important characteristics, that being gay is just as healthy as being heterosexual, and that sexual orientation is not a willful choice. Proponents of reorientation therapy thus strongly discount biological evidence (LeVay, 2011), and espouse instead social or psychological explanations, those assumed to have the greatest probability of being reversed through therapeutic efforts (Abbott & Byrd, 2009; Dahle et al., 2009; Jones, 2012; National Association for Research and Therapy of Homosexuality, 2010).

The line of reasoning that emerges begins with the assertion that LGBQ individuals are intrinsically inferior to those who are heterosexual—an opposite-sex orientation being the only natural and therefore legitimate human state. This view is often defended on religious grounds and is based (for Christians) on a Biblical literalism that condemns same-sex behavior as a reflection of disapproval by deity. Tozer and Hayes (2004) showed that many individuals who hold religion as a central organizing principle in their lives, and who are orthodox in their denominations, have a propensity to seek conversion therapy, which is driven by accompanying internalized homonegativity. In this perspective, a transition to heterosexuality is not only warranted but also required.

Proponents of reorientation therapy must deal with the professional consensus that evidence for meaningful change is lacking (American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). They counter by asserting bias on the part of members of the American Psychological Association Task Force, contending that the standards used in reviewing the published literature were artificially elevated and unreasonable, and arguing that if studies claiming change are flawed by methodological inadequacies, then so are those studies claiming that therapy may have harmful consequences (Jones et al., 2010). Spitzer (2003), whose work was widely cited as evidence that change is a valid outcome for

some individuals, has repudiated his claims and now takes the position that the self-reports of his participants were not sufficient indications of actual alterations in sexual orientation (Arana, 2012; Spitzer, 2012).

Psychotherapy Among LGBQ Latter-day Saints

Members of the Church of Jesus Christ of Latter-day Saints (LDS; also known as Mormon) who identify as having a same-sex attraction constitute an ideal population in which to investigate orientation change efforts. In this denomination, theology, a hierarchical institutional organization, and uniform instruction come together to strongly promote a traditional heterosexual expectation. The nuclear family headed by married male and female parents, both now and in the life to come, is at the heart of Mormon doctrine (First Presidency and Council of the Twelve Apostles of the Church of Jesus Christ of Latter-day Saints, 1995). Messages from ecclesiastical leaders are disseminated worldwide from semiannual General Conferences, in official church magazines, and from letters read in every local congregation. Instructional materials produced in hundreds of languages for auxiliary organizations (for children, youth, and adult men and women) reinforce the heterosexual family-centered emphasis in the religion. As a result, LDS members who are LGBQ face intense internal conflict related to integration of their religious and sexual identities (Dahl & Galliher, 2012; Dehlin, Galliher, Bradshaw, & Crowell, in press), which is manifested for many in concentrated, dedicated efforts to change their sexual orientation.

Even though the LDS Church does not formally endorse any particular therapeutic approach for unwanted same-sex attraction (Oaks & Wickman, 2006), it has supported Evergreen International, a lay organization committed to helping people "who want to diminish same-sex attractions and overcome homosexual behavior" (Evergreen International, 2010). This was also the earlier perspective taken by LDS Family Services, the support agency to which many LDS ecclesiastical leaders refer LGBQ church members (LDS Social Services, 1995). LDS Family Services no longer promotes sexual orientation change, but it focuses more broadly on therapeutic outcomes that permit individuals to maintain full fellowship in the church. Most nonofficial publications on the subject of homosexuality directed at LDS readers promote sexual reorientation. For example, Abbott and Byrd (2009, p. 3) advocated using the term *sexual preference* instead of *sexual orientation*, given that the former "implies both choice and change," and argued that "change is achievable, though difficult" (p. 76). Robinson (2009) claimed that orientation change can occur through recognition that homosexuality is a cultural construct. Byrd (2009) reiterated his contention that "some people can and do change" (p. 168; but see the criticisms by Bradshaw, 2011). Scharman (2009) echoed the view that "real and lasting change" (p. 210) has been achieved through counseling and spiritual means. These observations suggest that LDS members who are LGBQ would provide an ideal population in which to assess the outcomes of therapist-assisted sexual orientation change efforts.

Research Questions

This study reports selected results from an online survey of a large sample of LGBQ individuals who are or had previously been affiliated with the LDS Church. We have reported elsewhere the

sexual orientation change efforts of this population broadly across nine different interventions (including private, religious, professional, and informal group approaches; Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2014) but focus in detail here on data relevant to psychotherapy. We addressed the following research questions:

1. What were the psychotherapy experiences of same-sex oriented LDS individuals? How frequent was change identified as an explicit goal? What were the positive and negative outcomes?
2. As a result of psychotherapeutic change efforts, how many reported an alteration in their core erotic attractions, and what was the qualitative nature of such change?

METHOD

Participants

The complete sample consisted of 1,612 persons who took part in an online survey and met eligibility requirements: (a) 18 years of age, (b) a history of same-sex attraction, (c) a history of LDS Church membership, and (d) completion of a majority of survey items. Twenty-three persons who failed to meet criteria were excluded. The mean age of participants was 36.9 years (SD = 12.58) and 24.1% (n = 387) were women. The majority identified as White (n = 1,544; 95.3%) and resided in the United States (n = 1,515; 94%). The U.S. geographical distribution of the sample (all but two states were represented) closely mapped the LDS population in the country (MormonHaven, n.d.). Most participants were highly educated (n = 1,002, 62.2%, reported college degrees or graduate/professional degrees). The percentage of participants in various income brackets was almost identical to the estimate for the LDS population in the United States (Pew Forum, 2011).

The subsample for the present study comprised 898 individuals (56%; 197 women and 700 men) who indicated they had engaged in psychotherapy ("talk therapy with a licensed mental health professional in an attempt to understand, cope with, or change your sexual orientation"). Of the 898 psychotherapy participants, 30 did not respond to a group of secondary questions (e.g., age of onset of therapy, duration, goals of therapy), resulting in a reduced data set of 672 men and 194 women for primary analyses related to psychotherapy processes and outcomes. Because some items were not relevant for some participants (e.g., a participant had not had a particular psychotherapy experience being assessed), there is slight variation in sample size across analyses. Additional demographic characteristics for the psychotherapy subsample of n = 898 are reported in Table 1. Women were more likely than men were to report sexual orientation labels that denoted sexual fluidity (e.g., bisexual, queer, pansexual), whereas men were more likely to report sexual orientation labels that denoted strong attraction to only one sex (e.g., gay, heterosexual), $\chi^2(7, n = 878) = 64.09$, $p < .001$. Women also reported both greater variability and more mid-scale scores (indicating bisexuality) than did men for all Kinsey scales: sexual behavior–women $M = 3.70$, $SD = 1.97$; men $M = 4.63$, $SD = 1.92$, $t(855) = -5.85$, $p < .001$; sexual attraction–women $M = 4.33$, $SD = 1.63$; men $M = 5.18$, $SD = 1.25$, $t(866) = -7.72$, $p < .001$; sexual identity–women $M = 4.42$, $SD = 1.98$; men $M = 4.93$, $SD = 1.88$, $t(845) = -3.17$, $p = .002$.

TABLE 1
Demographic Characteristics of the Psychotherapy Subsample at the Time of Survey Completion

	Men (n = *700*)		*Women* (n = *197*)	
	n	%	n	%
Age (years), *M* (*SD*)	38.8 (12.66)		35.0 (11.06)	
Sexual orientation				
Lesbian	—	—	116	58.9
Gay	576	82.2	6	3.0
Bisexual	68	9.7	46	23.4
Heterosexual	28	4.0	10	5.1
Attracted to same sex	15	2.1	0	0
Other	13	1.9	19	9.6
Kinsey Scale scores, *M* (*SD*)				
Behavior	4.63 (1.93)		3.75 (2.00)	
Attraction	5.18 (1.25)		4.36 (1.65)	
Identity	4.93 (1.88)		4.48 (2.00)	
Marital status				
Single	285	41.5	69	37.7
Heterosexual marriage	114	16.6	20	10.9
Legal same-sex relationship	96	14.0	23	12.6
Committed, nonlegal same-sex relationship	148	21.5	58	31.7
Divorced or separated	44	6.4	13	7.1
LDS Church status				
Active	206	30.8	36	18.8
Inactive	209	31.3	78	40.8
Disfellowshipped	31	4.6	5	2.6
Excommunicated	60	9.0	9	4.7
Resigned	162	24.2	63	33.0

LDS = Latter-day Saints.

Measures

The survey, titled "Exploration of Experiences of and Resources for Same-Sex Attracted Latter-day Saints," contained 149 items and took participants, on average, more than 1 hr to complete. The larger survey contained a number of measures of psychosocial well-being and sexual identity–related minority stress that were not used in this study. Items developed by the authors, on the basis of a careful review of the literature, assessed sexual identity developmental history; ratings of sexual attraction, behavior, and identity using the Kinsey 7-point rating scales (i.e., 0 = exclusively heterosexual to 6 = exclusively homosexual); past and present attitudes about LGBQ issues; childhood history (including abuse); perceptions about the causes of homosexuality; personal religious experiences relative to sexual orientation; and experience in and affiliation with the LDS Church. An analysis of missing data for the descriptive and psychosocial variables used in this study (sex, age, relationship status, LDS Church status, sexual orientation, Kinsey scores) revealed that 242 of the 899 cases (26.9%) contained at least some missing data, and 344 of the 10,788 fields overall (3.2%) were left blank. Because previous attempts to

use multiple imputation analyses with these data generally failed to change statistical significance levels (Dehlin, Galliher, Crowell, Hyde, & Bradshaw, 2014), the original data have been maintained.

Most relevant for the present study, participants were asked to complete an in-depth exploration of nine intervention efforts that they might have undertaken in an effort to "understand, cope with, or change same-sex attraction." These interventions appeared in the following order in the survey: individual effort, personal righteousness, psychotherapy, psychiatry, group therapy, retreats, support groups, ecclesiastical counseling, and family therapy. The present study focused narrowly on the experiences of participants who reported that they had engaged in psychotherapy (psychotherapy, third in that list). In addition to their involvement in psychotherapy, these persons reported being engaged in an average of 3.7 additional interventions.

Individuals who reported prior involvement in psychotherapy were directed to a second set of items assessing the following details:

1. Age when first beginning therapy
2. Duration of therapy
3. An indication of goals and relevant issues going into therapy (i.e., depression, anxiety, eating, family, friends, partner, work/school, anger, or substance abuse, and change/acceptance/understanding of their sexuality)
4. An indication of what issues were actually addressed during the course of therapy (same options as in the previous item)
5. A rating of the overall effectiveness of psychotherapy using a scale from 1 (*highly effective*) to 5 (*severely harmful*)
6. The opportunity to provide a written narrative in which to describe their experiences in detail; the length and content of these responses seem to reflect that the survey was a needed cathartic release for many

Procedures

This study was approved by the Institutional Review Board of Utah State University. Following guidelines established for internet research (Michalak & Szabo, 1998), it was administered online and was advertised on a number of websites and globally through an *Associated Press* news story and several online news sources (e.g., KSL.com, an LDS Church-owned site). Among the participants, 21% indicated that they heard about the study through online and print publications (e.g., *Huffington Post*, *Salt Lake Tribune*). An equal number reported that they learned of the study through LDS-affiliated LGBT support organizations (e.g., http://affirmation.org, http://northstarlds.org, http://mormonstories.org, http://LDS Family Fellowship.org) covering a full spectrum of religious and political views. Only one group, Evergreen International, refused invitations to advertise it. Another 5% learned of the study from nonreligious LGBT support organizations (e.g., Equality Utah, Salt Lake City Pride Center), and 47% indicated they had been recruited through word of mouth, e-mail, or social media. The survey was available online from July 12 through September 29, 2011. Participants provided informed consent and certified that they had taken the survey only once.

For the method of coding written responses see the Online Appendix and Note, Figure 1.

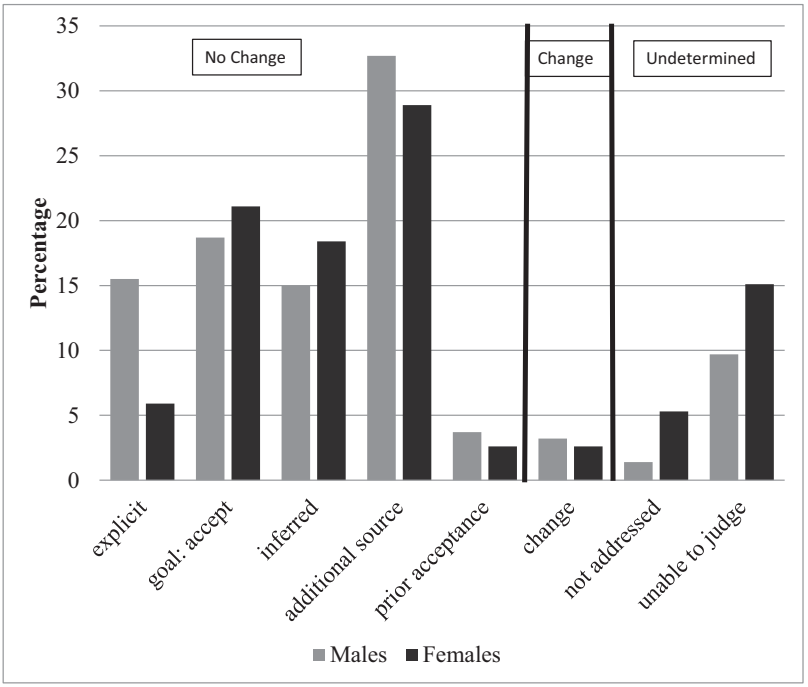

FIGURE 1 Assessment of sexual orientation change efforts. Narratives relating 720 participants' sexual orientation change efforts in psychotherapy were cataloged using the following criteria: (a) an explicit statement that no change occurred; (b) a statement that a goal of orientation change had been replaced by a goal of acceptance; (c) that a change had not occurred was inferred using additional information besides the narrative; (d) a statement that change had not occurred was retrieved from narratives directed at other interventions; (e) a statement to the effect that the decision that orientation could or should not be changed was made before therapy began; (f) an indication of some modification of sexual orientation; (g) sexual orientation was not addressed by the client or therapist during counseling; and (h) information inadequate to make a decision relative to orientation change. Participants included 566 men, 152 women, and 2 did not declare their sex.

RESULTS

Sexual Identity Development and Religious Histories

Table 2 reports the average age at which men and women reported a number of sexual development milestones. All sex differences were statistically significant (t values range from 2.12 to 7.52; p values ranged from .034 to .001), with men achieving all developmental milestones at a younger age than women. Milestone values were dependent on the current age of the participants; in the cohort of those ages 18–29 years, the average times for telling someone else and self-labeling, in both sexes, were 3–5 years earlier than for the entire group.

Of participants, 84.9% were born in an LDS family, while the remainder converted to the LDS faith. All participants had been baptized in the LDS Church, but only 26.9% reported

TABLE 2
Milestones in Sexual Identity Development

	Age			
	Men		Women	
When did you first . . .	M	SD	M	SD
Sense a difference (feeling, attitudes, behavior) between yourself and others of your same age and biological sex that you now attribute to your same-sex sexual orientation?	8.81	3.9	11.00	6.2
Realize you were attracted romantically or sexually to persons of the same sex?	12.74	4.6	15.91	7.0
Have a same-sex romantic or sexual experience?	18.15	8.4	21.61	8.1
Tell someone of your same-sex attraction?	21.96	8.0	23.38	8.8
Label yourself gay, lesbian, bisexual, transgendered, questioning, queer, or another label you have chosen for yourself?	22.28	8.6	24.51	8.8

currently attending church regularly. Of the participants, 45% resided in Utah at the time of survey completion, relevant because of the possible effect on orthodoxy and religious practice of residency in the state where the Church is headquartered.

Description of Psychotherapy Experiences

The age of onset of psychotherapy for men and women was similar, with a mean age for men of 25.13 years ($SD = 9.09$ years) and for women of 24.34 years ($SD = 9.42$ years), $t(855) = -1.06$, $p = .291$. The average time spent in psychotherapy was 4.3 years ($SD = 5.6$ years) for men and 5.0 years ($SD = 6.1$ years) for women, $t(849) = 1.59$, $p = .112$. Length of psychotherapy ranged from less than 1 month to 30 years, and about 15% of clients engaged in therapy for 10 to 30 years. The distributions for both onset and duration of therapy were skewed dramatically to older ages and longer periods, indicating the persistence of homosexuality as an unresolved issue for many.

Participants replied to the broad question, "How effective was this experience in meeting your goals?" on a 5-point scale ranging from 1 (*very effective*) to 5 (*severely harmful*). On average, participants described psychotherapy as "moderately effective," although men reported higher (less effective) scores ($M = 2.40$, $SD = 1.12$) than women ($M = 2.06$, $SD = 0.96$), $t(852) = -3.81$, $p < .001$. About 38% ($n = 266$) of men and 27% ($n = 52$) of women reported therapy as not effective or harmful (scores of 3–5). Table 3 more explicitly presents an evaluation of therapy derived from four different approaches or models. Average ratings indicated that participants viewed counselors who worked with individuals to clarify their own values and goals without setting an agenda for either change or acceptance as most helpful. Both men and women rated efforts aimed at orientation change with average scores greater than 3.0. Said differently, 80% of those whose therapy focused on sexual orientation change efforts evaluated the experience as either "not at all effective" (42%), "moderately harmful" (21%), or "severely harmful" (16%). *Aversion therapy*, the practice of using aversive conditioning techniques to explicitly alter same-sex attraction, was viewed as the most harmful. Tests of gender differences were nonsignificant, with the exception of evaluations of aversion therapy. Men described aversive conditioning techniques as

TABLE 3
Broad Descriptions of Goals and Outcomes of Psychotherapy Related to Sexual Orientation

	Men			*Women*					
Therapist emphasis	M	SD	n	M	SD	n	t	df	p
Change	3.25	1.08	393	3.40	1.10	63	< 1.0	454	*ns*
Acceptance	1.74	0.92	317	1.63	0.84	103	−1.05	418	*ns*
Client choice	1.58	0.87	416	1.56	0.97	131	< 1.0	545	*ns*
Aversion	4.33	0.87	73	3.60	1.31	20	−2.96	91	.004

	Men				*Women*				
	A priori goals		*Actually worked on*		*A priori goals*		*Actually worked on*		
Psychotherapy goals	n	%	n	%	n	%	n	%	%
Change	387	57.6	330	49.1	47	24.2	37	19.1	19.1
Accept	178	26.5	219	32.6	50	25.8	64	33.0	33.0
Understand	247	36.8	255	37.9	65	33.5	71	36.6	36.6

Note. The survey question was "If you have participated in formal therapy or counseling, please identify any of the following models of counseling (philosophy, ideology, conceptual framework) that was adopted by your counselor/s. Using the scale below, please rate your experience of the model's overall effectiveness in meeting your therapy goals: 0 = not applicable, 1 = highly effective, 2 = moderately effective, 3 = not at all effective, 4 = moderately harmful, and 5 = severely harmful."

significantly more harmful than did women. Sample sizes for these analyses varied, since only participants who had engaged in therapy from a particular approach would respond to that specific item.

Exploratory correlational analyses were conducted to assess for relations among therapy effectiveness ratings and sexual development histories, religious variables, and therapy characteristics. Correlations between the overall therapy effectiveness rating score and sexual development milestones described in Table 2 were all very small (all rs $< .10$) or between therapy effectiveness and therapy duration ($r = .06$) or age of onset ($r = .15$). However, current LDS affiliation was linked to ratings of therapy effectiveness. Those no longer affiliated (i.e., excommunicated, disfellowshipped, or resigned) were more likely than those who were still affiliated (i.e., active or inactive in the church) to describe their therapy experiences as "severely harmful," $\chi^2(N = 841, df = 8) = 24.93, p = .02$.

Participants selected from a list, all their a priori goals for therapy, as well as the concerns that were actually addressed. The choices included depression, anxiety, family/peer/work issues, anger problems, eating problems, and others. The most common issues worked on in therapy that were not explicitly related to sexual orientation were depression (56.2%), anxiety (43.0%), and family concerns (35.2%). Change, accept, or explore/understand were the three goals relative to sexual orientation. Table 3 shows the number of men and women who selected change, acceptance, and understanding as goals for therapy. Men (58%) were more likely than women (24%) were to report that they entered therapy with the goal of sexual orientation change, $\chi^2(n = 860, df = 1) = 67.88, p < .001, \Phi = .281$, and to report that they actually worked on sexual orientation change in therapy, $\chi^2(n = 868, df = 1) = 56.82, p < .001, \Phi = .256$; men $–n = 330$; women $–n = 37$. However, 80% of the total psychotherapy cohort ($n = 898$) explicitly marked

change as a goal in one of the interventions in which they engaged, or indicated efforts to change or pressure from their social contexts to change (e.g., from parents or ecclesiastical leaders) in their written narratives. There were no significant sex differences in the proportions of men and women who endorsed acceptance and understanding as goals for therapy. Also, the proportion of participants who endorsed change as an a priori goal for therapy was larger for both men and women than the proportion who endorsed change as an actual therapy activity, while the reverse pattern was true for the goal of acceptance. This suggests that a number of participants experienced a goal shift—from change to acceptance—as they engaged in therapy.

Analysis of Open-Ended Descriptions Related to Change

Effectiveness ratings were subject to important limitations. Many individuals had engaged in multiple therapy efforts (at different times and with different therapists), which were not differentiated in their overall rating scores. Our reading of the open-ended responses that accompanied the majority of the ratings demonstrated that the focus of what was or was not effective varied widely among individuals. Some applied the score narrowly to sexual orientation change efforts. Others took a broader view of the beneficial or harmful aspects of therapy overall.

A direct assessment of whether core sexual attraction was amenable to change through psychotherapy was made by examining the content of the written descriptions provided by 83% of the psychotherapy subsample ($n = 720$). Each narrative was categorized using the coding scheme described in the Online Appendix. The results are reported in Figure 1. Overall, 13.2% ($n = 95$) of the written reports were indeterminate, either because sexual orientation had not been addressed during therapy or the reports did not contain sufficient information. The distribution patterns for men and women were similar. However, a chi-square analysis revealed that although men and women were equally unlikely to report sexual orientation change, men were more likely than chance to explicitly state that no change occurred, and women were more likely to provide indirect or indeterminate responses, $\chi^2(7, n = 718) = 21.68$, $p = .003$, $V = .174$. Overall, these data showed that, across both sexes, where a determination could be made ($n = 624$), 96.5% indicated that a change in core sexual attraction had not occurred.

Details about the 22 individuals (4 women, 18 men) who indicated some modification of their same-sex attraction are provided in Table 4. For both men and women, average age was in the early 40s but exhibited a wide range. Therapy was initiated on average in the early 20s and lasted (on average) for many years. Mean duration of therapy was skewed upward for both men and women by three participants whose therapy lasted 20 or more years. Most men ($n = 14$) were married, but all women were divorced or single. Therapy was given a positive average rating by both men and women. Only four self-identified as being gay, and the remainder reported being bisexual, having a same-sex attraction, or being heterosexual. The average Kinsey Scale score for attraction for these 22 participants was at the midpoint of the scale. A two-point lower average score for identity (vs. attraction) appears to reveal their reluctance regarding a homosexual designation. Note that the standard used for accepting a "change" outcome was not stringent. In addition, the comments included results other than an actual alteration of core same-sex attraction. Examples included ". . . seeing that these temptations and thoughts do not define who I am" and ". . . a decrease in my negative reaction to my same gender attraction."

TABLE 4
Individuals Reporting Orientation Change

Sex	*Age (years)*	*Sexual orientation*	*Kinsey scale*			*Marital status*	*Age when therapy started (years)*	*Duration of therapy (years)*	*Therapy effectiveness rating*	*Narrative description*	*Current association with LDS Church*
			Behavior	*Attraction*	*Identity*						
Female	54	Heterosexual	5	5	0	Single	19	35	1	"While the same-sex attraction is still stronger than heterosexual attractions, the frequency and intensity and duration of those attractions have lessened."	Active
Female	51	Bisexual	4	3	—	Divorced	46	1	2	"I feel like I have been forgiven for my sexual behavior. I think of a same sex relationship every day but I don't act on it."	Active
Female	31	Bisexual	1	2	2	Divorced	30	.2	2	"The chemistry [SSA] diminished and eventually, I was able to feel attraction to men again."	Inactive

(Continued on next page)

TABLE 4
Individuals Reporting Orientation Change (Continued)

Sex	*Age (years)*	*Sexual orientation*	*Kinsey scale*			*Marital status*	*Age when therapy started (years)*	*Duration of therapy (years)*	*Therapy effectiveness rating*	*Narrative description*	*Current association with LDS Church*
			Behavior	*Attraction*	*Identity*						
Female	24	Heterosexual	0	3	0	Single	22	2	2	"My attraction to women hasn't completely gone away. But it has improved significantly. Often times I will go days without thinking about another woman or the fact that I am attracted to women."	Active
Male	66	Bisexual	4	4	0	Married	58	9	1	"SSA attractions have definitely lessened but are not difficult to understand and not act upon them."	Active
Male	58	Bisexual	2	4	1	Married	18	6	2	"Same sex attraction diminished, but never went away."	Active

Male	57	Heterosexual	1	3	1	Married	20	20	1	"I have experienced a significant reduction in SSA feelings."	Active
Male	57	Bisexual	2	5	0	Married	35	3	2	"Improved relationship with wife and decreased homosexual activity."	A*
Male	53	Gay	6	4	5	Single	26	4	2	"I started experiencing a change and control when I attended support groups."	Excommunicated
Male	52	Gay	2	5	1	Married	16	20	1	"God has brought about a mighty change in my heart that I have no desire to be sexual with men."	Active
Male	48	Gay	0	4	0	Married	29	1.5	2	"Same-gender attraction diminished substantially, and heterosexual attraction to fiancée/spouse increased significantly."	Active

(Continued on next page)

TABLE 4
Individuals Reporting Orientation Change (Continued)

Sex	*Age (years)*	*Sexual orientation*	*Kinsey scale*			*Marital status*	*Age when therapy started (years)*	*Duration of therapy (years)*	*Therapy effectiveness rating*	*Narrative description*	*Current association with LDS Church*
			Behavior	*Attraction*	*Identity*						
Male	42	Heterosexual	0	1	0	Married	24	2	1	"My SSA is dramatically diminished and different from when I started. "	A*
Male	41	Bisexual	2	1	0	Married	40	3	1	"Helps me to change some of how I feel and the attractions that I have."	Active
Male	37	Bisexual	2	3	—	Married	33	4	2	"[being true to my wife] has driven me to abstain from sexual relationships outside of marriage."	Excommunicated
Male	36	Heterosexual	3	—	—	Married	26	.5	2	"Everything changed in very impossible ways."	A*
Male	36	Heterosexual	0	1	0	Married	17	5	2	"Relapses [cross-dressing] generally occurred less and less frequently until it was finally in the past."	Active

Male	31	Heterosexual	1	2	0	Married	22	6	1	"Support me in my journey of change."	Active
Male	29	Heterosexual	0	4	0	Married	26	3	1	"I am more attracted to my wife and have healthier relationships with heterosexual men."	A*
Male	29	Heterosexual	0	4	0	Single	26	2	1	"I have felt so much strength from God to control myself."	Active
Male	28	Heterosexual	0	1	0	Married	18	2	1	"Helpful in overcoming my behaviors and seeing that these temptations and thoughts do not define who I am."	Active
Male	25	Same-sex attraction	7	4	4	Single	20	5	1	"Received much help . . . working on my same-sex attraction."	A*
Male	22	Gay	7	4	5	Single	22	.6	1	"It has largely helped me to increase my attraction toward women and decrease my negative reaction to my same gender attraction."	Active
Male average	42.5		2.1	3.2	1.1		26.4	5.4	1.4		
Female average	40.0		2.5	3.3	0.7		29.2	10.0	1.8		

Note. SSA = same-sex attraction. LDS = Latter-day Saints Church. On the Kinsey scale, 7 = asexual. On the therapy effectiveness rating, 1 = highly effective and 2 = moderately effective. For current association with LDS Church, A* = active but with policy or doctrinal reservations or reduced private devotion.

Broad Beneficial and Detrimental Psychotherapy Outcomes

Our review of the written comments regarding psychotherapeutic experience documented a broad range of potential benefits and harms ancillary to the goal of orientation change (Table 5). It is our view that many participants welcomed this opportunity to share important, sometimes intimate, details of their experience. Comments relative to psychotherapy averaged 68 words, but a number were 300–500 words in length. Many found therapy to be a helpful, even life-saving experience. To be able to talk to a knowledgeable professional about a very private concern was salutary. Others reported improved relationships with family or other close associates. Of particular interest was the large number of individuals who reported decreased levels of depression and anxiety and improved feelings of self-worth. These outcomes were often linked to having accepted same-sex attraction and explored ways to cope with or accommodate that reality. Consider the words of one individual: "I learned to love myself because I was gay. To celebrate my uniqueness and what I could bring to the world that was special."

For some participants, psychotherapy was clearly unrewarding. As a general rule, however, experiences of harm or iatrogenic distress were much less frequent than reports of benefit. The most salient examples of detrimental effects of therapy were the loss of self-esteem and loss of religious faith associated with the failure to realize the promise extended by some therapists that sexual orientation would change as a function of dedicated efforts in therapy.

> We explored some things in regards to my family dynamics that were helpful. The idea, however, was that those relationships contributed to my homosexuality and I dealt with some unhelpful anger along the way, too. It was also another unsuccessful attempt to be straight. Failure to change while getting professional help was hard to accept.

> I attempted to "change" myself through righteous behaviors. However, when the attractions remained despite how often I prayed, read scriptures, served others, attended church meetings, or was obedient, I became more depressed and felt more distant from God and others.

DISCUSSION

Descriptions of Psychotherapy Related to Sexual Orientation

The data reported here suggest that reversing a nonheterosexual orientation is likely a major emphasis for those who experience same-sex attraction in the LDS community. Of our psychotherapy cohort, 80% described sexual orientation change efforts as a central feature of their therapy-related experiences, extending over a heterogeneous spectrum of private and professional approaches. The average length of time spent in psychotherapy for those in our sample was 4.3 years for men and 5.0 years for women. It is clear that many individuals were dealing with significant issues associated with homosexuality that were not yielding to quick solutions. Consistent with our findings, other reports have shown that LGBQ individuals tend to engage in psychotherapy for longer periods than do their heterosexual counterparts (Liddle, 1997).

Entering therapy in the early- to mid-20s is consistent with classical developmental theory (Erikson, 1968). In general, this is a stage characterized by the need to develop a sense of self and personal identity and also by religious questioning, exacerbated almost certainly for LGBQ persons in a highly religious context. Many of our participants reported coming out to others

TABLE 5
Benefits and Detriments of Psychotherapeutic Sexual Orientation Change Efforts, as Reported in Open-Ended Narratives

	Benefit			*Detriment*		
Nature of outcome	*Description*	n	%	*Description*	n	%
Overall outcome	Positive, helpful	109	9.8	Not effective	102	9.1
Significance	Life-saving	12	1.1	Felt worse after	29	2.6
Disclosure	Helped to talk to someone	44	3.9			
Orientation change	Some change occurred	22	2.0	Same-sex attraction did not change	119	10.7
	Understand, accept	125	11.2			
	Cope with lack of change	25	2.2			
	Helped in coming out	17	1.5			
Self-worth	Improved self-esteem	98	8.8	Damaged, harmful	33	3.0
Same-sex attraction and faith	Helped to reconcile	13	1.2	Lost faith	10	0.9
Family	Improved relationships	60	5.4	Worsened relationships	7	0.6
Depression and anxiety	Decreased	80	7.2	Increased	7	0.6
Suicide	Avoid	15	1.3	Attempted	4	0.4
Child abuse issues	Helped	22	2.0			
Masculinity	Helped with body image	10	0.9			
Masturbation and porn	Reduced	14	1.2			
Sexual intimacy	Helped	6	0.5			
Therapy efficacy				Waste of time and money	20	1.8
Therapy cost				Lacked money for therapy	7	0.6
Therapist	Compassionate	3	0.3	Inept, untrustworthy	23	2.1
				Reluctant to target same-sex attraction	13	1.2
				Sexually attracted to[1]	4	0.4
Client commitment				Resisted help, pretended	32	2.9
Miscellaneous[2]		16	1.4			
Narrative				Insufficient information to code	25	2.2

Note. The written narratives of 720 psychotherapeutic clients (80% of those whom provided some details about the counseling they received) were coded as to the perceived outcomes of the experience. Many participants reported efforts with multiple therapists. Responses for the several outcomes (an average of 1.6 for each report) across all therapists are reported. The average effectiveness rating of these persons was 2.41. An additional 134 persons (15%) reported an average effectiveness rating of 2.17 but did not include a comment.

[1]Or became highly dependent upon.

[2]Included fewer than five reports each of issues such as cross-dressing, sex addiction, eating disorders, general heath, and specific mental illnesses.

and self-identifying as nonheterosexual at this time (Table 2). Some gay LDS men divulge their orientation to ecclesiastical leaders in preparation for 2-year missionary service at 19 years of age (women at 21 years of age). During the mission, it may become clear that personal efforts at righteousness do not reduce same-sex attractions. Subsequently, the pressure to marry appears to increase the conflict between their sexuality and following an orthodox LDS trajectory. Thus, many of this age turn to professionals for help. In addition, a significant number of our participants first sought assistance at ages 30 through 60 years, undoubtedly reflecting the need to resolve the culturally induced personal and religious tensions that persist for some people.

However, even the most optimistic expressions of "change" did not claim that same-sex attractions and opposite-sex aversions had been eliminated and replaced by strictly positive heterosexual romantic feelings. Rather, because "the feelings don't go away," some sort of accommodation had been achieved. This included redefining one's sexual self (Worthington, 2004) to reduce the effect of minority stress and internalized homonegativity (Tozer & Hayes, 2004). In contrast, 42% reported that their change oriented therapy was "not at all effective" and an additional 37% described it as moderately or severely harmful. Our results appear at the same time as the demise of the religious ministry of Exodus International (*Huffington Post*, 2013), and the admission of its president, Alan Chambers, that ". . . 99.9% [of our clients] have not experienced a change in their orientation . . ." (Throckmorton, 2012).

Our data showed that an accommodation is most probable for those who identify as bisexual. Most who claimed change indicated some capacity for arousal by both sexes, including self-identified heterosexuals who positioned themselves in the middle of the Kinsey Scale. These were the people most likely to attempt heterosexual marriage; the 14 married men in this group had been married an average of 17 years. One recent study reported that married men are more likely than single men to feel that change has occurred during sexual orientation change efforts (Karten & Wade, 2010).

Limitations

We consider here factors relative to the validity and generalizability of our results. Over 1,600 participants represented a very significant response (compare other sexual orientation change efforts reports: Exodus International programs [Jones & Yarhouse, 2011; $n = 98$] or Spitzer [2003; $n = 200$]). Further, the demographic characteristics of the participants suggest that our survey successfully reached the broad target population. The age of onset of same-sex attraction was similar to that reported by others (McClintock & Herdt, 1996). Active, inactive, and former LDS Church members were represented about equally. Women, however, were underrepresented. Data from national prevalence analyses suggests that bisexuals may also have been under-represented. The ratio of gay to bisexual men in the U.S. is estimated at 1.5:1, while there are two to three times more bisexual women than are lesbians (Gates, 2011). In our sample, the male ratio was about 4.5:1, and the female ratio was close to 1:1. Bisexual LDS members may not have enrolled because they maintain church activity and remain closeted (Dehlin, Galliher, Crowell, & Bradshaw, 2014). Our data show that inactive and disaffected LDS were 1.7 times more likely than the committed and active to be "out." If closeted individuals were underrepresented, their numbers were still sufficient to accurately represent their sexual orientation change efforts experience. It is also unlikely that larger numbers of persons in this particular circumstance would be disposed to

volunteer information of the sort reported here, if approached through any other methodological design.

Last, we acknowledge that the psychotherapy experiences and presenting problems of our participants varied immensely, a fact that we see as both a strength and a limitation. From our data, we know that therapeutic efforts aimed at both change and acceptance were common (Table 3), as were issues related to depression and anxiety. Lacking information about the diagnostic profiles of our participants or the specific therapeutic techniques employed, our ability to discuss what works and what does not work in therapy with LGBQ LDS is limited. However, given the variability inherent in these "real world" therapy experiences, we view the powerful and consistent findings with regard to sexual orientation change efforts outcomes as even more compelling.

Summary and Implications for Counseling and LDS Communities

To our knowledge, this study is the largest published analysis of therapist-assisted sexual orientation change efforts among LDS members. An early small-scale effort (4 male and 2 female participants), was aimed at identifying for therapists the issues facing LDS persons with unwanted homosexual attraction (LDS Family Services; Byrd & Chamberlain, 1993). In another qualitative study, seven men reported that reinterpreting their homosexual desires enabled them to maintain a successful heterosexual marriage (Robinson, 1998). An analysis of 136 persons (85% male) in the LDS LGBQ support group Affirmation suggested the unlikelihood of change (Schow, 1994). Horlacher and Horstmanshoff (2011) described the relation between sexuality and religiosity (including sexual orientation change efforts) on the basis of an online longitudinal study (2003–2007) conducted with 174 highly religious Mormons. From extensive interviews with 50 LDS participants in reparative therapy (with equal representation of positive and negative perceptions about counseling), Beckstead and Morrow (2004) concluded that sexual identity, not orientation, was a changeable variable, and they identified helpful outcomes that were possible through the therapeutic process.

The weight of empirical data to the contrary, belief in the possibility of sexual orientation change persists—in society at large, in the LDS community (Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2014), and among the small group of academics (Rosik, Jones, & Byrd, 2012) who continue to challenge professional consensus (Hancock, Gock, & Haldeman, 2012). While sharing some relevant doctrines with other religious groups (e.g., free will, repentance, grace), LDS members may be strongly resistant to the immutability of same-sex attraction because of faith in divinely mediated miracles, the sentiment that authority may be more trustworthy than science, and a tradition that any challenge can be overcome with sufficient effort (e.g., Eldridge, 1994). Or, "... successful treatment of unwanted homosexuality is more likely to result from a combination of secular counseling and religious faith" (Abbott & Byrd, 2009, pp. 76–77). That therapeutic approach views homosexuality as a social perturbation of normal development, and thus reversible. This model requires a parallel disregard for the large body of evidence demonstrating a biological origin for sexual orientation (Byrd, 2009; National Association for Research and Therapy of Homosexuality, 2010, 2012b).

For adherents to this line of reasoning, the claim of a successful sexual orientation change by a few individuals is sufficient to generalize to the population at large. The clear evidence, however, is that dutiful long-term psychotherapeutic efforts to change are not successful and carry significant

potential for serious harm, and that LGBQ LDS members find greater satisfaction in counseling approaches that result in acceptance or accommodation.

SUPPLEMENTAL MATERIAL

Supplemental material (Online Appendix) for this article is available at www.tandfonline.com/usmt.

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Journal of Homosexuality, 61:1242–1268, 2014

ISSN: 0091-8369 print/1540-3602 online
DOI: 10.1080/00918369.2014.926763

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Experiences of Ex-Ex-Gay Individuals in Sexual Reorientation Therapy: Reasons for Seeking Treatment, Perceived Helpfulness and Harmfulness of Treatment, and Post-Treatment Identification

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Therapy meant to change someone's sexual orientation, or reorientation therapy, is still in practice despite statements from the major mental health organizations of its potential for harm. This qualitative study used an inductive content analysis strategy (Patton, 2002) to examine the experiences of thirty-eight individuals (31 males and seven females) who have been through a total of 113 episodes of reorientation therapy and currently identify as gay or lesbian. Religious beliefs were frequently cited as the reason for seeking reorientation therapy. Frequently endorsed themes of helpful components of reorientation therapy included connecting with others and feeling accepted. Harmful aspects of reorientation therapy included experiences of shame and negative impacts on mental health. Common reasons for identifying as LGB after the therapy included self-acceptance and coming to believe that sexual orientation change was not possible. The findings of this study were consistent with recommendations by the American Psychological

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Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009), which concluded that helpful aspects of reorientation therapy could be achieved through affirmative treatment methods while avoiding potential harms that may be associated with reorientation therapy. Limitations of the findings, including a small, self-selected sample, are discussed.

KEYWORDS LGBT, conversion therapy, reorientation therapy, reparative therapy

Sexual reorientation therapy, or interventions that are designed to change someone's sexual orientation from lesbian, gay, or bisexual (LGB) to heterosexual, continues despite the fact that homosexuality and bisexuality are not mental disorders. These interventions are controversial and possibly iatrogenic, as most major mental health organizations have noted while criticizing the practice.

Position papers on reorientation therapy from major mental health organizations clearly object to its use. For example, the American Psychiatric Association has identified reorientation therapy as potentially harmful and lacking in scientific evidence (American Psychiatric Association, 2006). The National Association of Social Workers (2007) said in a position statement that reorientation therapy "cannot and will not change sexual orientation" (paragraph 5) and encouraged social workers to refrain from reorientation practices. The Ethics Committee of the American Counseling Association has said that reorientation therapy does not meet professional standards and that counselors must not offer reorientation therapy in their occupations as counselors but may offer it only in other roles, such as pastoral counseling (Whitman, Glosoff, Kocet, & Tarvydas, 2006). The American Psychological Association conducted a review of the relevant research on reorientation therapy and adopted a resolution stating that there is not enough research evidence to support the use of reorientation therapy, that available research indicates it is unlikely that patterns of sexual attractions will be changed by reorientation therapy, and it recommends the use of "affirmative multiculturally competent treatment" approaches (American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, p. 121). The resolution further states that the potential benefits of reorientation therapy can be achieved by therapeutic interventions that are not focused on changing sexual orientation (American Psychological Association, 2009). Despite these directives from the major mental health associations in the United States, reorientation therapy continues to be practiced by both mental health professionals and religious organizations (Exodus International, 2005).

REORIENTATION THERAPY AND SEXUAL ORIENTATION

The terms *sexual reorientation therapy, reorientation therapy, conversion therapy*, and *reparative therapy* are used to describe interventions that are meant to change someone's sexual orientation. Sexual orientation is a complex, multidimensional construct that encompasses an array of human sexual attractions, behaviors, emotions, and identities (American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Sell, 1997). Thus a single individual's sexual identity comprises that person's sexual attractions (i.e., to persons of the same sex or gender, opposite sex or gender, or more than one gender), sexual behaviors, and social connection with others who share similar sexual attractions and engage in similar behaviors. In turn, reorientation therapy is intended to alter one or more of these domains in such a way that an individual may stop (1) identifying as LGB; (2) engaging in sexual behaviors with partners of the same sex; (3) finding individuals of the same sex attractive; and/or (4) associating with people who have same-sex attractions and engage in same-sex sexual behaviors. A number of interventions, some of which may be tied to behavioral, cognitive, psychoanalytic/psychodynamic, and/or religious counseling principles, may be used during a course of reorientation therapy (Flentje, Heck, & Cochran, 2013).

To understand the emergence of reorientation therapy as a therapeutic intervention, the historical persecution and criminalization of individuals on the basis of sexual orientation must be considered as part of the context (Mogul, Ritchie, & Whitlock, 2011). One's motivation for sexual orientation change might include avoiding the real threat of prosecution for same-sex behavior, as well as other forms of societal discrimination. In addition, many major religions have historically identified same-sex behavior as a "sin," resulting in conflict for people who experience same-sex desires and a simultaneous commitment to a religious organization that decries same-sex behavior. Family pressures and internalized homophobia may also play a role in the motivation for sexual orientation change interventions. Finally, because the LGBT civil rights movement has a relatively recent history and is still ongoing, individual experiences of what it means to be gay, lesbian, bisexual, or transgender vary tremendously based on the individual's context. With all of these factors considered, the development and persistence of sexual reorientation interventions is not surprising.

Furthermore, the history of the mental health establishment's perspectives toward homosexuality also helps to explain the development of reorientation therapy. These therapies developed under the now-refuted perspective that homosexuality was a mental illness, and continued to exist through the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders, Second Edition* (DSM-II). In the third edition of the DSM, a new diagnosis of ego-dystonic homosexuality was created

(American Psychiatric Association, 1980); with this diagnosis, an individual could be diagnosed if he or she was experiencing conflict with his or her same-sex sexual attraction or behavior. When homosexuality was considered a mental illness, researchers examined potential treatments for homosexuality (e.g., Cautela, 1967; Conrad & Wincze, 1976; Feldman & MacCulloch, 1965; Tanner, 1974; for a review, see Haldeman, 1991, 1994). In a revision of the third edition of the DSM, ego-dystonic homosexuality was removed (American Psychiatric Association, 1987).

Despite the shift away from clinical interventions designed to change sexual orientation after homosexuality was depathologized, Zucker (2003) described a movement that began in the early 1990s that advocated for the existence of sexual reorientation therapy, with the position that clients' wishes to change their sexual orientation should be honored by their therapists. Zucker notes that this movement was led by Socarides, a psychoanalyst, and Nicolosi, a psychologist, and coincided with the creation of the National Association for Research and Therapy of Homosexuality (NARTH) in 1992. The organized ex-gay movement began a visible media campaign in 1998 when advertisements in major newspapers began emerging, claiming that sexual orientation change was possible (Lund & Renna, 2003).

Reorientation therapy is a political, emotional, and controversial topic, and perhaps as a result of this, there is little methodologically sound empirical research on this type of therapy. Arguments have been made that reorientation therapy should be offered, if the client requests it, to honor the client's autonomy (Benoit, 2005). Individuals may seek reorientation therapy for many different reasons, including religious or cultural beliefs. This is particularly clear in a controversial study by Spitzer (2003), who studied 200 individuals who had experienced some kind of reorientation therapy and, after the therapy, maintained gains in their efforts to secure aspects of a heterosexual identity. In his study, 79% of the participants identified conflict between religious beliefs and same-sex behaviors as reasons that they wanted to change their sexual orientation. Spitzer's sample was predominantly religious, with 93% reporting that religion was very or extremely important in their lives. Spitzer concluded that sexual orientation change was possible in areas including behaviors, identity, attraction, content of fantasies, and the extent to which individuals were bothered by same-sex sexual feelings. Additionally, Spitzer reported that participants reported less depression as a result of the therapy and increased masculinity and femininity for the respective sexes. Within Spitzer's sample, 78% had spoken publicly about their sexual orientation change, and 19% directed ex-gay ministries or worked as mental health counselors.

Beckstead (2003) suggested that the widespread interpretation of Spitzer's study as proof that people can change their sexual orientation is inaccurate—that Spitzer's study, instead, shows that in rare cases people who are attracted to individuals of the same sex may be able to function

in relationships with individuals of the opposite sex. Additionally, Bancroft (2003) criticized the study in many different areas, including the lack of representativeness of the sample, the strong religious beliefs of the sample, the large percentage (78%) of the sample that had spoken publicly about their orientation change, recall bias, lack of clarity about the therapy provided, and the unfounded claims of sexual orientation change. Recently, Spitzer made a public apology for his study and indicated that the claims he made in his study were inappropriate (Besen, 2012). Nevertheless, Spitzer's (2003) study stands as one of the empirical underpinnings cited by the ex-gay movement.

Scholars have considered ways of coping with the conflict that can exist between religious beliefs and sexual orientation. Diamond (2003) suggested that individuals consider modifying, if possible, or leaving practices and relationships that are not supportive of LGB identification. She also acknowledged that, relative to a person's sexual orientation, these anti-LGB practices and relationships may comprise a large and important portion of the person's overall identity. In other words, the prioritization of LGB affirmation over other important aspects of a person's identity (e.g., religious identity; relationships with family members) may be inappropriate or invalidating, even if these practices and relationships are homophobic.

As noted earlier, reorientation therapy has also received criticism for its potential harmfulness. Bancroft (2003) suggested that the individual may experience "considerable conflict and unhappiness" (p. 421) as a result of feeling that he or she needs to change his or her sexual orientation. Bancroft thoughtfully considered the potential harmfulness of his early research on behavioral reorientation techniques as potentially reinforcing homophobic beliefs. Other researchers have argued that reorientation therapy should not be practiced because there is no pathological condition that needs treatment (Tozer & McClanahan, 1999). Yarhouse and Throckmorton (2002) rebut this type of argument by pointing out that treatment is often given for nonpathological conditions, and they state that not all reorientation programs reinforce the idea that same-sex attraction is pathological.

RESEARCH ON EXPERIENCES OF INDIVIDUALS IN AND AFTER REORIENTATION THERAPY

There is a relatively limited body of research on individuals who have sought out reorientation therapy. Most of this research has focused on factors leading to the decision of individuals to enter this therapy or on the experiences of clients post-treatment. The extant literature on reorientation is summarized below.

Beckstead (2001) analyzed qualitative data from 20 Mormon proponents of reorientation therapy who reported that they had benefited from the

treatment. The participants reported that being LGB was similar to having a disease and meant that their lives would consist of having multiple sexual partners, a high likelihood of contracting a sexually transmitted disease, and isolation (Beckstead, 2001). Several of the participants reported being told that they would be excommunicated from their religious communities if they were to continue to have same-sex relationships (Beckstead, 2001). Benefits of reorientation therapy included emotional relationships with persons of the same sex, increased identification with their own gender, which was a focus of treatment for many of the participants, and reduced same-sex sexual behaviors or desire; however, none of the participants reported increased sexual attraction to the opposite sex (Beckstead, 2001).

Beckstead and Morrow (2004) combined data from the 20 proponents with data from 22 individuals who had undergone reorientation therapy and reported negative outcomes to develop a model to capture the experiences of Mormon individuals who had experienced reorientation therapy. A preliminary model was subjected to a confirmatory process whereby eight additional participants with varied conversion therapy experiences and perspectives discussed the model in focus groups (Beckstead & Morrow, 2004). Beckstead and Morrow's final model, which is placed in the context of societal homophobia and heterosexism, provides a detailed overview of (1) factors and processes that may lead people to seek reorientation therapy; (2) positive and negative sexual reorientation therapy experiences; (3) post-treatment experiences and personal (identity) development; and (4) possible outcomes. Furthermore, the model specifies experiences that are unique to proponents or opponents of reorientation therapy and experiences that are shared by both groups.

According to Beckstead and Morrow's (2004) model, experiencing dissonance between same-sex attractions and religious beliefs, which can lead to disparaging self-labeling (e.g., fag, dyke, pervert), negative emotionality, and unhealthy coping behaviors, is often an impetus for seeking help from religious leaders or therapists and entering reorientation therapy. The model then suggests that both proponents and opponents of reorientation therapy experienced benefits, including finding and connecting with individuals in similar situations, having a framework by which to understand why they experienced same-sex attraction (same-sex attractions were primarily explained as occurring due to unmet same-sex emotional needs), and experiencing increased identification with their gender (Beckstead & Morrow, 2004). The model also specifies negative reorientation therapy experiences (e.g., disappointment; depression and suicidality; increased emotional distress; interpersonal and relational challenges; loss of faith), primarily voiced by opponents of the therapy, but with proponents and opponents alike indicating that they felt increasingly suicidal after feeling disappointed about "failing to sexually reorient" (p. 671, Beckstead & Morrow, 2004). Notably, eight participants (19% of the sample; four proponents and four opponents)

attempted suicide after the therapy, and many participants reported having known others who had completed suicides after reorientation therapy (Beckstead & Morrow, 2004). After therapy, the model highlights a number of possible experiences that may include vacillating between different identities, disillusionment, developing or solidifying values, and eventually finding self-acceptance. Finally, the model specifies a number of possible outcomes that range from adopting a positive sexual identity (e.g., LGB, same-sex attracted, heterosexual) to finding peace, congruence, and authenticity, to continuing to experience sexual orientation–related challenges. Based on the findings, Beckstead and Morrow (2004) conclude that the potential harms of reorientation therapy are considerable and outweigh the benefits, which could be obtained in other types of therapy.

Shidlo and Schroeder (2002) interviewed 202 individuals who had undergone some kind of reorientation therapy and were recruited through advertisements in newspapers, online, and through e-mail Listservs. As with previous research, women were largely underrepresented, comprising only 10% of their sample. Unlike other samples, there was a representation of nonreligious individuals, with 24% of the sample identifying as nonreligious. Participants had spent an average of 26 months in reorientation treatment, ending the last treatment episode an average of 12 years before their interview (Shidlo & Schroeder, 2002). Shidlo and Schroeder reported that many of the individuals that they interviewed said that at one point in time they would have identified themselves as reoriented, but that with time they realized that this was not the case. Shidlo and Schroeder found that persons who had gone through reorientation therapy had mixed experiences with the therapy, with many reporting that they had been both harmed and helped from the same episode of therapy.

Shidlo and Schroeder (2002) developed a model for a pathway to perceived treatment failure or success. The model begins with the preentry period, which was the time during which the participant became motivated to enter treatment. Strong motivators that were reported were a search for a social group where he or she felt comfortable, religious reasons, desire to hold together a marriage and family, threatened expulsion from a religious academic institution if treatment was refused, and mood or anxiety symptoms. For the latter group that sought therapy for mood or anxiety symptoms, they reported that their therapists suggested reorientation therapy in response to their symptoms. Overall, reorientation therapy was suggested to the client by the therapist in 26% of the interventions reported.

The next phase of Shidlo and Schroeder's (2002) model was identified as the "honeymoon period," in that participants reported a sense of hope and relief at entering therapy. The model then puts forth division into two groups: persons who perceive themselves as successful and persons who perceive themselves as failing, 13% and 87%, respectively, within the sample. The authors further divide the successful group into three subgroups:

"successful and struggling," which was defined by repeated same-sex sexual behaviors; "successful and not struggling," which was defined by using strategies to manage same-sex sexual urges; and "successful heterosexual shift," defined by individuals who were living actively heterosexual lives. Notably, of the eight individuals in the successful heterosexual shift phase, seven were providers of counseling to individuals who were reorienting or reoriented (Shidlo & Schroeder, 2002).

For individuals who saw themselves as not having reoriented, the honeymoon phase was followed by a time of disillusionment (Shidlo & Schroeder, 2002). At this time, the authors state that participants experienced a deadening of sexual desire, or they experienced strong feelings of same-sex sexual desire and felt disappointed in their treatment progress. The latter group often engaged in dangerous impulsive behaviors including substance use, suicidality, or unsafe sexual behaviors. From this point, Shidlo and Schroeder saw the participants as reestablishing a gay or lesbian identity with considerable residual reorientation therapy harm ($n = 155$) or with considerable renewal and strength ($n = 21$).

PURPOSE OF THIS STUDY

The present study is a departure from previous research on reorientation therapy for several reasons. First, in contrast to the controversial Spitzer (2003) study, the present study involved recruiting individuals who went through reorientation therapy and did not report a change in sexual orientation. To date, no studies have specifically focused on ex-ex-gay individuals, or those who have entered reorientation therapy at one point, then later reclaimed a gay or lesbian identity. Second, this study differs from the studies conducted by Beckstead and Morrow (Beckstead, 2001; Beckstead & Morrow, 2004) in that participants in the present study were not recruited on the basis of one particular religious identity, and therefore may represent a broader group of individuals who went through reorientation interventions. Finally, in contrast to the model-building approach of Shidlo and Schroeder (2002), the recruitment strategy of the present study was designed to capture individuals who perceived themselves as successful, not in having achieved sexual orientation conversion, but in having reclaimed a new identity as gay or lesbian.

The purpose of this study is to thematically examine the experiences of people who have undergone reorientation therapy and have determined that an ex-gay life is not for them: ex-ex-gay (or ex-ex-lesbian) individuals. This study seeks to identify the reasons that led these individuals to seek reorientation therapy and the reasons that they later chose to claim a gay or lesbian identity. Additionally, this study aims to determine how reorientation therapy was perceived to be beneficial or harmful to the individual.

METHODS

Recruitment of Participants

Participants met inclusion criteria if they had been through any type of intervention designed to change their sexual orientation from LGB to heterosexual and currently identified as LGB. Recruitment efforts targeted several online sources over a period of approximately 12 months in 2008 and 2009. First, a notice describing the study was included in an e-mail newsletter to individuals who had registered with an ex-ex-gay Web site. The notice suggested that information about the study could be passed on to others, which created a snowball effect that resulted in additional postings about the study on at least seven other Listservs or Web sites (according to participant reports when they were asked where they heard about the study), including a Listserv for people who identify as both gay and Christian. Additionally, a description of the study was sent out to a Listserv of psychologists who are interested in lesbian, gay, bisexual, and transgender (LGBT) issues. It was anticipated that it would be difficult to find participants for this study due to low base rates of individuals who met the criteria for study participation. In addition, previous researchers had also reported difficulty in recruitment. For instance, Throckmorton and Welton (2005) spent one year recruiting participants who considered themselves reoriented or reorienting and were able to find 28 participants who met their study criteria during that time. Similarly, Spitzer (2003) spent 2 years of intensive searching to locate 200 participants and ultimately ended up recruiting many activist ex-gays. A number of factors influence the decision of an optimal sample size for reaching saturation, or the point at which additional data collection would not offer new insights or themes; however, a general recommendation for sample sizes for interview data in sexuality research was recently offered as 25–30 participants (Dworkin, 2012). Considering the uniqueness of this population, recruitment difficulties in previous research, and the goal of identifying relevant themes regarding reorientation experiences, a target goal of 30 participants was set for the present investigation.

Measures

Demographic questions

Respondents were queried about their demographic characteristics, including age, gender (including queries for male, female, transgender male to female, transgender female to male, and other), education level, income, and relationship status.

Sexual orientation

Two items were used to measure sexual orientation. One question asked the participant if he or she identifies as gay, lesbian, heterosexual, or bisexual.

The Kinsey Scale (Kinsey, Pomeroy, & Martin, 1948) was also used to measure sexual orientation both because of its simplicity and because it is a scale with which persons who go through sexual reorientation therapy may be familiar. The Kinsey Scale is a 7-point scale where responses range from 0, indicating exclusively heterosexual, to 6, indicating exclusively homosexual (Kinsey et al., 1948). Because the focus of this investigation was on the shifts in identity that accompany an individual's self-definition as gay, ex-gay, or ex-ex-gay, the measures of sexual orientation in this study reflected LGB identity, rather than attraction or behavior.

Questions about therapy experiences

Several items queried the participants' experiences with reorientation therapy. These questions included number of episodes of therapy, the length of therapy, the modality of therapy, the designation of the person(s) who provided the therapy, and the setting of the therapy. If the participant had experienced more than one episode of reorientation therapy, these questions were asked for each episode.

Furthermore, participants were asked about reorientation experiences via the following questions: "What were your reasons for seeking reorientation therapy?"; "How did this therapy episode help you in the short term?"; and "How did this therapy harm you in the short term?" Similarly worded items were used to assess the long-term helpfulness and harmfulness of each therapy episode. Participants' reasons for LGB identification following therapy were assessed by asking: "What were your reasons for identifying as gay, lesbian, or bisexual after reorientation therapy?"

Procedure

Due to concerns that the data could be compromised if an open survey was offered to anonymous parties, participants were asked to contact the principal investigator via e-mail or telephone to participate in the study. After contact was made, the investigator mailed the individual a paper survey and a separate form and envelope to request an incentive of $15. This method was meant to prevent the same individual from completing the survey multiple times, with contact with the principal investigator being the deterrent.

Analyses

An inductive content analysis strategy (Patton, 2002) was used to analyze participants' responses to the open-ended survey questions. Verbatim responses were printed for the research assistants (research assistants were either advanced undergraduate students [$n = 5$] or graduate students who had

obtained MA degrees [$n = 2$]), who collaborated with the principal investigator to identify core themes in the responses and develop an open coding system (Strauss & Corbin, 1998) serving as both developers and coders. During this process, the developers were instructed to read all responses one or more times and to mentally note any themes that began to emerge. The code developers were then instructed to reread all responses and identify specific themes that could be captured using a short phrase or sentence. The developers were not limited in the number of potential themes they could identify. Once complete, the developers met to share their themes. Generally speaking, the most prominent themes were discussed first, and often the principal investigator would ask the theme developers to specify portions of responses that would be included under each theme category.

This process continued until a consensus had been reached about the themes that were present in the responses. Once a consensus had been reached either three research assistants (one of whom had a MA degree) or two research assistants and the principal investigator coded each of the responses. Responses were counted as resonating with a particular theme if at least two out of the three coders identified the theme as present in the specific response. Frequencies of responses that were classified as a particular theme were then tallied, and themes that occurred at least twice are reported. Fleiss's Kappa was calculated as a measure of agreement among raters. Kappa coefficients within this study ranged from .53–.71, in the *moderate* to *substantial* agreement range (as defined by Landis & Koch, 1977).

RESULTS

Participants

Relevant sample characteristics are reported here for convenience; sample characteristics are also reported in Flentje, Heck, and Cochran (2013). Thirty-eight people participated in the study; their demographic information is reported in Table 1. Participants indicated that they had continually identified as lesbian or gay for between 13 months and 23 years ($M = 7.09$ years, $SD = 5.62$) since their last episode of reorientation therapy. When asked about their current religious identification, respondents indicated that they identified with Protestantism ($n = 26$), no religion ($n = 4$), Judaism ($n = 2$), Greek/Eastern Orthodoxy ($n = 2$), Catholicism ($n = 1$), Buddhism ($n = 1$), or were undecided ($n = 1$). The group who identified as Protestant further identified with the following churches or denominations: nondenominational ($n = 5$), Methodist ($n = 5$), United Church of Christ ($n = 2$), Baptist ($n = 2$), Episcopal ($n = 2$), Quaker ($n = 2$), Lutheran ($n = 2$), Metropolitan Community Church ($n = 1$), Evangelical ($n = 1$), Presbyterian ($n = 1$), Christianity "emergent" ($n = 1$), Golden Rule Christian ($n = 1$), and the Reformed Church of America ($n = 1$).

TABLE 1 Demographic Information ($N = 38$)

Demographic variable	n, % (or M, SD, if applicable)
Age M (SD, range)	37.37 (11.98, 20 – 66)
Sex (n, %)	
Male	38 (81.6%)
Female	7 (18.4%)
Sexual orientation	
Gay	38 (81.6%)
Lesbian	7 (18.4%)
Sexual orientation: Kinsey scale[a]	
Predominantly homosexual, only incidentally heterosexual	16 (42.1%)
Exclusively homosexual	22 (57.9%)
Race (n, %)	
Caucasian	33 (86.8%)
African American	1 (2.6%)
Latino/Latina	1 (2.6%)
Asian/Pacific Islander	1 (2.6%)
Multi Racial	2 (5.3%)
Education (n, %)	
Some college	1 (2.7%)
4-year college degree	11 (29.7%)
Some graduate school	6 (16.2%)
Graduate/professional degree	19 (51.4%)

[a]Participants only endorsed these two categories for sexual orientation.

Reorientation Experiences

Participants provided information about multiple episodes of reorientation therapy when applicable, with 38 participants providing information on 113 episodes. Participants reported that 7.1% of episodes were inpatient, 50.4% were outpatient, and 42.5% were classified as "other." Responses to what was meant by "other" varied considerably and included things such as telephone or e-mail therapy, online support groups, conferences, and retreats. Characteristics of reorientation episodes are summarized briefly in Table 2. In-depth details of reorientation experiences are reported in Flentje, Heck, and Cochran (2013).

Reasons for Seeking Reorientation Therapy

A total of 36 participants provided responses regarding their reasons for seeking reorientation therapy, and eight distinct themes emerged. The theme "religious beliefs" was the most frequently identified theme within the responses ($n = 29$, 80.6%). The "religious beliefs" theme represented answers about specific religious beliefs (e.g., "I had been taught that God would punish me as a gay man") that led participants to see an LGB identity as incompatible with their religious belief system. Consistent with this

TABLE 2 Characteristics of Reorientation Therapy Episodes

Participant intervention experiences	Range	*M (SD)*	*Mdn*
Age at first reorientation intervention	11–52	23.18 (8.62)	20
Total number of hours in reorientation interventions	12–3000	487.20 (639.72)	200
Number of different reorientation episodes	1–9	3 (2.10)	2.5
Length of intervention episodes in weeks[a]	1–240	40.54 (42.64)	26
Professional designation of intervention provider[b]	*n*	%	
Religious leader	50	22.1%	
Religious individual without leadership duties	48	21.2%	
Licensed counselor	38	16.8%	
Pastoral counselor	29	12.8%	
Peer counselor	21	9.3%	
Marriage and family therapist	18	8.0%	
Psychologist	11	4.9%	
Social worker	6	2.7%	
Psychiatrist	5	2.2%	

[a]This and the following categories are calculated for all reorientation episodes (participants reported on multiple episodes), 113 total for the study.
[b]Participants could endorse multiple professional designations for providers, resulting in 226 total responses to this question.

theme, 100% of participants reported that they had been part of a religious or spiritual community that held negative beliefs about LGB people. Additionally, there was a "desire for a 'normal' heterosexual life" ($n = 14$, 38.9%). Responses that were coded for this theme indicated that the participants wanted to be married and have children and families, and again saw these desires as incompatible with being LGB. A complete listing of the themes that emerged and the frequency of their occurrences can be found in Table 3.

Perceived Helpfulness of Therapy

All of the participants ($N = 38$) provided responses regarding short-term and long-term helpfulness for each of the reorientation therapy episodes that they experienced, and 16 themes emerged from those responses (percentages are reported according to the percent of the total of the 113 therapy episodes that they were reporting). The most commonly occurring themes for short-term helpfulness of reorientation therapy included providing a "sense of connectedness, support" (21 occurrences, 18.6%) and that the participants "felt accepted, not alone" (15 occurrences, 13.3%). For both of these themes, it appeared that there was a benefit to the social aspect of being able to share experiences with people who felt similarly conflicted about same-sex attractions. After these two themes, the third most frequently occurring theme was that the therapy was not helpful in the short term (14 occurrences, 12.4%). It should be noted that although this seems to be a counterintuitive response

TABLE 3 Reasons for Seeking Reorientation Therapy: Themes That Emerged

Theme	Frequency	Example
Religious beliefs	29 (80.6%)	"Being gay was a sin and I couldn't be a Christian and gay."
Desire for a "normal" heterosexual life	14 (38.9%)	". . . I wanted to live a "normal" life, married with children- it was my dream."
Family acceptance/rejection	14 (38.9%)	"Wanted to be 'normal' so that my family and parents would love me again."
Religious community acceptance/rejection	11 (30.6%)	"I wished to continue actively in my church which I could not continue to do in that church as a gay man."
Mental health (depression, guilt, fear)	10 (27.8%)	"I felt defective, abnormal, depressed, and self-hatred toward myself and wanted to change."
Social stigma	7 (19.4%)	". . . social stigma of being perceived as queer, deviate, effeminate"
In a straight marriage or family	4 (11.1%)	"I was married with 4 kids."
Being gay associated with negative or risky health behaviors	3 (8.3%)	". . . fear of the 'gay lifestyle' (i.e., disease, promiscuity, loneliness, drug/alcohol abuse)."

(e.g., participants indicated that a "helpful" aspect of the therapy was that it was "not helpful"), the statements here reflect the participants' responses to the question and were coded accordingly. Suicide was explicitly mentioned in six responses (5.3%). In these cases, participants indicated that their therapists or being in therapy had helped them to deal with suicidal feelings or encouraged them to not act on suicidal impulses. When considering long-term helpfulness, the most frequent theme was that the episode of therapy did not provide long-term help (35 occurrences, 31.0%). The next most frequently occurring themes were that the therapy "solidified gay identity" (13 occurrences, 11.5%) and provided a "sense of connectedness, support" (12 occurrences, 10.6%). The complete list of themes that emerged regarding ways in which participants had found reorientation interventions to be helpful and the frequency of the occurrences of these themes are noted in Table 4.

TABLE 4 Themes in the Helpfulness of Each Reorientation Episode

Theme	Frequency	Example
How did this episode of therapy help you in the short term?		
Sense of connectedness, support	21 (18.6%)	"I found peers, support, love, and friendship. I had a free place to discuss my struggles. They helped me get through crisis situations."
Felt accepted, not alone	15 (13.3%)	"It helped me realize I wasn't alone in my 'struggle.'"

(*Continued*)

TABLE 4 (Continued)

Theme	Frequency	Example
Didn't help	14 (12.4%)	"This therapy did not aid me in the short term."
Hope (explicitly stated or implicit)	12 (10.6%)	"Therapy made me feel empowered over my own life, both in regards to my sexual orientation and the rest of my life in general. I would almost always leave each therapy session feeling great about myself and optimistic . . . It made me feel good in the short term."
Family or relationship issues	10 (8.8%)	"Gave me skills/tools and increased my self evaluation of areas in my life that could perhaps be improved—e.g., mother/father–son relationships, relationships/friendships with male peers, self esteem issues."
Mental health or other health issues addressed	9 (8.0%)	"Again, by providing a place where I didn't feel alone in my struggles, thereby staving off suicide and deeper depression."
Safe place to talk, be honest	6 (5.3%)	"Gave me an opportunity to talk about being homosexual for the first time in my life."
Helped to talk about same-sex attractions with family or community	5 (4.4%)	"It helped me to finally admit to others, including my parents, that I had same sex attractions."
Strengthening or reconciliation of faith	4 (3.5%)	"It helped to establish that I was a person of worth and to focus on God partnering with me."
Aided the coming out process	3 (2.7%)	"In settling the upset emotions of the coming out process."
Solidified a gay identity	2 (1.8%)	"Helped me to accept I was not straight"
Trauma issues dealt with	2 (1.8%)	"I was elated and felt my childhood memories of trauma were healed."
How did this therapy help you in the long term?		
Didn't help	35 (31.0%)	"This therapy has not aided me in the long term."
Solidified gay identity	13 (11.5%)	"It reinforced the fact that I was made gay and that it was not a lifestyle or a circumstances choice."
Sense of connectedness, support	12 (10.6%)	"I had a group of friends/acquaintances that I could talk to openly and honestly without fear of judgment. They understood me."
Strengthening or reconciliation of faith	7 (6.2%)	"I realized God's love was bigger than my homosexuality. I was His, and no power could negate that fact."
Felt dissatisfaction with reparative therapy	6 (5.3%)	"Showed me that ex-gay ministries/mentality was cult-like and destructive, overall, by proffering false hopes and promoting further/more rigid thinking and self condemnation."
Mental health or other health issues addressed	5 (4.4%)	"He recognized I was really depressed and connected me with medical professionals who diagnosed my depression and supplied antidepressants—possibly saving my life."

(*Continued*)

TABLE 4 (Continued)

Theme	Frequency	Example
Family or relationship issues	4 (3.5%)	"Opened up some opportunities for growth with my dad and family. Built the relationship levels with my parents to share about my homosexuality later in life. Allowed me to stop blaming my parents for my situation."
Safe place to talk, be honest	4 (3.5%)	"She is, to this day, the only therapist I've felt safe being honest with."
Aided with the coming out process	3 (2.7%)	"Started me on the road to come out."
Learned repressive techniques	3 (2.7%)	"It taught me a certain measure of self-control and made me aware of my abilities to deny sexual desires."
Met a partner or lover there	3 (2.7%)	"Met my future first gay lover."
Gained skills	2 (1.8%)	"Gave me skills"
Helped to talk about same-sex attractions with family or community	2 (1.8%)	"It began the ongoing journey of accepting my sexual orientation and sharing this with friends or family when I have a certain comfort level with them."
Trauma issues dealt with	2 (1.8%)	"I learned a lot about myself and was able to come to terms with some abuse and neglect from my past."

Perceived Harmfulness of Therapy

All of the participants responded to questions regarding short- and long-term harms for each therapy episode they experienced, and 17 themes emerged (percentages are representative of the percent of the total number of episodes experienced among the sample, $N = 113$). The most frequently identified short-term harms resonated with themes that represented "mental health (depression, anxiety)" and "shame, guilt, self-hatred," each with 17 occurrences (15.0%). Additionally, 17 episodes (15.0%) were identified as not being harmful in the short term. In the long term, participants identified that 24 episodes (21.2%) were not harmful. As with the question on helpfulness, these seemingly counterintuitive responses were the participants' verbatim answers to the question about harmfulness. The next most frequently cited long-term harm was "shame, guilt, and self-hatred" (21 occurrences, 18.6%). Suicide was specifically mentioned as a harmful aspect of reorientation episodes (four occurrences in both the short and long term, 3.5%). Identified themes and the number of occurrences of these themes are in Table 5.

Reasons for Identifying as LGB

Thirty-six participants provided responses when queried about their reasons for identifying as LGB after reorientation therapy, and eight distinct themes

TABLE 5 Themes in the Harmfulness of Each Reorientation Episode

Theme	Frequency	Example
How did this therapy episode harm you in the short term?		
Mental health (depression, anxiety)[a]	17 (15.0%)	"It was fear inducing—horrible. Almost like an exorcism performed on me. I had panic attacks and anxiety."
Shame, guilt, self-hatred	17 (15.0%)	"I felt shame about my urges/attractions."
Didn't harm	17 (15.0%)	"It probably did no harm in the short term. Finally getting to talk to someone was very calming."
False hope	13 (11.5%)	"It complied with my errant thinking that it was okay for me to get married, even though this was going on, that it would all work itself out and the situation would improve somehow—it fostered false hope."
Suppressing, not being honest, secrecy	10 (8.8%)	"Didn't face the problem. Tried to suppress to please the counselor."
Isolation, distance or loss of relationships	8 (7.1%)	"Isolation from family and friends."
Inaccurate or bad view of LGBT people	7 (6.2%)	"I was told many incorrect and untrue things about LGBT people . . . reinforced the idea that LGBT people are sick and evil."
Blamed parents, damage in relationship with parents	6 (5.3%)	"It also caused me to attempt to fit my past experiences into a reparative therapy model of attractions, which led me to begin blaming my parents for things they were not responsible for."
Delayed coming out or pursuing relationships	6 (5.3%)	"Also in the short term my experience with therapy delayed my ultimate coming out by about 2–3 years, which I view as short term in the grand scheme of things."
Financial cost	5 (4.4%)	"I didn't make much money and it was difficult to afford."
Can't change, failure, worthlessness	4 (3.5%)	"Also made me feel inadequate because my faith was too weak for me to change."
Distrust	2 (1.8%)	"The pastor counseled me in private and later told the whole church all we had spoken in private. It was a painful breach of trust."
Fear of going to hell	2 (1.8%)	"Constantly second guessing myself thinking I was going to hell."
Loss of faith in God or spirituality	2 (1.8%)	"Caused me to stop believing in God for a time."
Loss of time	2 (1.8%)	"The summer after I concluded ex-gay therapy was when I had my first relationship. However, the entire school year after that summer was a social black hole—I literally recall nothing of what transpired that year. To some degree I don't think I was ready to come out as gay, yet I knew I wasn't going back to therapy. It was a very strange year, I don't remember pursuing anyone of either gender romantically and it almost feels like my 'lost year.'"

(*Continued*)

TABLE 5 (Continued)

Theme	Frequency	Example
How did this therapy episode harm you in the long term?		
Didn't harm	24 (21.2%)	"Didn't. Was able to see what a load of crap it was."
Shame, guilt, self-hatred	21 (18.6%)	"It led me to more introspection and greater self-loathing. Every activity I performed had to be scrutinized for possible demonic overtures."
Loss of faith in God or spirituality	12 (10.6%)	"It caused me to feel separated from God and condemned to hell."
Mental health (depression, anxiety)[a]	10 (8.8%)	"In spite of the therapist's efforts, my depression grew worse under his care rather than growing better. I began cutting, secured a gun license in my state, and almost killed myself."
Blamed parents, damage in relationships	8 (7.1%)	"Based on this man's advice and others in his organization, I spent a lot of money and told my father that our relationship made me gay—I regret these things."
Isolation, distance or loss of friendships	8 (7.1%)	"I was not comfortable with myself and that was making people around me uncomfortable too. As a result, I was left behind by almost everyone, except my family."
Financial cost	6 (5.3%)	"Expense/debt of treatment."
Delayed coming out or pursuing relationships	5 (4.4%)	"Delayed accepting myself."
False hope	5 (4.4%)	"It created in me the false image that I could change my sexuality. I was kept in this lie for more than 12 years, trying to change it."
Career or academic consequences	4 (3.5%)	". . . it distracted me from my true course, i.e., from continuing in college (which I eventually went back to) pursuing my career and hobbies, friends through these interests, etc."
Distrust	4 (3.5%)	"Made me distrust sharing this with other counselors."
Inaccurate or bad view of LGBT people	4 (3.5%)	"Exposed me to a lot of very miserable gay people who I thought were representative of all gays."
Can't change, failure, worthlessness	3 (2.7%)	"Contributed to shame and self-hatred because my orientation never changed—not even a little. I felt like a failure."
Suppressing, not being honest, secrecy	3 (2.7%)	"I learned things that fed my anonymous sexual behavior. This ended up creating a cycle of shame and secrecy that would become very hard to break."
Fear of going to hell	2 (1.8%)	"I still struggle with the fact that I am not going to hell."

[a]Suicide was mentioned specifically regarding four (3.5%) episodes of therapy in reference to short-term harm and four (3.5%) episodes of therapy in reference to long-term harm; these responses were given by two different participants in the study.

TABLE 6 Reasons for Identifying as LGB After Reorientation Therapy

Theme	Frequency	Example
Acceptance of and being honest about being gay or lesbian	15 (41.7%)	". . . I decided that the change I needed to experience was accepting myself."
I couldn't change my sexual orientation	14 (38.9%)	"The realization that therapy did not get rid of sexual orientation; it only 'treated the symptoms.'"
Religious integration with LGB identity	9 (25.0%)	"This is how I was made—and God made me—so I was okay as is, in His image."
Desire for or finding intimacy or a relationship	7 (19.4%)	"I fell in love with another Christian woman."
Deterioration of mental health	6 (16.7%)	"The chaos in my life since the therapy, my life had become something close to hell."
Exhausting to be ex-gay, gave up	5 (13.9%)	". . . it was because I was simply exhausted from 13 years of suppressing my natural urges."
Ex-gay example falling from grace	2 (5.6%)	"A prominent ex-gay individual was caught using a restroom in a gay bar and made a lame excuse for being there."
Being gay or lesbian is not associated with negative, risky, or stigmatized health behaviors	2 (5.6%)	". . . I decided it would be OK to 'try out' a same-sex relationship provided it wasn't all the horrible things my church and my therapist said it would be."

emerged. These themes and their frequency of occurrence are reported in Table 6. The most frequently occurring themes included "acceptance of and being honest about being gay or lesbian" ($n = 15$, 41.7%), "I couldn't change my sexual orientation" ($n = 14$, 38.9%), and the experience of a "religious integration with LGB" ($n = 9$, 25.0%). When considering the theme of "religious integration with LGB" it is important to note that 100% ($n = 37$, 1 participant declined to answer this series of questions) of participants had been part of a religious community that held negative beliefs about LGB people, and 97.3% ($n = 36$) of participants had left these religious communities. Of the participants who had left their religious communities, 61.1% ($n = 22$) did so after reorientation therapy.

DISCUSSION

Sexual reorientation therapy remains a controversial area of practice; there are widespread concerns that reorientation therapy is harmful, and recent studies (e.g., Spitzer, 2003) that are cited to support the effectiveness of reorientation therapy have been heavily criticized on methodological grounds. The results of this study are not intended to resolve this controversy; rather, the results illuminate the experiences of individuals who have undergone reorientation therapy and identify as LGB.

The results of this study are consistent with previous research in several ways. First, the sample comprised mainly Caucasian and male individuals, which was similar to participant demographics from other studies (Schaeffer et al., 1999; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Throckmorton & Welton, 2005). Second, participants' motivations for seeking reorientation therapy and the delivery of therapy were driven by religious and heteronormative beliefs. Specifically, religious beliefs and desires to have or maintain a heterosexual lifestyle, which includes marriage and children, were the most commonly cited reasons for entering reorientation therapy, a finding that is consistent with previous research (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002; Spitzer, 2003; Tozer & Hayes, 2004). Although previous research suggests that mental health professionals (e.g., psychologists, pastoral counselors) are often identified as the most common providers of reorientation therapy (Shidlo & Schroeder, 2002; Spitzer, 2003), the most frequent providers reported by participants were individuals with a religious affiliation, while very few psychologists, psychiatrists, and social workers were identified as the participants' providers of reorientation therapy. On the other hand, the fact that any mental health professionals were identified as providers of reorientation therapy is inconsistent with the statements made by virtually all major mental health organizations that such practices are ineffective and possibly unethical.

With respect to perceived helpfulness of reorientation therapy, participants endorsed feelings of acceptance, connection, hope, and support. Beckstead and Morrow (2004) reported that most of their participants derived a sense of belonging and were provided with hope as a result of treatment, and as Shidlo and Schroeder (2002) pointed out, conversion therapy "may offer a powerful social component as part of the treatment" (p. 252). In the long run, many participants acknowledged that treatment would not help them to become heterosexual; rather, treatment helped to solidify aspects of their sexual identity and integrate (or reconcile) this identity with their religious beliefs. Furthermore, 97.3% of participants reported that they had left religious communities that held negative beliefs about LGB individuals, with 61.1% of these individuals doing so after reorientation therapy.

Once again, acceptance of one's sexual orientation and a realization that sexual orientation could not be changed were the most frequent themes identified in participants' reasons for leaving reorientation therapy and identifying as gay or lesbian. In sum, these findings echo the results of Shidlo and Schroeder (2002) and suggest that for some, reorientation therapy was very much part of the process by which they came to accept their own sexual orientation and to feel freed to identify as gay or lesbian.

There are many reasons that individuals who have undergone reorientation therapy might be motivated to identify beneficial aspects of the experience. Studies of psychotherapy outcome have repeatedly identified "common factors" of all forms of therapy that are beneficial components

of the experience, and one of the most consistent of these factors is the therapeutic alliance (Wampold, 2010). Even though participants in our study later reclaimed an identity that was opposite of the intended goal of reorientation therapy, many of these individuals were likely to have experienced a good working relationship, or alliance, with treatment providers they encountered in the process. The psychological theory of cognitive dissonance (Festinger, 1957), in which individuals are motivated to justify their decisions through modifying their interpretation of the outcome, may also apply to reorientation therapy. Individuals who have invested a great deal of time, money, and effort into the process of reorientation therapy may be motivated to find benefits of the experience to explain such an investment of resources. Finally, an individual undergoing reorientation therapy may experience a mitigation of shame or internalized homophobia by attempting to overcome unwanted aspects of his or her identity. Although the ultimate result of reorientation therapy could be an increase in shame through the process, as some of the participants in this study noted, temporary amelioration of shame may occur while one is attempting to become heterosexual.

Participants' perceptions of how reorientation therapy was harmful in this study were consistent with the results of Shidlo and Schroeder (2002). These include increased psychological distress that centered on depressed mood, increased anxiety, and suicidality. Many of the responses resonated with a theme of "shame, guilt, and self-hatred." While client deterioration as a result of treatment is considered harmful (Lilienfeld, 2007), additional themes (e.g., "not harmful," "financial costs," "loss of time") that emerged from the participants' responses reflect opportunity costs, or the harm that is derived from receiving ineffective or suboptimal treatments (Lilienfeld, 2002). The varying responses to questions of helpfulness and harmfulness could indicate that a person's unique background, psychosocial history, and preconceived notions about reorientation therapy may affect his or her perceptions of helpfulness and harmfulness. Additionally, the variability in interventions that exists among providers of sexual reorientation therapies (see Flentje et al., 2013) further complicates matters when attempting to discern how and why differences in perceptions of helpfulness and harmfulness might arise.

Implications

The results reported herein are not only consistent with previous research but also have important practical implications that warrant attention. Perhaps the largest implication of this study involves the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009). The results of this study support the report's conclusions, which indicate that the helpful components of reorientation therapy could be obtained through other treatments, while minimizing the potential

for harm that appears in the reports of participants who have undergone reorientation therapy.

Specifically, the most frequently identified helpful components of reorientation therapy (a sense of connectedness with others or acceptance) could be achieved through other, less stigmatizing, treatment methods. Within this vein, it is important to increase the availability of alternatives to reorientation therapy, especially in communities and treatment centers that may offer or promote reorientation therapies. Silverstein (2003) pointed out that ex-gay organizations have attractive and easy-to-use Web sites, and that other therapy options are not well publicized. This means that persons who are concerned about their sexual orientation, or family who are concerned about the sexual orientation of their children or teens, may find these Web sites and see them as a viable, and perhaps the only, option. On this front, mental health organizations should continue to work to increase the visibility of therapy options that are affirming of LGB identities.

It is also important to consider this study's clinical implications. Phillips (2004) raised the importance of appreciating the complexity of sexuality when working with clients who experience both same-sex attraction and religious promotion of non–gay friendly values. It may be tempting to suggest that a client change or leave religious communities that are anti-LGB; however, this suggestion may be harmful to both the client and the therapeutic relationship. Alternatively, affirmative and client-centered interventions may help clients come to this conclusion on their own or help clients develop positive coping skills to navigate homophobic environments and relationships (American Psychological Association, 2009). Miville and Ferguson (2004) noted that for some individuals, religion may not be optional, and in respecting client diversity and autonomy, it is important to value both the client's religious and sexual identity (Haldeman, 2004), even if these may seem to be in conflict with one another.

Haldeman (2004) recommended a therapeutic approach that focuses on the client; such an approach may not necessarily advocate for openness about one's sexual orientation, nor would it advocate for a change in sexual orientation, but instead it would integrate the client's own values into his or her sexual orientation, thereby finding some resolution between the conflicted aspects of the client's identity. Haldeman's recommendation is supported in the findings of this study, in that a frequently cited reason for identifying as gay or lesbian was an integration of religious beliefs and sexual orientation.

The results indicate that the "desire for a 'normal' heterosexual life," including children, marriage, and families, is a common reason for seeking reorientation therapy. A therapist who is approached by a client who wishes to change his or her sexual orientation may want to be aware of this motivation and should attempt to find a way to explore alternatives to traditional marriage and family structures with his or her clients. The results also

suggest that suicidal ideation was addressed in the context of reorientation therapy, and some participants found this to be beneficial. Even if suicidality is not a result of participation in reorientation therapy, this helpful component of the therapy could be addressed within the context of an affirmative approach to sexual orientation. In their review of the literature, Haas et al. (2010) concluded that there is a large body of literature indicating LGB individuals have increased rates of suicide risk. Two participants within this study perceived a link between reorientation interventions and an increase in suicidal ideation or behaviors. If suicidality is caused or exacerbated by participating in reorientation therapy, the case for abandoning the therapy and adopting an affirmative, client-centered approach is strengthened. This is particularly important given that LGB people are presumed to already be at higher risk for suicidal ideation (Haas et al., 2010). Therapists should inquire about current and past suicidality, especially when treating clients who have been through reorientation therapy. When confronted with a client who is expressing interest in changing his or her sexual orientation, a treatment provider should be keenly aware of the potential for suicidality, as this theme occurred both in the helpful and harmful components of reorientation therapy episodes.

Future Directions

This study also points to the need for future research. There were several instances of participants reporting reorientation episodes that were helpful because these episodes involved participants' feeling supported, accepted, or hopeful or because these episodes helped to resolve family or relationship challenges and mental health issues. Future research could assess the psychological health and wellbeing of individuals with varying levels of motivation for seeking reorientation therapy in an effort to approximate the prevalence of psychological disorders and suicidality among individuals who are highly motivated to seek this form of treatment. Next, future research could examine the helpfulness of non-reorientation-focused therapies in persons who are presenting for treatment wanting to change their sexual orientation. This could evaluate whether or not the helpful components of reorientation therapy could be achieved through other means with this population and could help determine the effectiveness of affirmative, client-centered interventions in treating individuals who are highly motivated to change their sexual orientation.

Similarly, future research could build on other findings regarding the perceived harmfulness of reorientation therapy episodes. Areas of perceived harmfulness of reorientation therapy that warrant future research include the consequences of the shaming or suppression aspects of reorientation therapy, the loss of or damage to important relationships, and the delays experienced prior to coming out.

Limitations

This study has several limitations that should be noted in the interpretation of the results. First, due to the design of this study, no conclusions can be made regarding causality, and causal inferences regarding the potential benefits and potential harm experienced by persons who undergo reorientation therapy cannot be made. Longitudinal research would be required to examine the relationship between reorientation therapy and psychological functioning in a scientifically rigorous way. However, longitudinal research or a randomized controlled trial may be unethical and difficult or impossible to conduct, given that a review of the scientific evidence for sexual orientation change efforts (SOCE), which includes reorientation therapies, concluded that "enduring change to an individual's sexual orientation as a result of SOCE was unlikely. Furthermore, some participants were harmed by the interventions" (American Psychological Association, 2009, p. 54).

A second important limitation of this study involves the reliance on participants' retrospective self-reports, which may not accurately reflect behavior or experience. For some participants, reorientation therapy episodes were more than a decade prior to this study; thus, it is possible that some information that was provided was incorrect or distorted. Next, the participants for this study were self-selected volunteers, and there is no way to know if the results would generalize to individuals who were exposed to the recruitment information and decided not to participate. In addition, the measures of sexual orientation used in the study focused primarily on identity and did not include the dimensions of attraction and behavior emphasized in the definition of sexual orientation provided by Sell (1997). Given that some recent research has identified different findings when measuring sexual orientation identity, attraction, and behavior, future research with this population could incorporate a more multidimensional conceptualization of sexual orientation.

Finally, the inductive/open coding analysis (Patton, 2002) that was used to analyze the results represents a preliminary step toward developing or replicating a theoretical model meant to capture the reorientation experiences of ex-ex-gay and lesbian people. However, the results of the inductive/open coding analysis are promising, given their similarity to the results of Shidlo and Schroeder (2002) and Beckstead and Morrow (2004). Despite these limitations, this study has provided important information about the motivation for seeking reorientation therapy, the perceived helpfulness and harmfulness of reorientation therapy, and the reasoning behind identifying as LGB after treatment.

FUNDING

This research was supported by the Roy Scrivner Grant of the American Psychological Foundation. The results reported herein do not necessarily reflect the views of the American Psychological Foundation.

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Journal of Gay & Lesbian Mental Health, 15:242–259, 2011

ISSN: 1935-9705 print / 1935-9713 online
DOI: 10.1080/19359705.2010.544186

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ORIGINAL RESEARCH

Self-Reported Sexual Orientation and Identity Before and After Sexual Reorientation Therapy

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Researchers disagree on whether sexual reorientation (i.e., conversion or reparative) therapy (SRT) can change sexual orientation. Much of the recent research relies on participants from a particular religious denomination or from SRT organizations. This study recruited participants from SRT organizations and from gay-affirming ones. In this cross-sectional study, 37 former SRT participants reported no statistically significant differences in sexual orientation and sexual identity from before SRT participation to the time of their participation in this study. Practitioners with clients struggling with their sexual orientation or identity must be informed of SRT alternatives, including person-centered and gay-affirmative approaches.

KEYWORDS gay, lesbian, reorientation therapy, sexual identity, sexual orientation

INTRODUCTION

Sexual reorientation therapy (SRT), also known as conversion, ex-gay, or reparative therapy, attempts to change an individual's sexuality from same-sex oriented to opposite-sex oriented. Proponents maintain that SRT works to successfully rid individuals of unwanted same-sex desires, attractions, and behaviors (Byrd & Nicolosi, 2002). Critics see SRT as a harmful

The author wishes to thank Dr. Nancy J. Smyth, Supervisory Committee Chair, and Committee Members Drs. Howard J. Doueck, Shelly Wiechelt, Susan Kahn, and Tai Kang for their guidance on the dissertation from which this paper originated, and Justin Ulrich and Drs. Sandy Beverly, Daphne S. Cain, and Catherine M. Lemieux for comments on an earlier version.

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practice that promotes stigmatization and intolerance of gay, lesbian, and bisexual people (Jenkins & Johnston, 2004). Several major professional organizations—among them the National Association of Social Workers (2000), the American Psychological Association (2009), the American Psychiatric Association (2000), and the American Counseling Association (1998)—discourage their members from engaging in such treatments. The National Association for Research and Therapy of Homosexuality (NARTH, 2004), on the other hand, "seeks to support the many homosexual men and women who are profoundly distressed by their condition. . .and their [own] conviction that all men and women would normally be heterosexual were it not for disturbances in their early lives" (¶ 1).

The present research adds to the body of knowledge regarding SRT participants' self-reported changes or lack thereof in their sexual orientation (i.e., thoughts, feelings, behaviors) and sexual identity. Unlike most other studies on this topic, this study invited participants of any religious or nonreligious background, as well as participants from organizations not affiliated with sexual reorientation therapy and those that were. Knowledge about SRT participants' sexual orientation and identity after treatment can help practitioners choose best practices with clients struggling with, and especially those wanting to change, their same-sex thoughts, feelings, behaviors, and/or identities.

LITERATURE REVIEW

Background

SRT is not new. It has been practiced in various forms for more than a century (Murphy, 1992). Behavioral therapy attempts were popular through the mid-20th century and included systematic desensitization (Latimer, 1977; LoPiccolo, 1971), covert sensitization (Barlow & Agras, 1973; Kendrick & McCullough, 1972), and aversion techniques, such as administering electric shock and nausea-inducing drugs (McConaghy, 1969; Rhodes, 1973). Since then, SRT has been administered primarily via psychoanalysis and psychodynamic psychotherapy (Berger, 1994; Drescher, 1998; Nicolosi, 1991) and various religious interventions (Throckmorton, 2002; Yarhouse, Burkett, & Kreeft, 2002).

SRT practitioners cite respect for a client's needs, goals, values, and self-determination as justification for the practice (Benoit, 2005; Yarhouse & Throckmorton, 2002). However, numerous authors have challenged SRT, stating that it violates professional ethics, specifically competence, integrity, respect, and social responsibility (Tozer & McClanahan, 1999), and asserting that SRT clients, because they live in a heterosexist and heteronormative society, are never truly voluntary (Davison, 1976, 2005).

Recent SRT Literature

Within the past decade, two empirical studies have claimed to demonstrate the success of SRT. Four empirical studies in the same time period have claimed to demonstrate the contrary. A review of these studies is presented here. Studies whose authors characterized SRT as successful are presented here under "successful treatment"; studies whose authors characterized SRT as unsuccessful are presented under "unsuccessful treatment."

Successful Treatment

Nicolosi, Byrd, and Potts (2000) presented the retrospective self-reports of 882 SRT participants (689 men and 193 women) whom the authors identified as "dissatisfied homosexually oriented people" (p. 1077). Participants were recruited through NARTH membership lists; conversion therapists; ex-gay organizations, newsletters, and conferences; and word of mouth. All participants identified with a religious denomination, and 96% reported their religion or spirituality as very important.

Study participants rated their pretreatment sexual orientation and current sexual orientation on a 7-point scale ranging from *exclusively homosexual* to *exclusively heterosexual*. Survey results indicated that 37% of participants identified as exclusively homosexual before SRT or reorientation self-help (Nicolosi et al., 2000). At the time of the study, following SRT or self-help, 5% identified as exclusively homosexual. Conversely, only 1% identified as exclusively heterosexual before SRT or other attempts, and 16% identified as exclusively heterosexual afterward. With a chi-square probability of $<.00001$ ($\chi^2 = 201.3$), the authors characterized participants' sexual orientation changes as significant.

Perhaps the most well-known of the recent studies is that of Robert Spitzer's (2003), who advocated removing homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* in the 1970s (Bayer & Spitzer, 1982). Indeed, his study generated so much debate that the *Archives of Sexual Behavior*, which published the study, simultaneously published 26 peer commentaries, many of which contested Spitzer's methodology (see, e.g., Bancroft, 2003; Carlson, 2003; Cohen & Savin-Williams, 2003; Hartmann, 2003; Herek, 2003; Hill & DiClementi, 2003).

Spitzer's (2003) sample included 200 SRT participants (143 men and 57 women) who recognized a shift in their same-sex attraction and identity. Participants were recruited primarily from ex-gay ministries and therapists, through NARTH, and by word of mouth. Almost all (99%) identified as Christian or Jewish, and 93% felt that their religion was very or extremely important to them. Spitzer (2003) reported changes in sexual attraction and identity among participants. On a scale ranging from zero (*exclusively heterosexual*) to 100 (*exclusively homosexual*) men reported a mean score of

91 and women a mean of 88 in sexual attraction before SRT. Following SRT, men reported a mean score of 23 and women a mean of 8. Using the same scale, men exhibited a pre-SRT mean sexual identity score of 77 and women a mean of 76.5. Men exhibited a post-SRT mean score of 8.5 and among women a mean of 3. Based on these and other data from his study, Spitzer affirmed participants' claims of sexual orientation change.

These studies represent what their authors have defined as successful SRT. Four other studies, presented next in chronological order, represent what others consider unsuccessful SRT.

Unsuccessful Treatment

Schaeffer and his colleagues (Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000) sampled 248 attendees (184 men and 64 women) at the 1993–1995 annual conferences of Exodus International, a worldwide organization that promotes religion-based SRT (Exodus International, 2005). Participants were not asked to report their religious affiliation; however, Exodus International is a network of Christian ex-gay ministries, and participants responded to the survey item, "Theological beliefs influenced me to change," with a mean score of 4.66 ($SD = 0.77$) on a scale of 0 (*strongly disagree*) to 5 (*strongly agree*). Participants were, on the other hand, asked to report whether they had participated in SRT. Using ANOVA, the authors found that the main effect of therapy on the participants' sexual feelings (referred to as feeling-based sexual orientation) was statistically significant but not in the direction expected. Participants who had ever engaged in SRT experienced fewer opposite-sex sexual feelings, which the authors characterized as experiencing less heterosexuality, than did participants who had never undergone SRT. The authors dropped behavior-based sexual orientation from the analyses because many participants reported not recently engaging in same-sex sexual activity. Schaeffer et al. (2000) concluded that SRT had not been successful in changing participants' sexual orientation.

In a one-year follow-up study, Schaeffer and his colleagues (Schaeffer, Nottebaum, Smith, Dech, & Krawczyk, 1999) received completed surveys from 140 (102 men and 38 women) of the original 248 participants. Nearly two-thirds (64%) of the sample reported behavioral success over the previous 12 months, defined by the authors as abstinence from same-sex kissing, sexual touching, mutual masturbation, and intercourse, and behaviorally successful males experienced significantly more heterosexual feelings than unsuccessful males. (Females were excluded from the analysis due to low numbers in the unsuccessful female group.) However, fewer SRT participants (55.9%) were behaviorally successful than non-SRT participants (70.8%).

Shidlo and Schroeder (2002) sampled 202 former SRT participants (182 men and 20 women) on their perception of treatment success or failure

and benefit or harm caused by the intervention. Participants in this mixed-methods study were recruited through both gay-affirming and ex-gay organizations. Two-thirds (66%) of the sample identified as religious. Twenty-six participants (13%) considered SRT successful (including 8, or 4%, who identified as heterosexual), reported more opposite-sex than same-sex sexual desire, engaged in opposite-sex and no same-sex sexual behavior, and reported being in an opposite-sex intimate relationship. The authors defined these combined factors as a "heterosexual shift." The remaining 96% did not experience a heterosexual shift. A majority of participants (87%) considered SRT unsuccessful.

Beckstead and Morrow (2004) interviewed 42 Mormon conversion therapy participants (38 men and 4 women). Twenty were identified by the authors as SRT proponents (those experiencing positive results), and 22 were identified as SRT opponents (those experiencing negative results). Participants were recruited through conversion therapists, religious organizations (e.g., Evergreen), a public forum on reparative therapy, SRT and gay-affirming mailing lists, and word of mouth.

None of the SRT opponents currently identified as heterosexual, yet two of the SRT proponents identified as same-sex oriented (Beckstead & Morrow, 2004). In other words, even some proponents, those who considered their SRT experiences successful, did not identify as heterosexual. Furthermore, those who did identify as heterosexual following SRT "reported no generalized or substantial increase in heterosexual arousal and did not deny their tendency to be aroused by the same sex" (p. 681). That is, even those who identified as heterosexual following SRT were not necessarily free of same-sex arousal.

Summary

The literature does not settle the debate over SRT's effectiveness or ineffectiveness in changing one's sexual orientation and its ability or inability to maintain those changes over time. Researchers who characterized SRT as successful reported changes in participants' sexual orientation (Nicolosi et al., 2000), attraction, and identity (Spitzer, 2003) from same-sex oriented to opposite-sex oriented. Researchers who characterized SRT as unsuccessful found no evidence that SRT changed participants' sexual orientation (Schaeffer et al., 1999, 2000). They found only short-term behavioral changes (Schaeffer, 1999) and minimal (Shidlo & Schroeder, 2002) or incomplete (Beckstead & Morrow, 2004) shifts toward heterosexuality.

Unlike most of these studies, the present study sample does not consist of individuals from a particular religious denomination (Beckstead & Morrow, 2004) or those who were recruited only from religiously oriented SRT organizations or ministries (Nicolosi et al., 2000; Schaeffer et al., 1999, 2000;

Spitzer, 2003). The current study recruited participants from both change and gay-affirming organizations and welcomed those of any religious, spiritual, or nonreligious background. Furthermore, sexual orientation was measured quantitatively along three dimensions (i.e., thoughts, feelings, and behaviors) and not by participants' qualitative perceptions alone (Shidlo & Schroeder, 2002).

Research Question and Hypothesis

Given the lack of consensus in the recent reorientation empirical literature, the question remains: Are there statistically significant shifts in sexual thoughts, feelings, behaviors, and identity from before SRT to various points in time afterward, particularly among individuals from various religious/spiritual and nonreligious/nonspiritual backgrounds and recruited from organizations not associated with SRT as well as those that are? The author expects to find quantitative results equivalent to the qualitative results of Shidlo and Schroeder (2002). Shifts, if any, in sexual thoughts, feelings, behaviors, and identity from before SRT to the time of survey completion will not be statistically significant.

METHODS

Participants

This study was approved by the university's institutional review board. The sample was obtained using convenience sampling methods from a national solicitation. The author contacted 343 religious (e.g., Exodus International) or secular (e.g., counseling) organizations and individuals whose purpose was to help individuals change their same-sex sexual desires, attractions, identity, behavior, and orientation, and 333 gay-affirming organizations and individuals whose purpose was to provide support and a sense of community to lesbian, gay, bisexual, and transgender (LGBT) individuals. Exodus International (Christian interdenominational), Courage (Roman Catholic), and Transforming Congregations (United Methodist) were three primary change organizations among several that were contacted, while gay-affirming organizations included the Metropolitan Community Church (Christian denomination), the National Association of Lesbian, Gay, Bisexual and Transgender Community Centers (secular), and That All May Freely Serve (Presbyterian), an organization that promotes the full inclusion of LGBT people in the life of the Presbyterian Church.

SRT organizations and gay-affirming organizations were contacted via e-mail or postal mail and asked to distribute a study announcement among their constituents. The announcement invited persons 18 years of age or

older who currently or previously identified as lesbian, gay, bisexual (LGB), or questioning to participate in a study. More than 300 individuals completed the survey, 266 of whom were eligible to participate. Respondents who failed to provide consent or who indicated having never identified as LGB or questioning were excluded from this sample.

Of the initial sample of 266, 52 identified as having participated in SRT. Fifteen were participating in SRT at the time of the study and were thus excluded, as the purpose of the study was to assess sexual thoughts, feelings, behaviors, and identity before and after SRT. This left a final sample of 37 former SRT participants, who averaged 41.2 years of age ($SD = 11.98$) and were primarily gay (40.5%), White (73.0%), male (62.2%), college educated (62.1% with a Bachelor's degree or higher), middle class (62.1% with an income of $20,001–50,000 annually), married or partnered to the same or other sex (51.4%), and Christian (54.1%). Complete demographic data are presented in Table 1.

Measures

Absent a physiological marker, measuring sexual orientation poses a challenge to researchers who must sort through various definitions and conceptualizations. In his review of the literature on sexual orientation definition and measurement, Sell (1997) found that most definitions contain psychological and behavioral elements. Gonsiorek, Sell, and Weinrich (1995) expound on the psychological concept and define sexual orientation more specifically as comprising fantasies, affectional orientation, and behaviors, reframed here as sexual thoughts, feelings, and behaviors, respectively.

Participants completed a survey regarding their pre-SRT and current sexual thoughts, feelings, behaviors, and identity. Sexual orientation was measured along its individual dimensions of thoughts, feelings, and behaviors because, as Sell (1997) asserts, valuable information may be lost when sexual orientation is assessed as a single, unidimensional construct. Sexual thoughts, feelings, and behaviors were each captured separately using a scale adapted from the work of Kinsey and his colleagues (Kinsey, Pomeroy, & Martin, 1948). For example, sexual thoughts were assessed by respondents finishing the statement, "Are your sexual thoughts (e.g., fantasies, daydreams)," using a 7-point scale ranging from 0 (*exclusively opposite sex*) to 6 (*exclusively same sex*). Each item was asked twice, once to assess sexual thoughts, feelings, and behaviors before SRT participation and once currently. A reliability analysis based on the present sample yielded a Cronbach's alpha of .72 for pre-SRT sexual thoughts, feelings, and behaviors and .91 for current sexual thoughts, feelings, and behaviors. Sexual identity was captured using a single item consisting of six response options: *gay, lesbian*, *bisexual*, *questioning*, *heterosexual*, and *other*.

TABLE 1 Demographic Characteristics of Former Sexual Reorientation Therapy (SRT) Participants (N = 37)

Characteristic	*n* (%)	*M* (*SD*)
Pre-SRT sexual identity		
Gay	11 (29.7)	
Lesbian	4 (10.8)	
Bisexual	3 (8.19)	
Heterosexual	8 (21.6)	
Questioning	9 (24.3)	
Other	2 (5.4)	
Current sexual identity		
Gay	15 (40.5)	
Lesbian	7 (18.9)	
Bisexual	7 (18.9)	
Heterosexual	2 (5.4)	
Questioning	1 (2.7)	
Other	5 (13.5)	
Race		
Black/African Amer.	2 (5.4)	
Hispanic/Latino	2 (5.4)	
Native American	1 (2.7)	
White/European Amer.	27 (73.0)	
Biracial/Multiracial	5 (13.5)	
Sex		
Male	23 (62.2)	
Female	14 (37.8)	
Age		41.2 (11.98)
Education		
Professional/Trade cert.	1 (2.7)	
Some college	11 (29.7)	
Associate's degree	2 (5.4)	
Bachelor's degree	10 (27.0)	
Graduate degree	13 (35.1)	
Income		
<$10,000	2 (5.4)	
$10,000–20,000	4 (10.8)	
$20,001–30,000	8 (21.6)	
$30,001–40,000	8 (21.6)	
$40,001–50,000	7 (18.9)	
$50,001–60,000	4 (10.8)	
>$60,000	4 (10.8)	
Relationship Status		
Single/Not partnered	10 (27.0)	
Married/Partnered	19 (51.4)	
Divorced/No longer part.	7 (18.9)	
Other	1 (2.7)	
Religion		
Christian	20 (54.1)	
Jewish	4 (10.8)	
Spiritual	8 (21.6)	
Other	5 (13.5)	
Years since SRT		13.5 (10.58)

Note. Percentages may not total 100 due to rounding.

Procedure

The study was conducted using survey research methods and a cross-sectional design.

The study announcement asked potential participants to contact the principal investigator (PI) to request a hard copy version of the survey or the Web address to access the online version. Online completers were required to furnish their e-mail address at the end of the survey so that duplicate submissions could be tracked. Those who submitted a survey without contacting the PI first were sent an e-mail, using the address they provided in the survey, asking them to respond to verify the validity of their e-mail address. Hard copy completers were tracked by postal address. All respondents were invited to self-enroll in a random drawing at the end of the study for one of five $5 gift certificates to one of three retail stores. Twenty-nine (78.4%) of the 37 participants did so.

Data Analysis

Pre-SRT and current sexual thoughts, feelings, and behaviors were analyzed individually as continuous variables. Many of the response options of the categorical sexual identity variable were collapsed. *Gay* and *lesbian* response categories were combined to form the category *same-sex identified*, coded 0; *bisexual* remained an individual category of *bisexually identified*, coded 1; and *questioning*, *heterosexual*, and *other* were combined to form *not same-sex/bisexually identified*, coded 2. Furthermore, responses of *other* were reallocated, where possible, to specific categories. For example, the "pre-SRT sexual identity" *other* responses of "exclusively same sex attr" and "homosexual" were reallocated to the *same-sex oriented* response category. In the same manner, responses to the item "current sexual identity"—"exclusively same sex attracted," "gay, but would love a different term," "Queer," and "same gender loving"—were reallocated to *same-sex oriented*. The remaining *other* qualifier, "I don't label it," could not be definitively reallocated and was thus left in the *not same-sex oriented* category.

Variables were analyzed according to their level of measurement. Continuous variables were analyzed using Pearson's correlation and *t*-tests for dependent means, categorical variables were analyzed using Cramer's *V* and Chi-square, and relationships between categorical variables with continuous variables were analyzed using point-biserial correlation.

RESULTS

Descriptive data for pre-SRT and current sexual thoughts, feelings, behaviors, and identity are presented in Table 2. *T*-tests for dependent means were not statistically significant between pre-SRT and current sexual thoughts

TABLE 2 Pre-Sexual Reorientation Therapy (SRT) and Current Sexual Thoughts, Feelings, Behaviors, and Identity of Former SRT Participants (N = 37)

Characteristic	*n* (%)	*M* (*SD*)
Pre-SRT		
Sexual thoughts		4.92 (1.38)
Sexual feelings		4.89 (1.47)
Sexual behaviors		4.24 (2.23)
Current sexual orientation		
Sexual thoughts		4.92 (1.48)
Sexual feelings		5.03 (1.44)
Sexual behaviors		4.68 (2.27)
Pre-SRT sexual identity		
Gay/Lesbian	17 (45.9)	
Bisexual	3 (8.1)	
Quest./Hetero./Other	17 (45.9)	
Current sexual identity		
Gay/Lesbian	26 (70.3)	
Bisexual	7 (18.9)	
Quest./Hetero./Other	4 (10.8)	

Note. Sexual thoughts, feelings, and behaviors: *exclusively opposite sex* = 0; *exclusively same sex* = 6.

(t = .000, df = 36, p = 1.000), feelings (t = .589, df = 35, p = .560), or behaviors (t = .772, df = 32, p = .446). Mean pre-SRT and current sexual thoughts, feelings, and behaviors scores were between 4.24 and 5.03, more same-sex than opposite-sex oriented, indicating no significant change from before SRT to the time of survey completion. A Chi-square analysis of change in sexual identity from pre-SRT to the time of survey completion also was not statistically significant (χ^2 = 6.266, df = 4, p = .180). This suggests that sexual identity, too, did not markedly change from before SRT until the time they completed the survey.

Correlations among these variables are reported in Table 3. Pre-SRT sexual thoughts, feelings, and behaviors were significantly intercorrelated, as

TABLE 3 Correlations Among Pre-Sexual Reorientation Therapy (SRT) and Current Sexual Orientation and Identity of Former SRT Participants (N = 37)

Orientation and identity variables	1	2	3	4	5	6	7	8
1. Pre-SRT sex. thoughts								
2. Pre-SRT sex. feelings	.913**							
3. Pre-SRT sex. behaviors	.358*	.432*						
4. Current sex. thoughts	.350*	.316	*−.007*					
5. Current sex. feelings	.315	.323	*−.082*	.943**				
6, Current sex. behaviors	.159	.125	*−.115*	.760**	.800**			
7. Pre-SRT sex. identity	*−.290*	*−.234*	*−.525***	.232	.183	.161		
8. Current sex. identity	*−.140*	*−.121*	.202	*−.816***	*−.816***	*−.762***	*.291*	

Note. Coefficients in italics indicate negative values.
*$p \leq .01$, **$p \leq .001$

were current sexual thoughts, feelings, and behaviors. Pre-SRT behaviors and pre-SRT identity negatively correlated significantly, and current thoughts and feelings as well as behaviors negatively correlated significantly with current identity. Pre-SRT and current sexual thoughts significantly correlated.

DISCUSSION

This study's hypothesis, that there would be no statistically significant shifts in sexual orientation or sexual identity from before SRT to the time of survey completion, was supported. Mean sexual orientation scores from the two time periods—pre-SRT and the time of survey completion—were similar, demonstrating no statistically significant change in sexual orientation (i.e., sexual thoughts, feelings, and behaviors). Similarly, no statistically significant change between pre-SRT and current sexual identity was found following a Chi-square analysis.

Change may have occurred during or following SRT, but it appears they were not maintained. Therefore, it cannot be stated that statistically significant change *never* occurred during or following SRT; rather, statistically significant change was not found using the current study's cross-sectional design. A finding of no statistically significant change in sexual identity suggests that 1) participants retained their identity throughout SRT and beyond; 2) their identity changed only slightly, for example, from bisexual to gay or from questioning to heterosexual; or 3) they reverted back to their pre-SRT identity if they had, in fact, experienced a change during or soon after SRT. Thus, the hypothesis that shifts in sexual thoughts, feelings, behaviors, and identity from before SRT to the time of survey completion will not be statistically significant is supported in the sense that any shifts that may have occurred were not maintained.

A statistically significant correlation between pre-SRT sexual behaviors and pre-SRT sexual identity and between current sexual behaviors and current sexual identity represents congruency, at each time period, between participants' sexual behaviors and their sexual identity. That is, participants' sexual behaviors matched their sexual identity and did so at both time periods: before their participation in SRT and again after their termination of SRT. For example, an individual who was engaging in same-sex sexual behaviors was also identifying as gay or lesbian. This may mean that same-sex-oriented participants, for example, are in the later rather than earlier stages of their sexual identity development. In her six-stage model of sexual identity development, Cass (1979) described the early stages of development as ones of identity confusion (stage one) and identity comparison (stage two). In these stages, an individual begins to recognize his or her same-sex sexual thoughts, feelings, and behaviors as incongruent with his or her identity as a heterosexual person. In later stages, identity pride (stage five) and identity synthesis (stage 6), the individual has integrated his or her same-sex sexual

thoughts, feelings, and behaviors with his or her identity as a gay man or lesbian into a congruent whole.

Not surprisingly, statistically significant negative correlations did not exist between pre-SRT and current sexual feelings, behavior, or identity. According to the data, study participants reported sexual thoughts, feelings, and behaviors in the range of predominantly same-sex before and after SRT, rather than before but not after SRT, which would have been expected following successful treatment.

Only pre-SRT and current sexual thoughts were positively significantly correlated. That is, unlike subtle shifts from pre-SRT sexual feelings, behaviors, and identity, sexual thoughts experienced no shift from before SRT to after. This finding suggests an enduring pattern of sexual thoughts despite time and intervention. Unlike pre-SRT and current sexual thoughts, surprisingly, sexual feelings, behaviors, and identity were not positively significantly correlated from before SRT to after. In the absence of change, pre-SRT orientation scores should have matched current orientation scores, and pre-SRT identity should have matched current identity. However, there are at least two reasons that may explain why this did not occur. First, pre-SRT thoughts, feelings, and behaviors scores do not completely covary with current thoughts, feelings, and behaviors scores. Current scores were higher than pre-SRT scores, meaning that participants' sexual thoughts, feelings, and behaviors were even more same-sex oriented than they were before SRT. Second, a chi-square analysis yielded no significant change between pre-SRT and current sexual identities, yet identities changed just enough to yield a nonsignificant correlation coefficient, indicating that identities were not entirely the same before SRT and at the time of the survey. It is apparent that some change did occur. Indeed, 13 people who identified as questioning, heterosexual, or other prior to SRT were now identifying as gay, lesbian, or bisexual at the time of the survey. Not only had SRT not changed participants' sexual identity to heterosexual, but also the number of participants identifying as gay, lesbian, or bisexual had increased.

That no statistically significant differences were found between pre-SRT and current sexual orientation and between pre-SRT and current sexual identity supports similar previous findings (e.g., Johnston & Jenkins, 2006; Schaeffer et al., 2000) and stands in contrast with still others that claim to have demonstrated change (e.g., Byrd, Nicolosi, & Potts, 2008; Nicolosi et al., 2000; Spitzer, 2003). However, some findings of change are subject to definitional limitations, as there is no definitive marker for sexual orientation. Some authors may narrow the definition of sexual orientation or fail to accurately distinguish between homosexuality and bisexuality. For example, some proponents equate behavioral changes alone to a shift in sexual orientation or misattribute repression of nondominant same-sex thoughts, feelings, and behaviors to sexual identity or orientation change (Parelli, 2007). Others define orientation by "impulses and fantasies" (Throckmorton, 2002, p. 243). In the present study, sexual orientation was defined by sexual

thoughts, feelings, and behaviors, and identity encompassed the spectrum of gay, lesbian, bisexual, heterosexual, questioning, and other.

Limitations

LGB people are a difficult population to find, ex-gay people perhaps even more so, which makes random sampling impossible (Mark, 1996). The purposive and snowball sampling methods used in this study render the findings not generalizable beyond the current sample. Furthermore, the sample represents a self-selection bias because these individuals voluntarily responded to a call for study participants. It is impossible to know how the current sample differs from SRT consumers who chose not to participate in the study, a population that may have had very different SRT experiences.

Retrospective self-reports are subject to recall fallibility, meaning there may be inaccuracies in the responses given by an unknown portion of the sample. Study participants were asked to remember their sexual thoughts, feelings, behaviors, and identities from an average of more than 10 years earlier. How the participants remembered their pre-SRT selves, how they wanted to perceive themselves now, and how they felt about SRT and their experience as SRT consumers may have skewed participants' responses. However, as other authors have noted in their own similar work (Spitzer, 2003), this particular study design was the most feasible at the present time.

Lacking an objective measure of sexual orientation leaves only subjective measures as options. The subjective self-report method used in this study is susceptible to unintentional and intentional inaccuracy in reporting. Unintentional inaccuracy may stem from participants misunderstanding survey items or incorrectly recalling prior experiences. Intentional inaccuracy may result from participants' investment in treatment outcome. For example, those who were invested in SRT's success but experienced no change may have reported their current sexual thoughts, feelings, and behaviors as more opposite-sex oriented than they really are in an attempt to fulfill their desires of perceiving themselves as heterosexual. Likewise, those who have negative feelings toward SRT may report their current sexual thoughts, feelings, and behaviors as more same-sex oriented in an attempt to demonstrate little to no shift.

Despite these limitations, this study does lend valuable insight into SRT, a concerning clinical practice that has a limited empirical base.

Clinical Implications

This research adds to the body of knowledge that contests the validity of SRT and its ability to change sexual orientation. When encountering clients

seeking to change their same-sex sexual thoughts, feelings, behaviors, or identity, clinicians should avoid interventions such as SRT that pathologize same-sex sexuality. Clinicians also should steer clear of practices denounced by organizations representing the mental health professions, including the National Association of Social Workers (2000), the American Psychological Association (2009), the American Psychiatric Association (2000), and the American Counseling Association (1998). Clinicians are cautioned against utilizing treatment techniques, including SRT, that have not been consistently shown to be effective. Instead, mental health professionals might consider investigating the client's desire to change his or her same-sex thoughts, feelings, behaviors, or identity. If, as Davison (1976, 2005) asserts, there is no such person as a voluntary SRT participant, a client's desire to change might lie in his or her internalization of society's negative messages regarding same-sex sexuality and gay and lesbian people.

SRT's goal is to help the client control or "overcome" his or her same-sex sexual thoughts, feelings, or behaviors (Nicolosi, 1991; Yarhouse & Burkett, 2002) and, as some proponents assert, eventually identify as heterosexual (Nicolosi et al., 2000; Spitzer, 2003) or at least become celibate (Courage, 2000; Yarhouse & Burkett, 2002). However, definitions of success are often vague or broad (Yarhouse et al., 2002). Gay-affirmative practice, on the other hand, supports the struggling or questioning client by challenging the negative messages about same-sex sexuality he or she undoubtedly received and likely internalized (Hunter, Shannon, Knox, & Martin, 1998; Malyon, 1982; Morrow & Beckstead, 2004; Tozer & McClanahan, 1999). For gay men for whom neither SRT nor gay-affirmative therapy fits, Haldeman (2004) proposes a person-centered approach. This model lets the same-sex attracted man with a strong religious orientation work through his struggle of reconciling these two seemingly incompatible identities.

Several resources exist to assist the clinician with becoming more knowledgeable about gay affirmative practice. Clinicians may wish to assess their own competence and efficacy with LGB clients by completing the *Gay Affirmative Practice Scale* (Crisp, 2006) or the *Lesbian, Gay and Bisexual Affirmative Counseling Self-Efficacy Inventory* (Dillon & Worthington, 2003). For a quick tutorial on gay affirmative counseling, Granello (2004) presents a workshop outline for introducing new counselors to affirmative practice. For more in-depth information, the reader is referred to the works of Chernin and Johnson (2003), Hunter and Hickerson (2003), Kort (2008), and Ritter and Terndrup (2001). Lastly, gay affirmative practice has been indicated for use with specific groups within the LGBT populations including, but not limited to, bisexual men and women (Fox, 2006), transgender people (Korell & Lorah, 2007), LGB youth (Crisp & McCave, 2007), and older LGBT people (Hunter, 2005).

Future Research

Retrospective recall is not an ideal method of data collection. Instead, SRT research participants should be surveyed immediately prior to beginning therapy. However, finding this population is difficult. Another option might be to more broadly sample individuals struggling with their sexuality and follow them over time, in the event that they eventually engage in SRT. These and other, alternative recruiting and data collection strategies must be considered in future research.

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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-

Adopted by the American Psychological Association Council of Representatives on August 5, 2009.
For more information, please see **www.apa.org/pi/lgbt**.

PLEASE CITE AS:

Anton, B. S. (2010). Proceedings of the American Psychological Association for the legislative year 2009: Minutes of the annual meeting of the Council of Representatives and minutes of the meetings of the Board of Directors. *American Psychologist, 65*, 385–475. doi:10.1037/a0019553

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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Therapeutic Antidotes: Helping Gay and Bisexual Men Recover from Conversion Therapies

Douglas C. Haldeman, PhD

SUMMARY. Studies of sexual orientation conversion therapies have focused on the efficacy, or lack thereof, of treatments designed to change sexual orientation. Recently, given the typically low success rate achieved in most conversion therapy studies, some researchers have examined the potential for such treatments to harm patients. It is the author's impression, after twenty years' clinical work with individuals who have undergone some form of conversion therapy, that these treatments can indeed be harmful. This article identifies the various problems commonly presented by patients following an unsuccessful therapeutic attempt to change sexual orientation. Such problems include poor self-esteem and depression, social withdrawal, and sexual dysfunction. Case material illustrates these concerns, and therapeutic approaches to address them are suggested. Directions for future study are identified.

KEYWORDS. Gay and bisexual men, homosexuality, conversion therapy, reparative therapy

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[Haworth co-indexing entry note]: "Therapeutic Antidotes: Helping Gay and Bisexual Men Recover from Conversion Therapies." Haldeman, Douglas C. Co-published simultaneously in *Journal of Gay & Lesbian Psychotherapy* (The Haworth Medical Press, an imprint of The Haworth Press, Inc.) Vol. 5, No. 3/4, 2001, pp. 117-130; and: *Sexual Conversion Therapy: Ethical, Clinical and Research Perspectives* (ed: Ariel Shidlo, Michael Schroeder, and Jack Drescher) The Haworth Medical Press, an imprint of The Haworth Press, Inc., 2001, pp. 117-130. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: getinfo@haworthpressinc.com].

To date, the controversy over conversion therapies has focused almost exclusively on the question of whether or not they are effective. Only recently has the potential harm to patients of such treatments been considered (Shidlo and Schroeder, 1999). It is the author's impression, after twenty years' clinical work with individuals who have undergone some form of conversion therapy, that these treatments can indeed be harmful. The present discussion will consider common negative psychological *sequelae* of conversion therapies and suggest therapeutic remedies.

In 1998, the American Psychiatric Association adopted a resolution rejecting therapies based upon the premise that homosexuality is a mental disorder (American Psychiatric Association, 2000). This resolution notes that treatment for homosexuality is most often provided to people who have been adversely affected in some way by their culture or society, and that such treatments put some people at risk for a variety of emotional problems. The American Psychological Association (1998) adopted a policy on conversion therapy in 1997, which reaffirms the view that homosexuality is not a treatable mental illness. The resolution further opposes portrayals of lesbians, gay and bisexual men as mentally ill due to their sexual orientation, and reminds the practitioner of the numerous ethical principles related to the treatment of sexual orientation.

In addition, the American Psychological Association recently adopted practice guidelines for practitioners working with lesbian, gay and bisexual clients (American Psychological Association, 2000). One guideline in particular, "Psychologists strive to understand how inaccurate or prejudicial views of homosexuality or bisexuality may affect the client's presentation in treatment and the therapeutic process," offers empirically based suggestions for how a therapist might deal with a client whose discomfort with his/her sexual orientation is so severe that he or she wishes to change it. The policies of these professional associations support the rights of lesbian, gay and bisexual psychotherapy clients to respectful treatment that is not based on the disproved theory that homosexuality is a treatable disorder. Although these policies allude to the possibility that some patients will be harmed by attempts to convert their sexual orientation, they do not specify the nature of the potential concerns. The following discussion will therefore examine the issues commonly faced by individuals who have had adverse experiences in conversion therapy.

THE POTENTIAL HARMS OF CONVERSION THERAPY

The professional literature has examined the theoretical and empirical bases of conversion therapy (Drescher, 1998; Haldeman, 1994; Stein, 1996; Tozer and McClanahan, 1999). Theoretical discussions in the conversion therapy literature have included speculations as to what might cause a homosexual orien-

tation, inevitably with the underlying assumption being that homosexuality is pathological. Usually, some variant of the "distant or absent father and over-intimate mother" configuration is blamed for causing men to become gay.[1] Such studies generally examine outcomes after a conversion treatment procedure of one sort or another; these have historically included behavioral (including aversive therapy), cognitive and psychodynamic interventions. These studies are characterized by serious methodological flaws that render them difficult to interpret, and make it impossible to generalize from them. The most common flaws include subject selection and classification, defining what constitutes change of sexual orientation, the effects of response bias in self-report, and what follow-up is conducted to assess the stability of treatment effects. These methodological problems have been noted and assessed by several reviewers (Haldeman, 1994; Stein, 1996; Tozer and McClanahan, 1999).

Even the most enthusiastic of conversion therapists claim roughly a 30% "success" rate (Haldeman, 1999). This low frequency is typically explained by the fact that sexual orientation is very difficult to change. Where others might consider a 30% success rate as less than optimal, in the domain of conversion therapy it is the accepted standard. The apparent lack of concern on the part of conversion therapists regarding their treatment "failures" is significant. Only recently, for example, has the obvious question been raised, "What about the other 70%?" (Shidlo and Schroeder, 1999). Given the tremendous psychological implications of trying to change something as profound and complex as sexual orientation, it might be reasonable to wonder if any harm results in the vast majority of individuals who do not successfully change in these treatments. That possibility has not been addressed, and is even ignored by conversion therapists who, because of a strong anti-gay bias, see any chance at changing unwanted homosexual or bisexual orientation as being worth whatever risks might be involved.

What follows are the author's impressions of those risks, based on twenty years of clinical practice with individuals who have been through a variety of efforts to change their sexual orientation. Typical adverse responses have been thematically grouped according to the clinical issues most often presented by the treatment failures of conversion therapies. It should be noted that although these observations are not systematically derived, they do convey common clinical presentations of individuals who feel they have been harmed by conversion therapies. Clearly, all of the potential outcomes of conversion therapy need to be further documented and assessed.

The term "reparative therapy" has often been used interchangeably with conversion therapy. The term "reparative therapy," however, supports an inaccurate theoretical construct, namely, that homosexuality and bisexuality are a form of "brokenness." Therefore, the term "conversion therapy" is used here. It should be further noted that there is no universal response to the experience

of having undergone a conversion therapy. Individuals' reactions may depend upon a variety of factors: their own constitutional resilience, the level of "invasiveness" of the treatment they have undergone, and the relative degree of social support, or lack thereof, that they enjoy. Not all individuals appear to be harmed by conversion therapy. It is not uncommon, in fact, for some to report that a failed attempt at conversion therapy had an odd, indirectly beneficial effect. This effect can be described as an individual's final "letting go" of the denial surrounding his sexual orientation. One patient stated, in reference to his experience in an ex-gay Christian counseling group, "I finally 'got' it. There was nothing else I could do and nowhere else to turn, so I figured I'd better get on with my life as a gay man."

Unfortunately, this is not everyone's experience. For many, a failed attempt–or a series of failed attempts–at conversion therapy signals an ending, not a beginning. The hope of conforming to social expectations of family, culture and church comes to an end with a failed attempt to change sexual orientation. With the end of this hope comes a host of potential losses: expulsion from family, loss of position in society, rejection from familiar institutions, loss of opportunities to raise children, loss of faith and community, and vulnerability to anti-gay prejudice. Combined with the difficulty that many "ex-ex-gay" individuals have integrating themselves into the gay community, the period following "unsuccessful" conversion therapy can be fraught with emotional issues. Generally, these include depression and guilt related to multiple losses, intimacy avoidance, sexual dysfunction, and religious and spiritual concerns. These issues can be overlapping in nature, and an individual may experience one, several, or all of them. They will be described in greater detail with brief case material, followed by suggestions for how therapists can address them clinically.

DEPRESSION RELATED TO LOSS

When asked why he attempted to change his sexual orientation–several times in individual therapy and in spiritually based prayer groups as well–Dan answered: "I just felt it wasn't *me* to be gay." When pressed further, he explained that he saw nothing wrong for others to be gay, but that it was incongruent with a picture he had of himself that included having a wife and children. Elaborating on this picture, he described a life in which he enjoyed support from his family and church community as a heterosexual, married man with children. Now, having been unable to make this fantasy a reality, he reported feeling very depressed, guilty and hopeless. He feared that the dream of support from his family would never come true if he were to live openly as a gay man; furthermore, he believed that he would no longer be able to partici-

pate in the church community that had been the mainstay of his social world since early childhood.

Conversion therapy alone did not induce Dan's depression. Rather, the failure of the treatment signaled to the client what he likely felt all along: that the social benefits derived from his family and community would require him to engage in a lifelong masquerade to hide his homosexual orientation. The fact that Dan now realizes the impossibility of this situation, however, makes it no less painful to relinquish. His future, which was once founded on a desired image of himself that would become possible with a successful course of conversion therapy, is now in doubt. He is letting go of the fantasy that he would somehow overcome a significant element in his identity in order to take his place in society, but as yet has nothing with which to replace it. He has no sense of connection to the gay community; on the contrary, he is afraid of what he perceives as its strangeness, and has difficulty conceptualizing himself as part of it. In general, he is plagued by guilt, and his self-esteem is contaminated with feelings of failure.

These significant losses require grief work. The feelings associated with these losses cannot be dispelled with optimistic encouragement to come out, be proud, find a partner and adapt to life in the gay community. Dan's first task is to acknowledge the pain associated with the losses he has suffered, and to begin neutralizing the toxic effects of the shame and guilt he has internalized. In so doing, he begins the process of disengaging what he will come to experience as his true self from the numerous expectations that have been placed on him. Part of the neutralization of shame takes place by examining a self that has been firmly embedded in a sociocultural environment that did not value the self for who it was, but that required it to change (or hide) in order to be acceptable. Ultimately this is not a problem of the self, but of the social environment. The environment, imbued with such powerful attributes as love, acceptance and potential for success, and the threat of eternal damnation, seemed implacable. Ultimately, however, one lesson of a failed conversion treatment is that life must be lived for the self, not for the environment.

In further assessing a depression related to loss, it is important to inquire specifically about what the client has learned about sexual orientation in conversion therapy. It is not uncommon for clients to need re-education, because conversion therapists have either convinced them that homosexuality is a state of arrested psychological development or a moral insufficiency. Initial research in this area (Shidlo and Schroeder, 1999) suggests that many clients in conversion therapy report that their therapists presented them with distorted information about homosexuality. This misinformation can only serve to intensify whatever guilt the client is already feeling. If there are inaccurate beliefs about sexual orientation that linger, they need to be examined and challenged. Shidlo and Schroeder (1999) also note that a significant number of

conversion therapy clients report having lied to their therapists in order to please them. It is important to reinforce the notion that post-conversion therapy treatment does not require the client to switch to a pro-gay perspective. Although he will probably be experiencing ambivalence about his sexual identity, the ambivalence need not be hidden to please the gay-affirmative therapist. It should be treated as a welcome element in the treatment.

Gonsiorek and Rudolph (1991) propose a model of gay identity development that is useful in working with men who have just come out. This model is particularly useful for individuals who have recently abandoned conversion therapy, but as yet have a limited frame of reference for what it might mean, both psychologically and socially, to be gay. The model draws parallels with Kohut's self-psychology theories of childhood psychosocial development. According to Gonsiorek and Rudolph, the first stage of gay identity development involves an exploration of one's own narcissism. The gay man seeks encouragement simply to "be" himself, and as he is ready, avails himself of environments that provide support, encouragement and connection. Often, those who have struggled with conversion therapy have avoided the company of other gay men, save for impersonal sexual encounters. When the time is right, clients who are in the first stages of distress over identity disruption can benefit from being in the company of others who can reflect the new (gay) aspect of identity in a positive way.

An important concern with clients like Dan involves the individual's emotional state. It is important not to minimize the impact that the multiple losses of family and self-concept can have; some clients experience depression to the point of feeling suicidal. Suicidal clients should be offered the resources needed to keep them safe–including psychiatric consultation or hospitalization, if necessary. For more stable clients, it is important, in a gentle way, to offer resources through which the individual can inform him or herself about sexual orientation. In addition to a number of excellent self-help and workbooks available for newly out individuals (Alexander, 1997; Clark, 1997; Hardin, 1999; Signorile, 1996) there are resources on the Internet and support groups that meet in most medium-sized cities. In some cases, the treatment with clients such as Dan may amount to ego reconstruction.

INTIMACY AVOIDANCE

Intimacy issues are often of central importance in psychotherapy with gay men (Alexander, 1997; Haldeman, 2001). This can be especially true for clients who have undergone conversion therapy. Paul came to therapy following a lengthy, traditional "talk-therapy" format of conversion treatment that relied heavily on cognitive-behavioral interventions. Part of this therapy involved

exercises in assertive behavior toward women and heterosexual dating. Paul reported that he realized, after many unsuccessful attempts at heterosexual relating, that he was "undeniably gay" and terminated treatment. In the time that followed, he believed that he had resolved all of the shame and self-recrimination he had experienced about being gay. However, he reported a pattern of difficulty in developing long-term relationships, which he attributed to a pattern of seeking out either unavailable or unsuitable people. Paul did not, however, connect this pattern to his experiences in conversion therapy.

Therapy with Paul revealed that his primary beliefs about himself as a gay man were not as settled as he had thought. Although he generally endorsed the belief that as a gay man he was entitled to satisfying, functional interpersonal relationships, he acknowledged that he still harbored a certain degree of critical judgment against himself for being gay. In theory, Paul reported, it was acceptable to be gay, but coming out tapped into a significant level of his internalized homophobia. This resulted in a pattern of seeking out unavailable men, or focusing on men to whom he was not particularly attracted, and then quickly losing interest in the relationship.[2]

The pattern of sequential, unstable attachments in same-sex relationships appears to be rooted in Paul's lack of acceptance of himself as a gay man. This lack of acceptance, and the implications thereof, need to be examined and understood before Paul will be able to participate fully in a primary relationship with another man. Furthermore, the adverse effects of Paul's conversion therapy experiences need to be understood. His efforts at heterosexual dating stemmed from a neurotic need to please his therapist, as well as his having adopted the belief that his value as a man was rooted in his success at dating women. The conversion therapy, which used the transference as the fulcrum on which heterosexual orientation ultimately develops, is responsible for Paul's intimacy dysfunction. Instead of achieving a heterosexual shift, Paul became doubly shamed at his gayness, as well as his failure at becoming a "real" man because of his inability to date women.

Conversion therapies typically rely on the therapeutic relationship to catalyze a shift in sexual orientation. The client is expected to identify with the male therapist, to bond with him emotionally, and to delight in his approval when the client is able to develop heterosexual relationships. When the process fails, the potential for harm is significant. The failure at heterosexual dating, once admitted, did not leave Paul an enthusiastic and self-affirming gay man. Rather, the awkwardness he felt in response to his failed attempts at heterosexual dating has been resurrected in his life as a gay man. Paul's homoerotic feelings trigger conflict between his natural arousal and the conversion therapy-induced overlay of shame. To correct this, appropriate risk-taking and careful exploration of the feelings associated with intimacy with another man set Paul on a path of interpersonal relating that was right for him.

Paul's case illustrates the second stage of Gonsiorek and Rudolph's model of gay identity development. In this stage, the individual has progressed through the narcissistic stage and is ready to internalize the values and beliefs of the (gay) community around him. Such values and beliefs that might be applicable to Paul have to do with the understanding that gay identity can be expressed in relationships, both affiliative and romantic, and that both kinds of relationships are positive and necessary enhancements for a fulfilling life.

SEXUAL DYSFUNCTION

Jim came to therapy having undergone one of the more brutal and psychologically invasive forms of conversion therapy: electric shock treatments. While still in college, Jim had agreed to aversive treatment for homosexuality on the advice of a leader in his church. This leader explained to Jim that unless he eradicated his homosexuality, not only he, but his entire family would be barred from heaven. A devoted son and brother, these words had such a strong impact on Jim that he agreed to undergo this treatment. As part of his therapy, he was instructed to visit pornographic bookshops and select homoerotic material that he found particularly arousing. During treatment sessions, Jim would view the pictures while an electric shock was simultaneously delivered to his hands and genitals. The cessation of the shock would be accompanied by heteroerotic material. The goal of this method was to extinguish homoerotic responses, and replace them with heteroerotic ones.

This treatment was not successful in changing Jim's sexual orientation. It did, however, leave him extremely confused and conflicted about his natural homoerotic feelings. When the conversion therapy failed, Jim finally acknowledged his homosexuality to his family who promptly disowned him. He moved to a large city, where he worked as a model. He tried unsuccessfully, with a number of individuals, to establish a loving relationship, but was troubled by chronic erectile dysfunction. These were the days before Viagra, and Jim was rarely able to sustain an erection. For him, sexual arousal was associated with an aversive experience. Additionally, he had deeply rooted shame related to his sexual response, partly as a result of his culture, and partly having been reinforced by his conversion therapy. His newfound cognitive recognition that it was permissible for to love another man paled in contrast to the firmly established sense of shame about his gayness, reinforced by conversion therapy. As a result, his new relationships were invariably affected by impotence. As the problem progressed, Jim started avoiding sex altogether.

Jim's situation is not uncommon among survivors of conversion therapies, although those who have been through aversive treatments seem to be especially vulnerable to sexual dysfunction. This may be due to the fact that

aversive treatments affect the individual on a physical as well as a mental level, and the body responds in kind by manifesting ambivalence about sexual expression. The stress associated with sexual difficulties is often exacerbated by the sometimes hypersexual climate of the gay male community. Frequently, conversion therapy refugees who struggle with sexual concerns avoid potentially romantic or sexual situations and become socially isolated.

Sex therapy resources for practitioners working with gay men are somewhat limited, since most of the sex therapy literature is written by and for heterosexuals. However, work with clients whose sexual functioning concerns are in part attributable to a conversion therapy history is aided by the use of exercises that are equally applicable to gay, bisexual or heterosexual men (cf. Zilbergeld, 1994). These exercises vary depending upon the condition to be addressed. Typically, the sexual concerns of gay men who have been in conversion treatments include arousal problems or ejaculatory competence. The former can be successfully treated with sensate focus and relaxation exercises. The latter are often treated with the use of autoerotic exercises that gradually involve the introduction and participation of the partner. This assumes, of course, that a partner is available for practice, which is often not the case. Sexual concerns are partly caused by sex-negative attitudes, reoccurrence of the problem, and shame. Successful treatment of psychogenic sexual dysfunction requires that the attitudes and feelings surrounding sexual interaction be considered.

DE-MASCULINIZATION

Many conversion therapy models conceptualize homosexuality as an arrest in normative psychosexual development due, in part, to an inadequate identification with the same-sex parent. In order to correct this hypothetical defect, conversion therapists often rely on therapeutic transference to replicate the paternal attachment. Additionally, some conversion therapists encourage their clients to engage in a variety of "male bonding" activities, including attending and participating in sporting events, or visiting social venues for heterosexual men. In these conversion therapies, the desired shift to heterosexuality is strongly connected to stereotypically male social activities. For those who discontinue their conversion therapy, there can be an accompanying sense of lost masculinity. The client equates his failure at heterosexuality with failed manhood.

For a gay man, a sense of male identity is important, given that his affiliative and romantic relationships will be with other men (Haldeman, 2001). Some men feel de-masculinized after abandoning conversion therapy. This, in turn, has an adverse effect on self-concept and relationships with

other men. Post-conversion therapy treatment often includes an assessment of the degree to which the individual's sense of "maleness" is intact. This means reinforcing the legitimacy of their decision to abandon conversion therapy. Furthermore, it may mean supporting them in developing a male identity consistent with their own sense of self. For some, this may still mean playing basketball, going fishing, or watching the Super Bowl. Conversely, it may mean engaging in stereotypically female pursuits, and yet not feeling less masculine. One's gender identity is the unique right and responsibility of the individual to define. It may rely upon conformity to stereotypical gender roles only to the extent that this matters to the individual.

SPIRITUALITY AND RELIGION

Without question, the single most difficult area to be navigated with many clients following conversion therapy is that of spirituality and religion. This is in part due to the fact that deeply held religious and spiritual beliefs can be as important an aspect of the self as sexual orientation. The reasons for this importance may be varied and complicated, but many individuals' religious beliefs and experience serve as a primary rudder in an otherwise anxiety-provoking, amorphous existence. Religion can be associated with comfort, structure, and the nurturing of family. As mentioned before, these are significant losses to contemplate. When religion and sexuality are in conflict, a tremendous obstacle to integration of the self is created. For most individuals, the very reason they sought out conversion therapy in the first place is related to their religious beliefs. The failure of conversion treatment does not necessarily dissipate the strength of the religious feelings, or provide an easy mechanism for reconciling them with sexual orientation.

Bill came to therapy seeking to reconcile his religious beliefs with his sexual orientation. After a series of ex-gay ministry experiences, he began to entertain the notion that perhaps he was intended to be gay, and that he should adopt a more accepting attitude toward himself. As soon as he abandoned his efforts to become heterosexual, Bill reported feeling an enormous sense of relief, and a deep spiritual conviction that he had taken the correct path. At the same time, he found that it was difficult to integrate his spiritual self with others in the gay community. He remarked that the challenges associated with yet another "coming out" process, of being a gay man with strong religious beliefs, was surprisingly difficult. One main reason for this is that the influence of organized religion as an oppressive force in the lives of gay, lesbian and bisexual people is without institutional parallel. Many mainstream religious denominations still preach that homosexuality is a sin, or at least that celibacy is a prerequisite for welcoming lesbians and gay men in their congregations. Many

denominations still forbid the ordination of openly gay or lesbian clergy. These prohibitions are frequently used by persons who seek to justify their prejudice against lesbian, gay and bisexual individuals. For this reason, many lesbian, gay and bisexual people see organized religion in a negative light.

Nonetheless, Bill pursued avenues within the gay community where he could be both openly gay and a person of faith. At present, there are a number of gay-specific congregations and houses of worship, as well as numerous mainstream denomination "reconciling congregations" that welcome lesbian, gay and bisexual people and affirm their spiritual needs. After having found a home in one such congregation, Bill was much better able to integrate these historically conflicted, but important, aspects of his self.

This illustrates the third and final stage of Gonsiorek and Rudolph's model of gay identity development. Following the establishment of an integrated self, including positive introjects from the community, the gay person enters the "idealized" sector. In this stage, the gay person is "one among many," whose sense of self is maximized by a connection to others. In this regard, significant others and the community itself serve a surrogate familial function, offering the individual a context for both comfort and contribution.

Not all internal conflicts between religion and sexuality end with a successful integration, however. Clients whose strongly held religious beliefs cannot be adapted to fit the emerging understanding of the (gay) self are those most likely to abandon gay-affirmative treatment and return to conversion therapy. For some, the power of familial rejection and religious condemnation, coupled with the possibility of a poor connection with the gay community, is simply too much to overcome. While the majority of lesbian and gay individuals who come from unaccepting religious backgrounds appear able to separate from their histories, and if need be, their families of origin, in a healthy way, this is not the case for all.

CONCLUSION

Public campaigns promoting conversion therapy harm gay, lesbian and bisexual people by distorting the truth about sexual orientation, and fueling prejudice (Haldeman, 1999; Kahn, 1998). The relationship between the religious political activists whose "purpose (is) to strike at the assumption that homosexuality is an immutable trait" (Hicks, 1999) and the groups promoting conversion treatments has been documented. The publicity surrounding "cures" of homosexuals is intended to influence public opinion that homosexuality can be changed, and that gay men and lesbians should not receive anti-discrimination protection in housing and employment, and that "sexual orientation" should be excluded as a category in legislation against hate crimes.[3] The offer-

ing of conversion therapists by antihomosexual religious conservatives is therefore a significant element in reinforcing social stigma against homosexuality.

In contrast to the social harms of conversion therapy, activists and professionals alike have paid less attention to the potential adverse consequences of conversion therapy to the individual. The present discussion is a cursory examination of issues common to individuals who have undergone some form of conversion therapy, and highlights those concerns that deserve further, systematic study. Each case is unique, and the cases mentioned here are intended to offer the clinician a perspective on the kinds of issues that are frequently presented by clients, as well as some considerations as to how they might be addressed therapeutically. The issues of depression and poor self-image, relationship and intimacy avoidance, sexuality and spirituality are certainly not exhaustive. Research in this area will undoubtedly expand and refine this list.

It is important, however, to document that conversion therapy practices can have adverse consequences–some very serious–on numerous individuals. These range in severity from poor self-esteem, to chronic unhappiness in relationships and up to suicide. This is not to suggest that all conversion therapies are harmful, or that the mental health professions should try to stop them. It must be remembered, however, that a client's request to change sexual orientation is fraught with socially driven implications. Such a request should not be met with reflexive agreement on the part of the therapist, but should be carefully questioned and examined.

As long as antihomosexual elements persist in our culture and our social institutions, there will be frightened, unhappy individuals seeking conversion therapy. The time has come for the research in this area to shift from the question, "Does it work?"–a question that has been answered many times. The more important research questions that are finally being addressed are, "Why did you attempt a conversion therapy in the first place?" "Did it help you?" should be accompanied by, "Did it hurt you?" (Shidlo and Schroeder, 1999). For years, critics of conversion therapy have maintained that these treatments do not change sexual orientation. For the sake of the clients who have been harmed, it is time to learn more about what the effects of conversion therapy truly are.

NOTES

1. The neglect of lesbians in the conversion literature suggests that they are of less concern to these theorists.

2. Paul's case raises another issue that has not been addressed in the conversion therapy literature. As part of their treatment, clients in conversion therapy are frequently

encouraged to date members of the opposite sex. What are the appropriate procedures for disclosure in this regard? What responsibilities does the conversion therapy client bear toward the opposite-sex partners who are serving as therapy homework? These issues are absent from the conversion therapy literature, yet the ex-girlfriends, ex-wives and children of such failed "experiments" constitute a significant element of the conversion therapy equation. Their needs, particularly when the relationships they thought were likely to last fail because of a partner's undisclosed homosexuality, deserve attention in this discussion.

3. Antigay forces call attempts to gain such protections the "special rights" argument.

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Ethical Issues in Sexual Orientation Conversion Therapies: An Empirical Study of Consumers

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SUMMARY. This study uses interviews with 150 consumers of sexual orientation conversion therapies to identify critical incidents of poor practice and ethical violations. We found that some licensed conversion therapists may be practicing in a manner inconsistent with the APA Ethics Code, similar professional codes, and recent guidelines on treatment of lesbians and gay men. Areas of ethical violations identified include: informed consent, confidentiality, coercion, pre-termination counseling, and provision of referrals after treatment failure.

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The authors wish to thank Jim Jasper for his invaluable editorial help with this article, Huso Yi, MA for his untiring help as their research assistant, and Michael Radkowsky, PsyD and Paula Solon, PhD for their help with interviewing.

This study was supported by a grant from the H. van Ameringen Foundation.

This study was conducted in association with the National Gay and Lesbian Task Force.

A version of this article was presented in August 2000 at the American Psychological Association in Washington, DC.

[Haworth co-indexing entry note]: "Ethical Issues in Sexual Orientation Conversion Therapies: An Empirical Study of Consumers." Schroeder, Michael, and Ariel Shidlo. Co-published simultaneously in *Journal of Gay & Lesbian Psychotherapy* (The Haworth Medical Press, an imprint of The Haworth Press, Inc.) Vol. 5, No. 3/4, 2001, pp. 131-166; and: *Sexual Conversion Therapy: Ethical, Clinical and Research Perspectives* (ed: Ariel Shidlo, Michael Schroeder, and Jack Drescher) The Haworth Medical Press, an imprint of The Haworth Press, Inc., 2001, pp. 131-166. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: getinfo@haworthpressinc.com].

KEYWORDS. Conversion therapy, reparative therapy, ethics, psychotherapy, gay and lesbian

How can we determine whether sexual orientation conversion therapy is ethical, in theory and in practice? Both opponents and proponents of conversion therapies have discussed its ethics (Davison, 1991; Drescher, 2001b; Haldeman, 1991, 1994, 2001; Silverstein,1977; Throckmorton,1998; Yarhouse, 1998). Critics of conversion therapies have four objections: they (a) are not efficacious; (b) purport to treat what is not a psychological disorder; (c) devalue the lives of lesbians and gay men and reinforce prejudice; and (d) cause harm (Haldeman, 1991, 1994, 2001; Davison, 1991; Drescher, 2001a,b; Isay, 1990, 1997; Schreier, 1998). These objections have been echoed by the American Psychiatric Association which has recently published a position statement that until there is rigorous scientific research to substantiate claims of cure, "ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind medical dictum to first, do no harm" (American Psychiatric Association, 2000). Similarly, the American Psychological Association (APA) adopted guidelines for psychotherapy with lesbian, gay and bisexual clients that remind psychologists of prohibitions against discriminatory practices, including "basing treatment on pathology-based views of homosexuality or bisexuality" (APA, 2000), and "a prohibition against the misrepresentation of scientific or clinical data (e.g., the unsubstantiated claim that sexual orientation can be changed)" (p. 1443).

Conversely, proponents of conversion therapies have focused on the ethics of withholding this intervention from patients who request it. Yarhouse (1998) has argued that based on his understanding of the APA Code of Ethics (1992), "clients should be seen as having the right to choose treatment for their experience of same-sex attraction" (p. 249). Similarly, Throckmorton (1998) has asked that the American Counseling Association and other mental health associations "not attempt to limit the choice of gays and lesbians who want to change" because of an obligation "to respect the dignity and wishes of all clients" (p. 301). Stern, interviewed in Nicolosi (1999a), has stressed the absolute value of the client choosing a therapy that is consistent with his goals. He says: "It should be a client's right, totally and completely, to choose a therapy which is consistent with his goals and values. Psychotherapy which limits a client's right to decide where and how he is suffering, *and how he wants to grow out of that suffering,* is untenable for both parties–the therapist and the patient [italics added]." This is an absolutist perspective that overlooks the fact that professional ethics and standards of practice sometimes do place restrictions on a therapist's responses to a client's goals. For example, if a client's goal were to feel less guilty about emotionally abusing his spouse, most therapists would

agree that their professional ethics would prevent them from assisting the client in this manner.

There is a paucity of empirical data on the extent to which conversion therapists' clinical practices are consistent with the APA Code of Ethics (1992) and similar guidelines from other mental health associations. The sources of data used in existing discussions have been limited to accounts by conversion therapists of their clinical work (e.g., Nicolosi, 1991, 1993; Socarides, 1978) or first-hand anecdotal reports of failed conversion therapies (Duberman, 1991; Ford, 2001; Isay, 1990, 1997; Moor, 2001; White, 1994).

In order to create an empirical basis for further discussion of ethical issues in conversion therapies, the authors interviewed consumers of these clinical approaches and identified critical ethical incidents. These empirical data can help determine to what extent conversion therapies are consistent with the ethical, scientific, and practice directives of several professional associations:

- American Psychological Association's 1975 resolution stating that "homosexuality *per se* implies no impairment in judgment, stability, reliability, or general social or vocational capabilities" (Conger, 1975, p. 633);
- American Psychological Association's (1992) "Ethical Principles of Psychologists and Code of Conduct";[1]
- American Psychological Association's (1998) "Resolution on Appropriate Therapeutic Responses to Sexual Orientation";[2]
- American Psychological Association's (2000) "Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients";[3]
- American Psychiatric Association's (1998) "Position Statement on Psychiatric Treatment and Sexual Orientation";
- American Psychiatric Association's (2000) "COPP Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)";[4]
- American Counseling Association's (1999) "Discrimination Based on Sexual Orientation: History of the American Counseling Association's Position";
- American Psychoanalytic Association's (2000) "Position on Reparative Therapy."

The material presented in this study derives from interviews with consumers of mental health clinicians licensed as psychologists, social workers, psychiatrists, marriage and family therapists, and counselors. The professional ethics document most frequently referred to in this paper is the American Psychological Association's (APA) Ethics Code (1992). Although we recognize that clinicians who are not APA members are not bound by APA codes, the

similarity of the APA Ethics Code (1992) to the professional ethics codes of the American Psychiatric Association, National Association of Social Workers (1996), the American Association for Marriage and Family Therapy (1991) and the American Counseling Association (1995) is such that the APA Code can be used heuristically as a proxy document for the purpose of elucidating critical incidents. In the illustrations below, we do not identify the profession of the clinician because we do not intend this to be a study of inter-disciplinary differences in ethical behavior toward lesbian and gay patients (cf. Liddle, 1999; Stein, 1999). Our work is intended to provide a conceptual guide for future empirical research on professional ethics in conversion therapies.

METHOD

Methodological Issues

Because we know so little about the experiences of consumers of conversion therapies, a qualitative approach seemed appropriate for this exploratory stage of inquiry. In addition, ethical principles and their application in psychotherapy are not easily reduced into quantitative data because patient, clinician, and intervention contexts are essential to their adequate understanding. Our methodological approach is inspired by that of Flanagan's (1954) paper on the critical incident technique, Garnets, Hancock, Cochran, Goodchilds, and Peplau (1991) report on psychotherapy with lesbians and gay men, and Pope and Vetter's (1992) work on ethical dilemmas encountered by psychologists.

A brief mention of the limitations of this study is indicated. The data presented in this paper do not provide any information on the incidence and the prevalence of ethical violations in conversion therapy. This exploratory study was based on the retrospective accounts of consumers. Their self-report may not always accurately reflect therapist behavior. Rhodes, Hill, Thompson and Elliot (1994), on a study of misunderstandings in psychotherapy, have written of the limitations of using retrospective data from clients: "Informants may . . . [engage] in narrative smoothing, that is, the process of changing a story when recalling events. Clients' retrospective reports that recollect misunderstanding events from the vantage point of distance may lose the detail of the event as clients make sense of the events over time" (p. 481). Complementary research needed would include interviews with sexual orientation conversion therapists and analysis of psychotherapy sessions by independent third party observers. The current paper reports on a segment of data from a larger study of sexual orientation conversion therapy (Shidlo and Schroeder, 2001).

Participants' Perception of the Study

Sexual orientation conversion therapy is a controversial and socially sensitive issue (cf. ABC News, 1998; Miller, 2000). Therefore, participants' perception of the research and researchers both before, during, and after the interview is a critical variable. In our case, the pre-interview perception of participants was affected by the *original* name of the study: "Homophobic Therapies: Documenting the Damage." Our initial goal in this study was to document negative effects and harm of conversion therapies (an area that had not been empirically studied, though it has been identified as a priority topic for research [cf. American Psychiatric Association, 2000; Haldeman, 2001]). After pilot interviews, we discovered that some participants who reported feeling harmed also reported feeling helped. We were contacted by participants who reported positive benefits only. *We then decided to broaden our inquiry by actively recruiting participants who felt helped as well as harmed.* After we changed the project name to a more inclusive one–"Changing Sexual Orientation: Does Counseling Work?"–we were contacted by additional participants who had felt helped by these interventions. (For a report on the subset of participants who felt helped by conversion therapies, see Shidlo and Schroeder, 2001.)

Many participants were curious about our own views on sexual orientation conversion therapies. We told them that we are openly gay psychologists and that our research was hosted by two gay organizations: the National Lesbian and Gay Health Association and the National Gay and Lesbian Task Force. At the end of each interview we asked the respondent about their perception of bias in the structured interview or any information that they may have heard about our investigation. Responses fell into two categories: no prior knowledge about the study or perception of bias; and *pre-interview* perception of a "pro-gay" bias, or concern that we may be affiliated with a religious organization or ex-gay group. Both groups reported that they felt the interview had allowed them to articulate their recollection of conversion therapy.

> [I was] very happy with the interview. I had no idea of your bias and felt you were very fair.
>
> I was hoping that . . . because I saw this was sponsored by the gay and lesbian center [sic], I was hoping this would truly be an unbiased study.
>
> Before [the interview], I thought, well, maybe you were looking for something and not wanting to hear what I had to say. But I felt like it's been very unbiased, and you listened. I feel you said that I [the interviewer] want to make sure you got your feelings down right. So I feel real comfortable with it.

When participants asked whether we could assure them of the fairness and lack of bias of our research, we told them that the design, execution or report of results was never influenced by the hosting organizations.

A related methodological issue affecting the quality of data is participants' feeling of safety during the interview. It is critical that they feel comfortable to speak freely about intimate and sometimes painful or embarrassing information about their attempts to change sexual orientation. We believe that this is an especially critical issue in research on conversion therapy, because many of our interviewees reported withholding information or fabricating information when discussing changes in their sexual orientation with their conversion therapists (Shidlo and Schroeder, 2001). With regard to their experience of the interview, our participants reported:

> I think your interview was very good. I didn't feel pressured or threatened to say certain things. It allowed me to be honest.
>
> It's hard to talk about it now and remember . . . It's embarrassing to talk about it . . .
>
> I was a little apprehensive and nervous about the interview. . . . It's tough, talking about things like this not easy for me at all, I, I'm trying to be as honest as I can with you, it's very difficult . . . in just trying to think back to thoughts that came to my head, they're difficult, trying to be accurate and honest as I can be. I'm looking for answers myself.

Sample and Procedure

Participants Inclusionary and Exclusionary Criteria

Structured interviews were conducted between 1995 and 2000. For the segment of data reported in this paper, participants who met the following criteria were included: (a) history of at least six sessions in sexual orientation conversion therapy with a licensed clinician; and (b) pre-treatment self-report of 5 to 7 (more homosexual than heterosexual to exclusively homosexual) on a modified 7-point Kinsey scale (Kinsey, Pomeroy, and Martin, 1948) assessing sexual desire, attraction, and feelings. We defined sexual orientation conversion therapy as any intervention administered by a licensed psychologist, psychiatrist, social worker, family and marriage therapist, or counselor which the consumer viewed as being explicitly aimed at changing a homosexual orientation.

Because of social sensitivity to questions about sexuality in general and homosexual orientations in particular, no pre-screening was conducted. Instead, we interviewed all individuals who contacted us reporting a history of any kind

of sexual orientation conversion intervention. The total number of interviews conducted was 216. Fifty-two were excluded from the current analysis because these participants reported that they attended para-professional conversion interventions only (see Shidlo and Schroeder, 2001 for a report on these participants). Fourteen additional interviews were excluded from the final analysis because the participant: (a) had less than six sessions of a conversion intervention (4); (b) reported 1 to 4 (exclusively heterosexual to bisexual) on a modified Kinsey scale (Kinsey et al., 1948) assessing sexual desire, attraction, and feelings (4); (c) did not go through an intervention explicitly aimed at changing homosexual orientation (1); (d) immersed himself in self-help conversion material but did not undergo a formal intervention (3); (e) was hard of hearing and had difficulty following structured interview (1); and (f) appeared to have a thought disorder (1).

Sample Characteristics

The number of participants included in this report was 150. Eleven (9%) of participants were female, 139 (93%) were male. Participants' mean age was 40 years, with a SD of 11.6 and range from 20 to 74. With regard to ethnicity, 128 (85%) participants were Caucasian, 8 Latino (5%), 1 (< 1%) African American, and 3 (2%) Asian American. Ninety-seven participants (65%) considered themselves religious and 33 (22%) non-religious; 85 participants identified with a Christian based faith, nine Jewish, two Pagan, and one Buddhist. Percentages do not add up to 100% because of missing data.

Participants reported receiving psychotherapy from a total of 203 practitioners: 122 psychologists (16 of whom were identified by the participant as religiously oriented therapists), 32 psychiatrists, 22 social workers (4 religiously identified), 11 marriage and family counselors (4 religiously identified), and 16 M.A. level therapists (5 religiously identified). Many participants reported courses of therapy with different practitioners.

Procedure

For the first two years of the study, participants were recruited through advertising in gay and lesbian web sites and e-mail lists. Upon receiving funding from the H. van Ameringen foundation in June 1997, we were able to embark on a national advertising campaign for recruiting participants. Neutral advertisements were placed nationally in gay and non-gay press, a web site for the study was established and direct mailings were sent to both gay and ex-gay organizations and to a national professional group of conversion therapists. A toll-free phone number was established to facilitate access by potential participants.

At the start of each 90-minute interview, participants were given an informed consent form; when the interview was conducted by telephone, verbal consent was obtained. If the interview was tape-recorded, additional consent was obtained. At the end of the interview, participants were offered the opportunity to see results of the study and to give feedback on the interview itself.

Four doctoral level psychologists were utilized for the administration of the structured interview. Interviewers were trained and supervised by the researchers. Most of the interviews were conducted by Schroeder and Shidlo. The researchers randomly reviewed audio tapes to confirm that the protocol was being observed.

Measures

A semi-structured protocol was used. Since this was an exploratory study with an emphasis on qualitative data, the protocol evolved through several iterations during the course of our study (for a discussion of the rationale of using iteration in research, see Rubin and Rubin, 1995). As interviews were completed, we identified new critical areas of questioning which were integrated into subsequent interviews.

The protocol included the following areas of inquiry:

- *Goals of treatment.* What were the goals and were they mutually agreed upon with the therapist? Was there a specific request to have sexual orientation changed?
- *Information about homosexuality and treatment.* What information was provided by the clinician about gay people and the gay communities? How was homosexuality framed by the counselor (e.g., mental disorder, developmental disorder, addiction, sin or spiritual disorder, learned behavior, sexual brokenness, caused by abuse, normal sexuality)? This was followed by a question on how the therapist explained the participant's homosexual orientation. Other questions included how the counselor explained the counseling would help the participant.
- *Emotional responses to information.* How did the participant feel when the framework for understanding the cause of his homosexual orientation was explained?
- *Informed consent.* Did the clinician provide information about possible therapy consequences, both positive and negative, of the intervention, explore the two APAs' positions on homosexuality, and explore treatment options including gay-affirmative treatment?
- *Intervention type.* What occurred in the treatment sessions and what was the approach to change?

- *Help versus harm.* Participants were asked open- and close-ended questions about perceived help and harm of each intervention they reported.

RESULTS AND DISCUSSION

The structure of this section is as follows: (a) representation of the APAs' positions on the scientific understanding of a homosexual orientation; (b) informed consent; (c) confidentiality; (d) the relationship between religion and conversion therapy; and (e) appropriate termination.

How the Two APAs Decisions Were Represented

We asked respondents whether their therapists told them that the American Psychological Association and the American Psychiatric Association do not view a homosexual orientation as a psychological disorder or mental illness. We distinguished between psychotherapies conducted before and after the year of declassification of homosexuality (1973) by the American Psychiatric Association. On this variable, we have information on 120 participants who reported on 149 *post-1973* conversion therapy courses (some individuals went through more than one conversion therapy). Participants reported only 38 instances (26%) where clinicians informed them of the APAs' positions. In these instances two salient themes emerged: (a) the APAs' views were based on political pressure from the gay community; and (b) the APAs' views were not based on empirical research. For example, one participant said: "[my therapist] felt like it was political pressure that had caused the APA to change it, rather than research. That there were militant pro-gay people who forced the change." Similarly, another participant reports that his therapist told him that "The APA was pressured politically into changing the diagnosis, but actually it still is a disorder. But the only reason they changed it was because they were politically pressured by protests of gay groups and such." One participant reported that his therapist told him the American Psychiatric Association's decision to de-pathologize homosexuality was "a tragedy." Another respondent said that he spoke to his therapist about his reading "a lot of stuff that says being gay is fine that there is no mental illness. He [the therapist] was very dismissive of it. He said it was more of like a political activism of the gay movement as opposed to any psychological model."

Other therapists seemed to view the APAs' decisions on homosexuality as secular information that should not have bearing on religion-based psychotherapy. These therapists told participants that religious values supersede secular and scientific attitudes and knowledge. One participant recalls that his therapist mentioned the APAs' decisions on homosexuality "in the context of

why it was important for me to see a Christian psychologist, because all psychologists are not Christian."

In conclusion, according to client reports, some conversion therapists may not be informing patients that the APAs do not view a homosexual orientation as a psychological disorder. Others who discuss this with patients may be misrepresenting the scientific basis for the APAs' views on a homosexual orientation.

Informed Consent

Informed consent is an integral part of the ethical practice of psychotherapy (O'Neill, 1998). Standard 4.02 (APA, 1992, p. 1605), titled "Informed Consent to Therapy," instructs psychologists to provide patients with significant information concerning the proposed intervention. Clarification is provided by the American Psychological Association document, "Guidelines for Psychotherapy" (2000), where psychologists are reminded that "Based on the APA Ethics Code, the 'Appropriate Therapeutic Responses to Sexual Orientation' policy calls on psychologists to discuss the treatment, its theoretical basis, reasonable outcomes, and alternative treatment approaches" (p. 1443). Our data strongly suggest that, in the area of informed consent, many conversion therapists may not be practicing in a manner consistent with the APA Ethics Code (1992).

In the subsequent section we identify several areas of informed consent relevant to conversion therapy followed by illustrative examples from our interviews with consumers. The areas of informed consent we examine are:

- Did the clinician provide accurate information about sexual orientation?
- Did the clinician provide accurate information about the proposed intervention and prognosis?
- Were other treatment options discussed?
- Was there coercion in the therapy?

Did the Clinician Provide Accurate Information About Sexual Orientation?

The APA Ethics Code instructs "psychologists . . . [not to] make false or deceptive statements concerning . . . the scientific or clinical basis for . . . their services" (APA, 1992, Standard 3.03(a), p. 1604). The most frequent violation of informed consent guidelines, based on our sample of conversion therapy consumers' reports, was a failure to provide accurate and scientific information about homosexuality. Participants were told by their therapists or counselors that: (a) homosexuality is in itself a psychological disorder or is a symptom of another disorder; (b) homosexuality does not exist; and that (c) gay lives are inherently unhappy. Defaming and fraudulent information about lesbians and

gay men is contradicted by widely available psychological research (cf. Anderson and Adley, 1997; D'Augelli and Patterson, 1995; Gonsiorek, 1991; Perez, Debord, and Bieschke, 2000). The propagation of inaccurate information on lesbians and gay men by conversion therapists represents a failure to uphold standard 1.05 of the APA Ethics Code (1992) which calls on psychologists to "maintain a reasonable level of awareness of current scientific and professional information in their fields of activity, and undertake ongoing efforts to maintain competence in the skills they use" (p. 1600). The following are examples of some of the misinformation provided by conversion therapists:

Claims That Homosexuality Is a Psychological Disorder in Itself or a Symptom of Another Disorder

Many participants reported that their therapist told them that their homosexual orientation was a psychological or developmental disorder. One participant stated, "for those guys [conversion therapists], it's always your mother's fault. He wouldn't say it exactly like that, but we always talked about mother issues. . . . [that it was a] developmental issue, that I had learned to love a woman, but not to love her sexually, because you're not supposed to love your mom sexually." Another participant said that his therapist told him that his homosexuality "was the result of my domineering mother and absent father and that I was searching for a connection to the masculine and that it had been fused incorrectly with sexuality. I needed to connect with men in a non-sexual manner as this was the route to healing." A clinician told a respondent that homosexuality was a disease that could be cured through aversion therapy:

> [He said] if you didn't do this you would go insane or kill yourself. . . . He called it a short circuit . . . what the chemicals in the body do, does not necessarily condone what you should be aroused to. But they are shorting out and making me aroused to men and not women. . . . therapy would help me get over that endorphin, it would train my body to relate to the scent of a woman as erotic, as opposed to a scent of men. That kind of scientific mumbo jumbo.

Other conversion therapists told patients that their homosexuality is a symptom of a psychiatric disorder. A participant reported that his therapist diagnosed him as suffering from obsessive-compulsive disorder and sexual addiction because of his homosexuality. He said, "I was not allowed to be gay-defined so . . . [the therapist] termed it sexual addiction even though I had never had sex." Another participant reported:

> My therapist believes that a large part of homosexuality is caused by not being able to process or access authentic emotion. By doing so, and by

> learning how to do so, that in fulfilling a lot of the emotional needs left over from whenever, positively, that homosexuality can diminish.

Interestingly, some participants recounted that their therapists would insist on a putative etiology for their homosexuality even when the patient denied the existence of any such events in their history. For example, several participants reported that their therapist identified the cause of their homosexuality as a supposed history of child abuse, even in the absence of memories or evidence for such abuse:

> He was making assumptions that I was molested as a child. I was never molested by anyone. *He said I must have been molested.*
>
> There was also an attempt to explain this as being sexual abuse although I was never abused and he tried to convince me that I was sexually abused when I was a small baby. He made these conclusions from drawings I had made.
>
> I had already assumed the cause to be my mother and father. When he tried to convince me I was abused and this was the cause I became angry and terminated the treatment.
>
> I was discouraged. The therapy was not being effective and the therapist was trying to fabricate a history of sexual abuse when it did not exist.

One participant spoke of feeling that his therapist was overly influenced by a pre-existing model of homosexuality and as a result was not hearing him accurately: "The last half of the private sessions I began saying things he expected to hear. The questions he would ask, *he never seemed to listen that I wasn't fitting in a pattern he expected*."

Other participants felt that their therapist would magnify the importance of events in their lives to explain their homosexuality. One participant reported that he had a good relationship with his father. Nonetheless, his therapist said that conversion therapy "would help me deal with any injustice that I felt my father showed me. [He said] I could work through that problem and heal the wounds and be okay. *I didn't think there were any big wounds to heal*."

Homosexuality Does Not Exist

Some participants reported that they were told by their therapists that their homosexual orientation did not exist. On this variable, we have information from 73 participants who reported on 94 courses of conversion therapy. Fifty-nine clinicians (63%) were reported to have told participants that they

are not *really* homosexual. Clients were frequently told that they had always been heterosexual in some form and just needed to re-discover their true (hetero) sexuality.

> [He said there was] no such thing as a true homosexual. People were just confused and had a mental disorder that had to be cured.
>
> The therapist said that homosexuality did not exist. Only in a perverse form in people who did not like themselves.
>
> The therapist said that I was absolutely heterosexual.
>
> The psychologist said that I struggled with homosexuality and that I didn't want to be gay. He said: you're not gay; you're homophobic. He said I feared it so much that I was afraid I was. It made me question my feelings. I have an attraction for men, none for women, I told him that. Made me question what does it mean to be gay? I was really confused. I didn't understand how I could not be gay. He said he didn't think there was anything to change, that I just thought I was gay. That I wasn't really, he said I wasn't gay.
>
> My therapists kept telling me I was straight yet I knew that I was gay. Things did not match. The mixed messages from the therapists were the most damaging of all. I still am coping with this.
>
> He followed the standard LDS [The Church of Jesus Christ of *Latter-Day Saints*] line which was that homosexuality did not exist and there was no such thing as a homosexual. God made you heterosexual. God does not create homosexuals therefore homosexuality does not exist.

These findings are consistent with the research of Nystrom (1997) who found that one-third of gay men and lesbians surveyed said their therapist "refused to acknowledge" their sexual orientation or dismissed it as a phase that would eventually pass.

Gay Lives Are Inherently Unhappy

Almost all of our participants were told by their therapists that gay persons' lives and relationships are undesirable, unhealthy, and unhappy. A clinician prominent for his work in conversion therapy told a patient at their final telephone therapy session: "Remember you'll never be happy gay and never find

fulfillment in another man." Earlier in treatment this same clinician said: "Why would you like to stick your penis in something that represents death like an anus, where shit comes out, versus where you can have it where life is, a vagina." Another respondent reports that when he told his therapist that he had read about "gay couples who are happy," the therapist responded, "I have never known a single gay person to be happy." Similar prejudiced and unscientifically based comments were made by other therapists:

> [The therapist said] homosexuality is a compulsive behavior, maybe not in the beginning, but 10 years down the road it will become compulsive. [He said that] his patients have dreams of 30 cocks in his [sic] face. [He treats] a guy who can't make it to his office without getting sucked five times. . . . [he said that] I had a confused core identity.
>
> He told me that homosexuals are quite promiscuous, and their lifestyle leads often to drugs, crime, and molestation of children. The usual stereotypes that you hear all the time. He asked me if I had molested my children or had been molested.
>
> [The] main sell . . . was that it inevitably lead you to an unhappy lonely life . . . He knew of no gay couples that lasted for significant time, and he knew no gay people who were happy or adjusted. He was also implying that there was something weak or mentally unhealthy too, by the way he described it, the way he was asking me about my sexual history, and the way he talked about how it could be changed. It sort of implied a mental illness model.
>
> [The therapist said] that gay people all get AIDS and that I can avoid hardship through leading a heterosexual lifestyle.
>
> He [the therapist] wanted me to read books . . . describing the gay lifestyle, how lonely and depressing [it was], no hope, *he wanted me to internalize that and make sure I knew that it was absolutely the worst, and I need to always think that* . . . He knew the one thing that pushed a lot of buttons. . . . [that I] wanted to . . . have a monogamous relationship. Settle down with woman for rest of our lives. He was showing and pushing that guys in the gay community are all very promiscuous, they have millions of partners, you will never get what you are looking for, monogamy with one guy. You will always be on the search and prowl. You would always be disappointed and depressed that these guys would leave you for another guy. That there was no stability, no true love.

Conclusion

Many conversion therapists appear to be providing patients false and prejudicial information on gay men and lesbians. In fact, there appears to be a significant element of propagandizing by some conversion therapists on the supposed horrors of life as a gay man or lesbian. Our data from participants who were in conversion therapy are consistent with the American Psychiatric Association (1998) finding that "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." Garnets and her colleagues (1991) and Nystrom (1997) have similarly documented many incidents of anti-gay bias among therapists. These findings are consistent with descriptions of gay men and lesbians' lives in the conversion therapy literature itself (Nicolosi, 1993; Satinover, 1996; Siegel, 1988; Socarides, 1978, 1995; van den Aardweg, 1997). For example, Nicolosi (1993), a founder of the National Association for Research and Therapy of Homosexuality (NARTH), writes: "Homosexual relationships are so characteristically volatile because the homosexual hates what he loves" (p. 152). Stern (Nicolosi, 1999a) views lesbians and gay men as "not having grown up"; he says: "The homosexual often fears otherness, and in this fear, may beckon to an idealized image of himself–'Be me, and I'll be you.' The world becomes an eternal playground, and growth is stymied." Satinover (Nicolosi, 1999b), who testified before Congress against legalizing gay marriage, has said: "Homosexuality . . . is a method of adapting to adverse circumstances. But like sociopathy, it exacts a cost in terms of constrictions of relationships. . . . I believe homosexuality–like narcissism–is best viewed as a spiritual and moral illness."

Patients in conversion therapy may not be advised about scientific or psychological information on gay, lesbian and bisexual individuals, relationships, and communities. Instead, they may be exposed to prejudice and falsehoods. This violates Standard 1.06 of the APA Ethics Code (1992) which states that "Psychologists rely on scientifically and professionally derived knowledge when making scientific or professional judgments or when engaging in scholarly or professional endeavors."

Did the Clinician Provide Accurate Information About the Proposed Intervention and Prognosis?

In this provision of informed consent, clinicians discuss with patients how they think a proposed intervention will be helpful. Informed consent for conversion therapy should include information about the workings and efficacy of the procedure. In addition to linking the procedure to the putative causes of a homosexual orientation, the clinician should offer a prognosis, and list any possible side-effects.

A question about whether consumers were informed about the possible negative effects of conversion therapy was introduced late in our study. Therefore, we have data from only 22 participants who reported on 47 courses of conversion therapies. Participants reported that only four clinicians (9%) informed them of possible negative effects of the intervention. Our findings also suggest that some therapists misled clients with:

- Unfounded prognoses based on patient personality characteristics.
- Assurances that a shift in sexual orientation is likely if clients are highly motivated and work hard in the treatment.
- Misrepresentations of the scientific evidence supporting the efficacy of the proposed intervention.

Unfounded Prognoses Based on Patient Personality Characteristics

Many of our participants reported that their therapists had informed them that they were promising candidates for change. They were told that prototype for a successful candidate for conversion therapy was an individual who possessed stereotypical male (for men) or female (for women) personality features, had little or no same-sex sexual history, had strong religious faith, did not identify as gay or lesbian, did not have gay friends, and who asserted a strong motivation to change. We have found no empirical data that demonstrates that these characteristics support a good prognosis for changing homosexual orientation.

> My parents basically got a promise from him that he would change me to straight. [He told my parents] that he had a lot of success and he could [help me] *if I was straight-acting enough*. . . . He would first have to interview me and see. He gave them a promise. Then I went in and had my first session. He listened to my story. He said *I was probably one of the best candidates for change. Not only that I had a strong religious belief system, and strong family support, and much more masculine and straight attributes than gay people. And that I hadn't accepted any of the identity of being gay.* He said I had a lot of hope and he said he didn't think it would be a problem for me to become straight. I asked him how long? He said about a year . . . that since I didn't latch on to the term gay and didn't identify with being gay, I was definitely a straight person, that something had developmentally . . . in my life gone wrong, and I could overcome it, it would be all fine and dandy at the end.
>
> He [the therapist] said "all of your tests and experiences show that I have good news for you. They indicate that you are straight, that you are not

> gay and that we have a few things to work through and everything will be fine." I'd wake up 17 years later and realize I am still gay.

Assurance That a Shift in Sexual Orientation Is Likely If Clients Are Highly Motivated and Work Hard in the Treatment

Many respondents reported that their therapists assured them of the success of conversion therapy if they were motivated and compliant with the intervention. These findings are consistent with NARTH's claim that, although change in sexual orientation usually takes "several years," the "keys to change are *desire, persistence,* and a willingness to investigate the *conscious* and *unconscious conflicts* from which the condition originated" (NARTH, undated document B, italics in the original). There is no empirical evidence to support the claim that the outcome of conversion therapy is associated with the level of the patient's motivation. In fact, our own work (Shidlo and Schroeder, 2001) documents that many individuals with exceedingly high levels of motivation and compliance with conversion therapies, in treatment for periods of over 10 years, failed to change their sexual orientation. The following are typical examples of respondents who were told that their motivation and compliance were the keys to success in conversion therapy:

> If I worked hard enough and trusted God enough, I would have these pathways in the brain, these habits, would be healed over, corrected or removed. And if I stuck with it long enough, it would automatically occur. Kind of like, being straight is the normal way, if you work hard enough and realize these pathways were causing it, eventually you would come back to place where you would be back to normal.

> He was more optimistic, he said the sky is the limit. *I could change as much as I was willing to work.*

> If my needs for male bonding were met my attractions would go away. *He said, anybody can escape homosexuality if you work hard enough.*

> [He said] that *it could be overcome, that I just needed to want to [change] bad enough, that I had to trust in God, and believe that God didn't create me this way,* that I was created in his image. [It was] a big play on my religious beliefs.

The psychological consequence of being told that hard work was a sufficient condition for changing sexual orientation is that clients who failed attributed the failure to themselves and came to believe that they were ineffectual and lazy. One respondent says: "It seemed to not be working and he would always tell me that I was not trying hard enough . . . that was the worst part."

Misrepresentation of the Scientific Evidence Supporting the Efficacy of the Proposed Intervention

A wide array of psychotherapies and behavioral procedures were presented by therapists to our participants as efficacious in changing a homosexual orientation. Interventions were presented together with a putative theory of the causes of a homosexual orientation. Proposed treatments included combinations of: (a) cognitive behavior therapy, (b) behavior therapy, (c) psychoanalysis, (d) aversive conditioning, and (e) covert sensitization. Many of these interventions also included a religious component. However, conversion therapists who tell their patients that these interventions are efficacious in changing their sexual orientation are disregarding the scientific consensus about the empirical data (APA, 1998, 2000; American Psychiatric Association, 1998, 2000; Davison, 1991; Drescher, 2001a; Gonsiorek, 1991; Haldeman, 1991, 1994; Martin, 1984).

We asked participants: "Did your counselor(s) tell you that s/he could make you become heterosexual or bisexual?" One hundred sixty-seven participants gave us information in this area on 167 clinicians. Of these, 112 (67%) therapists told them that therapy would help them become heterosexual or bisexual.

Toward the end of the study, we introduced a question asking whether clients were informed about the possibility that the intervention may not be successful in changing sexual orientation. A small data set is available for this variable from 23 participants who reported on 47 therapy courses. Participants reported that 18 (38%) therapists told them of the possibility that the intervention may not be successful in changing sexual orientation.

Our participants reported that they were offered the following interventions to change their sexual orientation:

Cognitive-Behavior and Behavior Therapy. Procedures included thought-stopping, aversion therapy (electric shock and noxious chemical), covert sensitization, systematic desensitization, modeling, shaping, and operant-conditioning. The following illustrate what participants were told by their therapists about these interventions:

> He felt it was a behavioral thing. . . . Like a Pavlov thing. By aversion or staying away from it and doing other things it would reinforce the good feelings of the heterosexual feelings and then, by negative things happening to you it would avert the homosexual feelings.

> He told me that in his experience he found that once he was able to get the patient to become comfortable with females, the homosexual issues went away.

> Being around other men will help me get the validation from men that I need from non-sexual relationships and then I would pursue relationships with women.
>
> If I made friends with heterosexual men, I would find myself attracted to women. It would help you lessen the homosexual attraction and put you in relationship with men and women so that . . . you become one of the boys, you would find yourself being attracted to the opposite-sex. To heal the masculine wound or hurt inflicted by men on you.
>
> That . . . [the therapy] would show me how the emotional deficits occurred and how I could learn how to fill those correctly. By taking appropriate action through proper socialization and proper heterosexual activities I could therefore become heterosexual.
>
> The therapist . . . didn't think I was gay and made that comment to me, I guess it was part of behavior modification. He said if you want to be like a man act like a man, start buying girly magazines and that will take your mind off men.
>
> In aversion shock therapy the idea was to train us to respond erotically to women and fear an erotic response to males.
>
> Aversive treatment where I was brought into a room and exposed to sexually explicit stimuli of pictures of naked men and injected with some substance which would induce vomiting [This participant reported that he got no support or guidance from the clinician].

Some participants were instructed in procedures to make them more stereotypically masculine or feminine. Men were encouraged to engage in team-sports, to go the gym, and to attend Promise Keepers[5] workshops. Women were encouraged to learn how to cook, sew, and apply make-up. One respondent was told by his therapist to stop playing the piano and change his course of music studies because "playing the piano is what makes you gay." The participant was told that if he discontinued playing the piano his homosexual attraction would be extinguished. Another male participant was encouraged to get married: "[the therapist said] that I could be happy with a woman. That's what I needed to do was to distract myself from the homosexuality, that I needed to get married. That I would be so focused on the family that the homosexuality could atrophy and go away."

Additional cognitive and behavioral interventions employed included tying one's hand to the bedpost to avoid masturbating, using sexual surrogates, imagining getting AIDS when aroused by the same-sex, masturbating to gay

pornography to minimize having actual sex with same-gender partners, abstaining from masturbation, using the HALT technique (framing same sex desire as being the result of feeling *H*ungry, *A*ngry, *L*onely or *T*ired), employing EMDR and hypnosis.

Psychodynamic Therapy. Participants who underwent psychodynamic therapies were told by their therapist that homosexuality is caused by faulty family dynamics. Therapists implied that if a patient understood the etiology of their homosexuality, they could make the necessary behavioral adjustments that would lead to its cessation. For example, one participant stated that his therapist told him his homosexual orientation "was a result of my domineering mother and absent father and that I was searching for a connection to the masculine which had been fused incorrectly with sexuality. I needed to connect with men in a non-sexual manner as this was the route to healing." Another participant explained, "it was a whole system of unmet needs, through exploring relationships I had with my father and men in general. . . . basically I never had real good relationships with men, or was always intimidated by men, the type of men I was attracted to was to a body image I wanted to achieve myself. If I found healthy ways to meet these needs, the homosexuality would go away or lessen over time."

Psychotropic Intervention. Psychotropic medications were employed either on their own or combined with conversion psychotherapy. Patients were prescribed anti-depressants and anxiolytics to help them control their homosexual behavior or to reduce their sexual fantasy life and desire:

> I would be medicated and dull my sexual desire. He said it would take two to three years. [I received] psychotherapy combined with medications to control my fantasies and control my masturbation. I was to follow a 12-step program for sexual addicts in a workbook. I had never had sex with another man up until that point, yet he diagnosed me as a sex addict.
>
> This would take a lot of hard work and commitment to not be gay. . . . Medication would help . . . nothing much more specific than that.
>
> I was gay. I was given all sorts of hormonal therapies to make me into a straight guy.
>
> He gave me Valium to treat my anxiety about my sexual orientation.

Religion-Based Psychotherapy. Many of the religion-based therapies incorporated numerous adaptations of interventions such as cognitive-behavioral therapy and behavior therapy. Testimonials, mentoring, prayer, Bible readings, and Christian weekend workshops were reported by our participants.

Some therapists introduced religious beliefs into the conversion therapy. One participant reports, "He thought if I dealt with my abuse issues and my misconception about God and the Bible . . . I had come from a fundamental background, that was the reason I thought I was gay, because of a guilt complex about God. If I investigated that stuff, I would realize I wasn't gay." Another respondent said, "His view was that once you understood your childhood and the pain of the relationship with your parents and let God in you could be changed by this and you then become attracted to women. If you could learn to do something masculine you could then eventually internalize this and become straight."

Were Other Treatment Options Discussed?

Although not explicitly mandated by the APA Ethics Code (1992), there is a growing recognition that discussing alternative treatments is an inherent part of true consent (APA, 2001; O'Neill, 1998). We asked participants: "Did your counselor(s) tell you that there are licensed mental health practitioners who do not treat homosexuality as a disorder, but rather help people feel less shame and distress about it?" Information for this variable is available on 118 participants who reported on 164 conversion therapy courses conducted as of 1974. Participants reported that only 27 clinicians (17%) advised them of the availability of therapists who are not biased against a homosexual orientation.

A second question asked was: "Did your counselor(s) encourage and support you to explore the option of going to a gay-affirmative practitioner who wouldn't try to change your orientation?" Information on this variable is available for 118 participants who reported on 166 courses of conversion therapies. Only four clinicians discussed with their clients the option of seeking therapy from a practitioner who would not try to change sexual orientation.

> By not giving me accurate information and telling me there were other options and choices he did a big disservice as a professional with the power of his role as psychologist and professor. Telling me it was the right thing to do took me on journey that lasted longer than it should have . . . it created more pain for me and my wife than it had to. I trusted him [when] he said it would work.
>
> It was not a choice. Either you will be gay and unhappy or stick with me and change.
>
> It made . . . me angry that he wouldn't give me a choice. . . . it was his way or the highway. It just hurt because I felt down deep that I needed to have the option of accepting myself as a gay man. When I saw him, I didn't

> have that option. If I wanted to keep seeing him I had to go straight. I had no option.
>
> I said I'd really want to continue the marriage, and I said, wasn't there something I could do, take drugs or something? He said the only way to change the feelings was this electroshock therapy.
>
> I flat-out refused to do the shock therapy. He said he couldn't do anything for me because I wouldn't cooperate.
>
> The therapist . . . didn't suggest that I would want to stay that way [i.e., gay]; it was never an option [to] . . . learn to accept it.

Was There Coercion in the Therapy?

The issue of coercion came up in two ways: Coercion by therapists and coercion by religious universities.

Coercion by therapists. Several participants spoke of pressure by their therapist to go to the media to tell of their success in changing sexual orientation. For example, one participant said: "We were encouraged a lot to tell the media about our alleged change. We were encouraged to go on Jerry Springer . . . he [the therapist] was a media-hound." Another participant, who ultimately failed conversion therapy, reported that his clinician, a nationally known conversion therapist, encouraged him to take part in a panel in an ex-gay conference to present his successful struggle with homosexuality. When we asked what it was like to be asked to appear with his therapist on a panel, the participant said: "I was very honored. I wanted to be poster child for NARTH. I believed in the cause so strongly." The same participant reports that his therapist referred him to our research project on conversion therapy, but was told not to reveal that he had been referred by this NARTH clinician. "He wanted people who would give a good report . . . [He said] call this number and say a friend sent you, don't say NARTH sent you."

Coercion by religious universities. Some of our participants were forced by religious universities to pursue conversion therapy subsequent to: (a) the student confiding in their advisor, (b) being identified by another student as gay, (c) being caught having sex on university premises, or (d) being entrapped by campus security. The penalty for not complying with the order to attend conversion therapy was expulsion from the university.

What are the ethical issues facing practitioners employed by an academic institution that requires conversion therapy for lesbian and gay students at the threat of academic expulsion? Should they provide conversion therapy for students who are mandated to attend? Do psychologists who engage in such practices violate the 1975 American Psychological Association statement (Conger, 1975, p. 633) opposing discrimination against lesbians and gay men? Does

providing conversion therapy under coercive circumstances, violate section 4.02 on informed consent of the APA Ethics Code (1992) which states that patients express consent freely and without undue influence?

For example, one participant we interviewed was a student at a large religious university. He says, "I am being forced to be in therapy. I sit there and agree with what he has to say to avoid confrontation. He is pushing me to marry a woman. My goal is basically just to graduate." Another student was entrapped at his school: "I responded to a note on a bathroom wall, and was caught by campus security. They sent me to one of the counselors. . . . This therapy is currently being mandated by . . . [large religious university] as a condition for me to continue and graduate . . . This therapist is a Nazi and is more radical about it. It focuses on early childhood and on my relationship with my father."

Conclusion

Many conversion therapists may be treating patients without obtaining full informed consent. This study found serious causes for concern in the areas of providing misinformation about sexual orientation, misrepresenting the efficacy of conversion therapies and their prognoses, and failure to discuss treatment options.

These issues are raised in the light of our findings that many participants in conversion therapies who fail to change sexual orientation appear to suffer significant psychological harm (Shidlo and Schroeder, 2001). It is troubling that many conversion therapists do not appear to discuss with their patients the possibility that there may be side-effects or harm from these procedures. These findings are consistent with a review of the conversion therapy literature, which, on the whole, neglects the issue of harm completely (for a further examination of this point see Drescher, 2001a, b; Haldeman, 2001).

NARTH, an organization representing conversion therapists, has said that conversion therapy should be provided only to those who seek it freely: "We believe that treatment should be offered to those who voluntarily seek it" and "acknowledge that many homosexual men and women do not wish to change their psychosexual adaption, and we respect their wishes not to seek therapy. . . ." (NARTH, undated document A). However, some therapists are providing conversion therapy under coercive situations–for example, lesbian and gay students are being forced into treatment or face expulsion from their religious academic institutions.

Confidentiality

Violations of confidentiality were reported primarily among participants who received treatment within a religious university or an affiliated counseling setting. Such violations included divulging information to school officials and

speaking with the (adult) patient's parents without consent. According to the APA Ethics Code (1992, p. 1606) Standard 4.09, "psychologists have a primary obligation and take reasonable precautions to respect the confidentiality rights of those with whom they work or consult, recognizing that confidentiality may be established by law, institutional rules, or professional or scientific relationships." Moreover, "psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose . . . "

Several participants reported a breach of confidentiality between their therapist and school officials. Some suffered academic consequences as a result of a school official being told by the university clinician about the content of the conversion therapy: "I ended up being thrown out from school because the counselor, who was married to the Dean of students, told him [the Dean] about the [sexual] incident that happened between me and my roommate in the dormitory. They wanted me to be healed and have God's forgiveness. . . . they kicked me out of school." Another respondent reports that when he went to a school therapist at a Christian college he was told: "You know that homosexual behavior is against the rules of the school. If you do anything and I know about it, I will tell them and they will kick you out." This resulted in the student both fearing therapy and feeling that his sexual orientation was demeaned: "I stopped seeing him. He wanted me to come back, but I didn't trust him. I felt like, this is how I'm viewed, how the lifestyle is viewed by the school. I didn't seem to know what to do with it."

Failure to maintain confidentiality was also reported by consumers of therapy in private practice settings. An adult participant reported that, to his surprise, his father arrived one day at his session: "My dad came in invited not by me but by the therapist, and apologized for not being a good father . . . Saying I wasn't gay because I had an overbearing mother . . . " Another patient states that the clinician "proceeded to tell my dad about my sexual history. This was after assuring me of confidentiality . . . including mentioning names [of men the participant had had sex with]." A married man who had been in conversion treatment reports that the clinician would give unsolicited updates on the treatment to the participant's wife without his consent, "He would talk to my wife, he had sessions with her once a month, updates, on the progress with me." And another participant states that, "Although it was supposed to be confidential, the counselor's son was my age. We went on a retreat together. He [the counselor] told his son. Things hit the wall. Even my parents were upset. We agreed that nothing was changing or getting fixed."

Conclusion

Clinicians employed at religious universities that expel lesbian and gay students, when told by patients about their homosexual orientation, may have a conflict of interest. Some of them may be in ethical violation of patient confi-

dentiality. General knowledge of this may discourage lesbian and gay students from seeking psychotherapy at university settings. Conversion therapists in private settings may involve family members in the treatment of their lesbian and gay patient without sufficient consideration of the clinical and ethical issues involved. Clinicians who treat patients whose therapy is paid for by the church may need to consider carefully the *clinical* consequences of sharing information with church officials, *even when consent is obtained.* For example, one respondent, who consented that his therapist share treatment information with his Bishop, reports that he was *consequently not truthful about changes in his sexual orientation with his therapist.* He says:

> [The therapist] told me that because church was paying for it that he would be in contact with my bishop about my progress. That seemed normal. . . . I just wanted the feeling to go away. I wanted to be normal. I loved my wife and wanted these feelings to go away so that I can be a better husband. *I was frantic about not losing my church membership and afraid it would be public and I would be shamed.* I thought if I had to die I would suicide. . . . He offered me shock therapy; I told him I didn't think I was that bad, because the talking helped the feelings go away and I was doing better with my wife. . . . *I went back in the closet and was better about hiding. I convinced the Bishop that I didn't need to go to counseling.* . . . When I look back, I would have quiet and sad times, mourn that it hadn't not worked out. It was so confusing to me.

Religion in Sexual Orientation Conversion Therapy

Psychotherapists are increasingly attending to the importance of a competent integration of religious issues into their clinical work (Bergin, 1991; Richards and Bergin, 2000; Yarhouse and VanOrman, 1999). Supporters of conversion therapy have argued that it is unethical to ignore the central role of religion for some patients who struggle with their homosexual orientation (Throckmorton, 1998; Yarhouse, 1998; Yarhouse and Burkett, 2000). They have written that lack of attention to a patient's religious beliefs is not consistent with the APA Ethics Code (1992) call on psychologists to respect the diversity of patients, including their religion.

The use or introduction of religious beliefs by the therapist into psychotherapy raises challenging questions. Restricting the discussion here to sexual orientation conversion therapies, one hypothesis is that clinicians who introduce religious beliefs into their practice of psychotherapy will have a greater impact, negative or positive, on religious clients. We found in our research that while some participants viewed having a religious clinician as essential in their struggle with their homosexual orientation, others felt adversely impacted. For

example one respondent said that his therapist "put the combined imprimatur of the church on homophobia because he had a PhD in psychology." Another clinician who worked for the LDS church told his patient that homosexuality was "a sin, that Satan has taken over you . . . you'll go to hell. Satan wants you to think that you can't change but you can. It's an illness. You need to be cured." Another respondent says: "He [the therapist] of course mixed a lot of religion into it; [he said] we would burn in eternal hell, and the Lord had sent me to him because it was his call in life to help the returning missionaries and members of church who had fallen astray."

Conclusion

Study is needed of the clinical and ethical implications of introducing religion into conversion therapy.

Termination of Conversion Therapy

Not only did many of our participants report a pressure to remain in conversion therapy, they also reported numerous accounts of less than optimal terminations characterized by poor preparation and inadequate treatment referrals. Section 4.09(b) of the APA Ethics Code (1992, p. 1606) states that "(b) Psychologists terminate a professional relationship when it becomes reasonably clear that the patient or client no longer needs the service, is not benefitting, or is being harmed by continued service. (c) Prior to termination for whatever reason, except where precluded by the patient's or client's conduct, the psychologist discusses the patient's or client's views and needs, provides appropriate pre-termination counseling, suggests alternative service providers as appropriate, and takes other reasonable steps to facilitate transfer of responsibility to another provider if the patient or client needs one immediately." In this section, two areas are examined: (a) coercion to remain in conversion therapy; and (b) failure to prepare for termination.

Coercion to Remain in Conversion Therapy

We found several instances of pressure to stay in therapy when a client wanted to leave or was not benefitting from treatment. One participant recounts: "I got accepted to . . . law school. I had to leave and move. Last session I told him that. He thought it was a mistake and that I shouldn't leave therapy. He felt if I left therapy I would not be able to resolve my sexual orientation issues. That was something he didn't want me to do as a mental health professional and as a Christian brother because I would loose my salvation." Another respondent tells of a therapist who pursued contact with him after termination: "I tried to leave him, he wouldn't let me leave. He would call me." A wish to

leave because of a lack of progress in therapy was frequently attributed, by the therapist, as a fault of the client for not working hard enough. One conversion therapist told a client that "I hadn't given it enough time. He had seen a lot of progress in me. To leave now would ruin everything, and destroy what I had improved on."

Failure to Prepare for Termination

For most of the participants who terminated conversion therapy as treatment failures, there was a lack of preparation for post-conversion life. Pre-termination counseling neglected: (a) re-entry into gay life; (b) loss of community; and (c) integration of homosexual desire with identity, relationships, and sex. Addressing these issues may be most critical for persons who end conversion therapy as self-perceived failures. This population appears to be more vulnerable to depression, anxiety and self-defeating behaviors (Shidlo and Schroeder, 2001). One participant says of the aftermath of failed conversion therapy: "Instead of getting closer to people I continued to keep it a secret. I felt like I didn't fit in or belong in the gay or straight community. Like I didn't fit anywhere like I was somehow in between. I felt I was afraid to be around gay people, like they would think less of me, because I was naive with no experience whatsoever. . . . in the straight community I had to keep it a secret."

As argued above, conversion therapies include inculcating lesbians and gay men with the belief that a homosexual orientation is a psychological disorder not compatible with a satisfying life. Individuals whose conversion therapies have failed are subsequently left with exaggeratedly negative attitudes toward their own homosexual orientation and without any appropriate tools to cope with either feeling like a failure or how to affirmatively integrate their homosexual orientation into their lives:

> When you have years and years of people telling you it's sick and wrong it wears on you and you start to believe it. I still don't have self-esteem because of negative stuff I've been told my whole life. . . . Because who I am is wrong. If I look in the mirror and I'm not gay or totally straight, where do I fit in? How do I come to terms with that? *They [conversion therapists] never taught me how to deal with that; just how to try and change it.*

Among supporters of conversion therapy, only Yarhouse (1998) has articulated the importance to informed consent of a discussion of the risk of failure. He says: "Those who have as their goal complete change of sexual orientation and who view failure to achieve a 'complete heterosexual shift' as evidence of lack of faith, lack of spiritual maturity, or as a sign of moral degradation may be in a far worse state than those who attempt change but recognize the poten-

tial limitations of change techniques. A related concern is that lack of success in treatment may lead to anger and resentment. These feelings may be directed inward (taking the form of depression or suicidality), or they may be directed at the therapist, family members, society, God, the church, support groups, and so on" (p. 256). Other conversion therapists frequently dismiss the possibility that they may have caused harm (cf. Dreifus, 1999; Nicolosi, 1999a).

CONCLUSION

Our study suggests that there are significant ethical issues in the application of sexual orientation conversion therapies. Interviews with consumers of conversion therapies indicate that many conversion therapists may not be practicing in a manner consistent with the APA Ethics Code (1992), similar professional codes by other mental health organizations, and guidelines on the appropriate treatment of gay and lesbian psychotherapy patients (Conger, 1975; ACA, 1999; APA, 1998, 2000; American Psychiatric Association, 2000).

It has been argued that any sexual orientation conversion treatment by a licensed mental health practitioner may be viewed as consumer fraud (Haldeman, 1991). According to these arguments, with the declassification of homosexuality as a mental disorder, the diagnosis of a homosexual orientation as a psychological disorder and subsequent interventions to treat it deceive the patient and the public that homosexuality is a pathological condition (Davison, 1991). Bryant Welch, former Executive Director of Practice Directorate of the American Psychological Association, stated in 1990 that "no scientific evidence exists to support the effectiveness of any of the conversion therapies that try to change one's sexual orientation" (as quoted in Herek, 2001). In Schreier's (1998) words, "The position . . . simply put, is: there is no illness, there is no cure" (p. 305). Many consumers reported to us that their conversion therapist did not inform them of the positions of the American Psychological Association and the American Psychiatric Association that scientific evidence demonstrates that a homosexual orientation is not associated with psychopathology.

This raises unsettling questions about the relationship between conversion therapists and the associations that determine the standards of practice for their profession. Nicolosi (2000), executive director of NARTH, has written a polemic entitled "Imagine . . . " in which he discusses the possibility of a class-action suit against the American Psychological Association and the American Psychiatric Association. Nicolosi justifies his adversarial position with the claim that the two APAs "*[fail] to disclose* that homosexuality is a treatable condition [italics in original]." He further argues that lesbians and gay men are not being "properly informed that acceptance of a gay identity would lead to greater risk for anxiety, depression, low self-esteem, loneliness, suicide at-

tempts, failed relationships, drug use, alcohol abuse, tobacco use, and addiction to unhealthy (exotic) [sic] sexual practices, as well as STD'S [sic] and AIDS." Other conversion therapists feel that the American Psychological Association has "restricted the flow of information . . . necessary for science to function objectively" and "employed coercion to enforce its politics" and have called for the founding of a "Psychologists for a Free APA" group (Johnson, 1995, p. 53).

Based on interviews with consumers, we identified the following critical issues on the ethics of conversion therapies.

Informed Consent

In the area of informed consent we found several ethical lapses:

1. Clinicians did not provide accurate information about sexual orientation. Clients were told that a homosexual orientation is a psychological disorder or that it does not exist. Clinicians provided purportedly scientific, fraudulent information about gay lives and relationships which characterized them as unhappy and dysfunctional. Such statements do not reflect the current status of social scientific knowledge regarding the lived lives of gay men and lesbians. Conversion therapists who tell patients otherwise may be practicing unethically. As Singer (1980) has stated, in a paper on the scientific basis of psychotherapeutic practice, "The practitioner who has not examined recent developments in the research literature . . . may well be violating a central ethic of the profession" (p. 372).
2. Clinicians did not provide accurate information about the efficacy of the proposed intervention and prognosis. Many clients were told that high motivation and hard work in the treatment would assure a change in sexual orientation.
3. Alternative treatment options such as gay-affirmative therapy were only infrequently discussed.
4. Clinicians who were employed by religious universities may have a professional conflict of interest if they provide conversion therapy to students who are mandated to change their sexual orientation at the threat of academic expulsion.

Religion

A frank discussion and empirical research are needed about whether and when it is appropriate for a clinician to use religious justification for behavioral change or to threaten a client with religious consequences from a failure to change their sexual orientation. How do religious exhortations affect the

practice of psychotherapy? When and how is it appropriate for the clinician to tell a patient about his own religious beliefs? What religious interventions are consistent with competent psychotherapy for lesbians and gay men who struggle with their sexual orientation? Richards and Potts (1995) have suggested that psychotherapists within each religious faith should develop ethical guidelines and standards of practice for clinicians who wish to use spiritual interventions. Although not writing about lesbians and gay men in psychotherapy, Bergin (1991, p. 399) has written a thoughtful statement on the issue of introducing religion into psychotherapy. He says:

> Although religious therapists often have a strong interest in value discussions, this can be problematic if it is overemphasized. It would be unethical to trample on the values of clients, and it would be unwise to focus on value issues when other issues may be at the nucleus of the disorder, which is frequently the case in the early stages of treatment. It is vital to be open about values but not coercive, to be a competent professional and not a missionary for a particular belief, and at the same time to be honest enough to recognize how one's value commitments may or may not promote health.

Pre-Termination Counseling

Proper pre-termination counseling with clients *who fail* conversion therapy appears to be especially neglected. Our respondents who failed to change sexual orientation indicated that they did not receive assistance from their conversion therapist in coming to terms with this failure or accepting a homosexual orientation. Clients not only blamed themselves for the failure to change, but were also sometimes blamed by their therapist. Furthermore, many conversion therapists do not appear to provide appropriate referrals for patients who failed to change.

Since a central component of conversion therapy is the indoctrination of patients with the belief that a homosexual orientation is a psychological disorder and is not compatible with a happy life and satisfying relationships (cf. Dallas, 1991; Moberly, 1983; Nicolosi, 1991, 1993; Satinover, 1996; Socarides, 1978, 1995), it is imperative that conversion therapy failures be provided with efficacious help to deal with the iatrogenically induced exacerbation of internalized homophobia.

Negative Side-Effects

In our view, informed consent has to include an accurate discussion of the possible negative effects of conversion therapy. Our research (Shidlo and Schroeder, 2001) suggests that many participants in sexual orientation conversion therapies are plagued by serious psychological and interpersonal problems

after termination. These negative effects include depression, poor self-esteem, and difficulties with intimate relationships. These findings are consistent with the observations of others (American Psychiatric Association, 1998, 2000; Drescher, 2001b; Haldeman, 1991, 1994, 2001; Isay, 1990, 1997). Conversion therapists and their supporters have historically ignored the possible harm of their interventions. The recent recognition by Nicolosi et al. (2000) and Yarhouse (1998) of possible negative effects of conversion therapies represents a welcome shift.

How are we to understand the general neglect of negative effects in the conversion therapy literature? Research on negative outcomes in psychotherapy suggests that clients and therapists alike may have difficulties expressing and dealing with harm of treatment. Marsh and Hunsley (1993) have written that:

> Failures in therapy may also not be readily noted because they are sometimes hidden by the client, perhaps out of deference to authority, a desire to please the therapist, or the anticipation of therapist disapproval. Surprisingly, such client behavior may be adaptive, as most therapists have difficulty in recognizing and responding appropriately to negativity or critical feedback from clients (e.g., Colson, Lewis, and Horwitz, 1985; Hill, 1990). (p. 292)

Thus, one hypothesis for the neglect of negative effects in the conversion therapy literature is that clients may not be always telling their therapists about harm. Hill, Gelso, and Mohr (2000) have studied the complex phenomenon of client concealment and found that:

> Clients have reported keeping secrets because of feeling deferent toward therapists, feeling ashamed or embarrassed, not being able personally to handle the disclosure, thinking that the therapist could not handle the disclosure, being afraid to express feelings, being concerned that revealing secrets would show the therapist how little progress had been made, not having enough time, not being willing to tell anyone, not being motivated to address the secret, or feeling loyalty to someone else (Hill et al., 1993; Kelly, 1998; Rennie, 1994).

These findings are consistent with our data that many conversion therapy patients withheld from their therapists information about unchanged homosexual desire and behavior, as well as misrepresented the appearance of new heterosexual feelings (Shidlo and Schroeder, 2001). Many respondents told us that they left conversion therapy pretending to their therapist to have changed their sexual orientation. One participant said:

> Toward the end, I just started acting, like going there and being all positive and happy; I still felt suicidal. Because I didn't know how to tell him I wanted to quit. I was afraid of him.

Conversion therapists need to assess and to attend to patients' concealed or unexpressed information about failure to change, desire to please, and fear of feeling blame. Process and outcome research on the long-term negative effects of conversion therapies are urgently needed.

NOTES

1. Hereinafter, this document is referred to as the APA Ethics Code.
2. Hereinafter this document is referred to as the APA's Resolution on Therapeutic Responses.
3. Hereinafter this document is referred to as the APA Guidelines for Psychotherapy.
4. Hereinafter this document is referred to as the Attempts to Change Sexual Orientation.
5. Promise Keepers (PK) describes itself as a "Christ-centered ministry dedicated to uniting men through vital relationships to become godly influences in their world." It has been termed a male supremacist group by the National Organization for Women (NOW) and, according to the Center for Democracy Studies, advances "the strategic political agenda of the Christian right." NOW reports that PK's leadership has been involved in anti-gay political activity (see www.promisekeepers.org, www.now.org/issues/right/pk.html, and www.cdsresearch.org/promise_keepers_watch.htm).

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Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

Topic: Health Care Delivery	**Policy Subtopic: NA**
Meeting Type: Interim	Year Last Modified: 2018
Action: Reaffirmed	Type: Health Policies
Council & Committees: Council on Science and Public Health	undefined

1. Our AMA: (a) believes that the physician's nonjudgmental recognition **of** patients' sexual orientations, sexual behaviors, **and** gender identities enhances the ability to render optimal patient **care** in **health** as well as in illness. In the case **of** lesbian, gay, bisexual, **transgender**, **queer**/questioning, **and** other (LGBTQ) patients, this recognition is especially important to address the specific **health care needs of** people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state **of** research in **and** knowledge **of** LGBTQ **Health and** the need to elicit relevant gender **and** sexuality information from our patients; these efforts should start in medical school, but must also be a part **of** continuing medical education; (ii) educating physicians to recognize the physical **and** psychological **needs of** LGBTQ patients; (iii) encouraging the development **of** educational programs in LGBTQ **Health**; (iv) encouraging physicians to seek out local or national experts in the **health care needs of** LGBTQ people so that all physicians will achieve a better understanding **of** the medical **needs of** these **populations**; **and** (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical **needs of** LGBTQ patients; **and** (c) opposes, the use **of** "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual **and** gender minority individuals to undergo regular cancer **and** sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; **and** (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; **and** (iv) that individuals who identify as a sexual **and**/or gender minority (lesbian, gay, bisexual, **transgender**, **queer**/questioning individuals) experience intimate partner violence, **and** how sexual **and** gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers **and** may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ **health** issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues **of** mutual concern in order to provide the most comprehensive **and** up-to-date education **and** information to enable the provision **of** high quality **and** culturally competent **care** to LGBTQ people.

Policy Timeline

CSA Rep. C, I-81

Reparative Therapy

The American Academy of Family Physicians (AAFP) opposes the use of “reparative” or “conversion” therapy of lesbian, gay, bisexual or transsexual individuals. The AAFP recommends that parents, guardians, young people, and their families seek support and services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority persons of all ages.

(2007) (2016 COD)

Reparative Therapy (Conversion Therapy)
https://www.aafp.org/about/policies/all/reparative-therapy.html

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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 Practice Parameters are developed by the AACAP CQI in accordance with American Medical Association policy. Parameter development is an iterative process between the primary author(s), the CQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP Committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the Parameter development process can be accessed on the AACAP website. Responsibility for Parameter content and review rests with the author(s), the CQI, the CQI Consensus Group, and the AACAP Council.

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.

The authors acknowledge the following experts for their contributions to this Parameter: Members of the AACAP Sexual Orientation and Gender Identity Issues Committee: Sarah E. Herbert, M.D., M.S.W., Chair, and Beth Belkin, M.D., Ph.D., Ledro R. Justice, M.D., Scott Leibowitz, M.D., William Martin, M.D., Edgardo J. Menvielle, M.D., Yiu Kee Warren Ng, M.D., R. Kaan Ozbayrak, M.D., Richard R. Pleak, M.D. (former Chair), Joel J. Stoddard, M.D., William M. Womack, M.D., and other topic experts: Deborah Carter, M.D., Jennifer I. Downey, M.D., James Farrow, M.D., Richard C. Friedman, M.D., Heino F. L. Meyer-Bahlburg, Dr. rer. nat., and Cynthia Telingator, M.D.

This Practice Parameter was reviewed at the Member Forum at the AACAP Annual Meeting in October 2010.

From September 2011 to February 2012, this Parameter was reviewed by a Consensus Group convened by the CQI. Consensus Group members and their constituent groups were as follows: Heather J. Walter, M.D., M.P.H., chair, Christopher Bellonci, M.D., shepherd, and Helene Keable, M.D. and Saundra Stock, M.D., members (CQI); Gerald Dabbs, M.D. and Cynthia Telingator, M.D. (Topic Experts); Theodore Petti, M.D. and Kathleen Trello-Rishel, M.D. (AACAP Assembly of Regional Organizations); and Kathleen Kelley, M.D. and Melvin Oatis, M.D. (AACAP Council).

This Practice Parameter was approved by the AACAP Council on May 31, 2012.

This Practice Parameter is available on the Internet (www.aacap.org).

Disclosure: Oscar Bukstein, M.D., M.P.H., co-chair, has received support from the National Institute of Mental Health (NIMH), the National Institute of Child Health and Human Development (NICHD), and Shire. He has received royalties from Routledge Press. Stewart L. Adelson, M.D., and Heather J. Walter, M.D., M.P.H., co-chair, report no biomedical financial interests or potential conflicts of interest. Disclosures of potential conflicts of interest for all other individuals named above are provided on the AACAP website on the Practice Parameters page.

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http://dx.doi.org/10.1016/j.jaac.2012.07.004

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NEWS

THE LATEST NEWS FROM ACA

Ethical issues related to conversion or reparative therapy

Jan 16, 2013

American Counseling Association members have consulted ACA staff and leaders regarding the practice of conversion therapy and the 2005 Code of Ethics. For this reason, the ACA Ethics Committee is sharing its formal interpretation of specific sections of the ACA Code of Ethics concerning the practice of conversion therapy and the ethics of referring clients for this practice.

By Joy S. Whitman, Harriet L. Glosoff, Michael M. Kocet and Vilia Tarvydas

American Counseling Association members have consulted ACA staff and leaders regarding the practice of conversion therapy and the 2005 Code of Ethics. For this reason, the ACA Ethics Committee is sharing its formal interpretation of specific sections of the ACA Code of Ethics concerning the practice of conversion therapy and the ethics of referring clients for this practice.

Committee members individually considered a hypothetical scenario that was based on actual questions posed to the members and staff. The Ethics Committee then met to reach a consensus opinion.

THE SCENARIO

During the third session of counseling, a client reports that he is gay and states, "I want to change my way of life and not be gay anymore. It's not just that I don't want to act on my sexual attraction to men. I don't want to be attracted to them at all except for as friends. I want to change my life so I can get married to a woman and have children with her." At the suggestion of a friend, the client has read about reparative/conversion therapy and has researched this approach on the Internet. He is convinced this is the route he wants to take.

The counselor listens carefully to what the client has to say, asks appropriate questions and engages in a clinically appropriate discussion. The counselor informs the client that, although she is happy to continue working with him, she does not believe reparative/conversion therapy is effective and no

empirical support exists for the approach. She further states that this form of therapy can actually be harmful to clients, so she will not offer this as a treatment. The client says he is disappointed that the counselor will not honor his wishes. He then asks for a referral to another counselor or therapist who will work with him to "change his sexual orientation."

INTERPRETATION

The ACA Ethics Committee considered many factors and derived a consensus opinion that addresses several sections of the ACA Code of Ethics and moral principles of practice present in such a scenario. We started with the basic goal of reparative/conversion therapy, which is to change an individual's sexual orientation from homosexual to heterosexual. Counselors who conduct this type of therapy view same-sex attractions and behaviors as abnormal and unnatural and, therefore, in need of "curing." The belief that same-sex attraction and behavior is abnormal and in need of treatment is in opposition to the position taken by national mental health organizations, including ACA.

The ACA Governing Council passed a resolution in 1998 with respect to sexual orientation and mental health. This resolution specifically notes that ACA opposes portrayals of lesbian, gay and bisexual individuals as mentally ill due to their sexual orientation. In addition, the resolution supports dissemination of accurate information about sexual orientation, mental health and appropriate interventions and instructs counselors to "report research accurately and in a manner that minimizes the possibility that results will be misleading" (ACA Code of Ethics, 1995, Section G.3.b). In 1999, the Governing Council adopted a statement "opposing the promotion of reparative therapy as a cure for individuals who are homosexual." In fact, according to the DSM-IV-TR, homosexuality is not a mental disorder in need of being changed. With this in mind, we have a difficult time discussing the appropriateness of conversion therapy as a treatment plan. Regardless, there are clients who seek out counselors in hopes of changing their sexual behaviors, orientation or identity, so the ACA Ethics Committee conducted a review of the literature on reparative therapy.

We found that the majority of studies on this topic have been expository in nature. We found no scientific evidence published in psychological peer-reviewed journals that conversion therapy is effective in changing an individual's sexual orientation from same-sex attractions to opposite-sex attractions. Further, we did not find any longitudinal studies conducted to follow the outcomes for those individuals who have engaged in this type of treatment. We did conclude that research published in peer-reviewed counseling journals indicates that conversion therapies may harm clients (refer to the full article posted on the ACA website for references).

These findings bring several questions to the forefront:

- Is a counseling professional who offers conversion therapy practicing ethically?
- Since ACA has taken the position that it does not endorse reparative therapy as a viable treatment option, is it ethical to refer a client to someone who does engage in conversion therapy?
- If a client insists on obtaining a referral, what guidelines can a counselor follow?
- If professional counselors do engage in conversion therapy, what must they include in their disclosure statements and informed consent documents?

Ethics Committee members agreed that it is of primary importance to respect a client's autonomy to request a referral for a service not offered by a counselor. In the 2005 ACA Code of Ethics, Standard A.11.b. ("Inability to Assist Clients") states, "If counselors determine an inability to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are

knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives." Additionally, Standard D.1.a. ("Different Approaches") reminds us that "counselors are respectful of approaches to counseling services that differ from their own."

Standard A.1.a. ("Primary Responsibility"), however, states that "the primary responsibility of counselors is to respect the dignity and to promote the welfare of clients." Referring a client to a counselor who engages in a treatment modality not endorsed by the profession and that may, in fact, cause harm does not promote the welfare of clients and is a dubious position ethically. This position is supported by Standard A.4.a. ("Avoiding Harm"), which says, "Counselors act to avoid harming their clients, trainees and research participants and to minimize or to remedy unavoidable or unanticipated harm."

Professionals also engage in treatment only after appropriate educational and clinical training and do not practice outside of their areas of competence (Standard C.2.a., "Boundaries of Competence"). This standard clearly states that "counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience." In addition, per Standard C.2.b. ("New Specialty Areas of Practice"), "Counselors practice in specialty areas new to them only after appropriate education, training and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm." Therefore, any professional engaging in conversion therapy must have received appropriate training in such a treatment modality with the requisite supervision. There is, however, no professional training condoned by ACA or other prominent mental health associations that would prepare counselors to provide conversion therapy.

In addition, requests by clients seeking to change their sexual orientation should be understood within a cultural context. Standard E.5.c. ("Historical and Social Prejudices in the Diagnosis of Pathology") requires that "counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment." Historically, the mental health professions viewed homosexuality as a mental disorder. But in 1973, homosexuality was removed from the Diagnostic and Statistical Manual as a mental disorder. However, within various religious and cultural communities, same-sex attractions and behaviors are still viewed as pathological. Yet the professional communities of counseling and psychology no longer diagnose a client who has attractions to people of the same sex as mentally disordered. To refer a client to someone who engages in conversion therapy communicates to the client that his/her same-sex attractions and behaviors are disordered and, therefore, need to be changed. This contradicts the dictates of the 2005 ACA Code of Ethics.

Clients may ask for a specific treatment from a counseling professional because they have heard about it from either their religious community or from popular culture. A counselor, however, only provides treatment that is scientifically indicated to be effective or has a theoretical framework supported by the profession. Otherwise, counselors inform clients that the treatment is "unproven" or "developing" and provide an explanation of the "potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm" (Standard C.6.e., "Scientific Bases for Treatment Modalities").

Considering all the above deliberation, the ACA Ethics Committee strongly suggests that ethical professional counselors do not refer clients to someone who engages in conversion therapy or, if they do so, to proceed cautiously only when they are certain that the referral counselor fully informs clients of the unproven nature of the treatment and the potential risks and takes steps to minimize harm to clients (also see Standard A.2.b., "Types of Information Needed"). This information also must be included in

written informed consent material by those counselors who offer conversion therapy despite ACA's position and the Ethics Committee's statement in opposition to the treatment. To do otherwise violates the spirit and specifics of the ACA Code of Ethics.

INFORMING CLIENTS ABOUT CONVERSION THERAPY

So what do ethical counselors do if clients state they are still interested in pursuing a referral for a counselor who offers conversion therapy? We advise professional counselors to discuss the potential harm of this therapy noted in evidence-based literature from scholarly publications in a manner that respects the client's decision to seek it. This again relates to Standard A.1.a. ("Primary Responsibility") and Standard A.4.b. ("Personal Values"), which requires counselors to be "aware of their own values, attitudes, beliefs and behaviors and avoid imposing values that are inconsistent with counseling goals." The responsibility of counseling professionals at this juncture is to help clients make the most appropriate choices for themselves without the counselor imposing her/his values. To do so respects a client's request and leaves open the possibility that the client can return to the professional counselor if the conversion therapy is ineffective and harms the client.

Again, Ethics Committee members agree that ethical practitioners refer clients seeking conversion therapy only under the conditions previously discussed. Further, it is imperative that counselors provide clients seeking conversion therapy with information about this form of treatment, including what types of information clients should expect from referral counselors. The following must be included in informed consent material and communicated to clients seeking referral:

1. Conversion therapy assumes that a person who has same-sex attractions and behaviors is mentally disordered and that this belief contradicts positions held by the American Counseling Association and other mental health and biomedical professional organizations. Additionally, the ACA passed a resolution in 1999 stating that it does not endorse reparative therapy as a "cure" for homosexuality. Any professional who engages in conversion therapy is not offering the professional standard of care and would need to include that he or she is offering it not as a professional counselor but is providing counseling within the scope of practice of some other profession (i.e., Christian counselor).
2. Conversion therapy as a practice is a religious, not psychologically-based, practice. The premise of the treatment is to change a client's sexual orientation. The treatment may include techniques based in Christian faith-based methods such as the use of "testimonials, mentoring, prayer, Bible readings, and Christian weekend workshops" (Shroeder & Shidlo, 2001, p. 150). It may also use cognitive-behavioral techniques such as aversion therapy (i.e.; stopping clients from masturbating to same-sex images; encouraging imagery of getting AIDS paired to same-sex arousal), reinforcement techniques that emphasize traditional gender role behavior (i.e., for men to "engage in team sports, to go the gym, and to attend Promise Keepers" and for women "to learn how to cook, sew, and apply make-up"; Shroeder & Shidlo, 2001, p. 149), and use of sexual surrogates. However, there is no training offered or condoned by the American Counseling Association to educate and prepare a professional counselor wishing to engage in this type of treatment.
3. Research does not support conversion therapy as an effective treatment modality. There have been "no objective screening criteria, no consensus about outcome measurement, and no blinded or side-by-side studies" (Forstein, 2001, p. 173) and there is "no article in a peer reviewed scientific journal" stating that conversion therapy alters someone's sexual orientation (p. 177). The results of some research indicate that some clients seeking this treatment do change their behavior approximately 30% of the time, but the same clients report changing only their behaviors but not their sexual orientation. This is an important distinction to share with clients, helping them understand the difference between behaviors and sexual identity. Further, no long-term studies

have been conducted to discern whether research participants who reported a change in their behaviors maintained these changes over time.

4. There is potential for harm when clients participate in conversion therapy. Results of studies indicate that there are clients who enter this type of treatment and then report that they function more poorly than when they entered (Nicolosi, Byrd, & Potts, 2000; Schroeder & Shidlo, 2001).
5. There are treatments endorsed by the Association for Gay, Lesbian, and Bisexual Issues in Counseling (see **http://www.aglbic.org/resources/competencies.html**), a division of the American Counseling Association and the American Psychological Association (see **http://www.apa.org/pi/lgbc/guidelines.html**) that have been successful in helping clients with their sexual orientation. These treatments are gay affirmative and help a client reconcile his/her same-sex attractions with religious beliefs.

In summary, if clients still decide that they wish to seek conversion therapy as a form of treatment, counselors should also help clients understand what types of information they should seek from any practitioner who does engage in conversion therapy. The Committee members agree that counselors who offer conversion therapy are providing "treatment that has no empirical or scientific foundation" (ACA, 2005, C.6.e.) and, therefore, must "must define the techniques/procedures as 'unproven' or 'developing' and explain the potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm" (ACA, C.6.e.). Additionally, any client seeking treatment is entitled to complete information about the treatment. This is consistent with A.2.b (Types of Information Needed) that state "counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information." Counselors who do not include this information would be considered by the Committee to be in violation of the ACA Code of Ethics.

There also was agreement among the Committee members that any counselors stating that they can offer conversion therapy must also offer referrals to gay, lesbian, and bisexual-affirmative counselors and should discuss thoroughly the right of clients to seek these professionals' counsel. In doing so, counselors must explore with clients the underlying reasons for their interest in changing their sexual orientation and discuss the social, political, and religious influences that underpin homophobia that may be harming the client.

COUNSELOR EDUCATION

Finally, in addition to educating potential clients about conversion therapy, the members of the Ethics Committee agreed that counselor education training programs must also adhere to section F.6.f (Innovative Theories and Techniques), which states that "when counselor educators teach counseling techniques/procedures that are innovative, without an empirical foundation, or without a well-grounded theoretical foundation, they define the counseling techniques/procedures as 'unproven' or 'developing' and explain to students the potential risks and ethical considerations of using such techniques/procedures." A similar approach to informed consent for clients seeking conversion therapy must be upheld when discussing this treatment with counseling students.

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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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Pediatrics 1993;92;631

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