EXHIBIT

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(Rebuttal Declaration of Christopher Rosik, Ph.D.)

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

ROBERT L. VAZZO, LMFT, etc., et al.,	)	
	)	
Plaintiffs,	)	
v.	)	Case No. 8:17-cv-2896-T-02AAS
	)	
CITY OF TAMPA, FLORIDA,	)	
	)	
Defendant.	)	
	)	

REBUTTAL DECLARATION OF CHRISTOPHER ROSIK, PH.D.

I, Dr. Christopher Rosik, hereby declare as follows:

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I. SUMMARY OF REBUTTAL POINTS AND PRELIMINARY CONSIDERATIONS.

1. Ordinance 2017-47 (City of Tampa, 2017) is a very serious curtailment of the rights and liberties of minor clients and their families to pursue and licensed therapists to provide change-allowing talk therapies. As such, it can only be justified by an extremely rigorous body of scientific evidence that is exhaustive in scope and undisputable in its integrity. Here I will add to my initial declaration and show further that this standard is not met on any level by Ordinance 2017-47, and the Declaration of Judith M. Glassgold (the "Glassgold Declaration") does not sufficiently advance a case to challenge this conclusion.

2. While it is impossible under time limited conditions to address all my concerns with the Glassgold Declaration, I will below attempt to bring to light some of my most serious concerns with this declaration in both fact and style. I will show that the Glassgold Declaration presents a straw version of "conversion therapy" not practiced by licensed therapists who provide change-allowing talk therapies to minors and adults. This straw therapy is then contrasted with supportive therapy, as if to imply (falsely) that professional SOCE clinicians do not support their clients in their self-determined goals.

3. I then attend to a representative sample of the more recent research on SOCE and contend that the Glassgold Declaration does not attend to the methodological limitations of these studies that make it scientifically inappropriate to generalize their findings to change-allowing talk therapies provided by licensed therapists. I go on to address the Spitzer study and the literature on sexual orientation stigma and discrimination, making it clear that justification is lacking for using professional SOCE as a proxy for these terms.

4. I also address the ubiquitous appeals to authority offered in the Glassgold Declaration and Ordinance 2017-47 and note the need for a healthy skepticism when professional organizations whose leaders lack ideological diversity make scientific claims concerning subject matter in which they are highly invested in advocacy goals. This is followed by my observations on the occurrence and meaning of the rapidly evolving and broadening scope of "conversion therapy" terminology. Finally, I point out the many overstatements in the Glassgold Declaration and suggest that many of my concerns can be understood in terms of the influence of confirmation bias.

5. Although ban proponents have many advocacy and political reasons for Ordinance 2017-47, the evidence I present in my declarations, both before and below, indicate there is not a sufficient nor scientifically justified basis for abolishing the right of minors and licensed therapists to engage in client-centered change-allowing talk therapies.

II. REBUTTAL ANALYSIS AND OPINIONS.

A. Creation of Straw Arguments and False Dichotomies Regarding Change-Allowing Talk Therapies.

6. As is common in legal proceedings pertaining to therapy bans, the Glassgold Declaration paints a picture of licensed mental health professionals who engage in change-allowing talk therapies as essentially monstrous human beings. These clinicians are described as

universally seeing same-sex attractions as psychopathological disorders, having predetermined etiologies, coercing and pressuring clients into therapy, imposing an *a priori* therapy outcome, forcing a singular gender expression, and teaching parents to invalidate their children's feelings. Although any association of therapists may include a few outlier bad actors, the Glassgold Declaration, along with other documents such as the SAMHSA report (SAMHSA, 2015), suggest there are no responsible, ethical, licensed therapists who provide change-allowing talk therapies. This characterization can only be described as a false caricature in the service of a straw argument.

7. I address some of these caricatures below. In my experience, licensed therapists who provide professional change-allowing talk therapy have a variety of beliefs regarding the origins of nonheterosexuality and its status as a normal expression of sexual and gender diversity. But in a real sense, this focus simply misses the point: It is not the therapist's view of etiology or normality that matters but that of the client. Change-allowing talk therapy clinicians are client-centered in focus. They know as do all good therapists that first and foremost one must *actually listen* to their clients. They know one must take special care when working with minors. And they do not pressure clients of any age toward adopting *either* their etiological and moral perspective *or* that of their professional associations (Benoit, 2005; Rosik & Popper, 2014).

8. Clients with distress about their same-sex attractions and behavior rarely seek out change-allowing therapies with a belief that they have a mental disorder needing cure, but rather they overwhelmingly report experiencing a moral and religious problem. These concerns are well acknowledged as legitimate within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013; Code Z65.8 – "Religious or Spiritual Problems") and therapists of all varieties regularly address other issues that are not considered to be mental disorders, such as relationship distress, unplanned pregnancy, or normal grief reactions.

9. The Glassgold Declaration concludes definitively ("no scientific basis") that parental dynamics or childhood sexual abuse play no causal role in any experience of nonheterosexuality. Although this was addressed in my initial declaration, I return to the issue here to underscore Defendant's premature and unjustified foreclosure of the scientific record. The scientific consensus is that the origins of homosexuality are multifactorial, which suggests there are likely to be many pathways to the development of same-sex attractions and behaviors. The Bell, Weinberg, and Hammersmith (1981) research cited in the Glassgold Declaration considered all known factors to that date and concluded each could only be numerically responsible for a small fraction of the causation. This means that no pathway to homosexuality was dominant for all individuals, which is often misinterpreted as meaning there can be no social or family influence on the development of homosexuality at all. However, the environmental factors, including family experiences, when taken together were statistically significant (Whitehead, 2011). This means a more accurate interpretation of the Bell et al. findings would allow for some (though perhaps not most) instances of nonheterosexual development to be strongly influenced by environmental factors such as family dynamics. Again, this underscores the necessity of *listening* to the client.

10. Regarding the potential role of childhood sexual abuse on the development of subsequent nonheterosexuality, I refer back to my original declaration to emphasize that the nature of the research pertinent to this issue cannot conclusively rule in *or* rule out a causal influence for some individuals. The indeterminate nature of the scientific record therefore allows for causal theorizing that involves trauma generally and sexual abuse in particular. As Mustanski, Kuper,

and Geene (2014) conclude in the *APA Handbook of Sexuality and Psychology* regarding this issue, "Overall, these associative or potentially causal links are not well understood and are in need of further research" (pp. 609-610). This uncertainty is a far cry from claims that such considerations have been "thoroughly discredited."

11. The issue of the normality of homosexuality is also much more complex than the Glassgold Declaration recognizes. Although it is not clear within the declaration, the definition of normality in view may be one common to these issues which alludes to nonheterosexual sexual expressions being found broadly within the animal kingdom and therefore not implicitly psychopathological. Science certainly supports these conclusions to some degree, although, as Bancroft (Jannini, Blanchard, Camperio-Ciani, and Bancroft, 2010) observed, "We should also keep in mind that whereas homosexual interactions are common across many species, exclusive homosexual involvement, with the rejection of opportunities for heterosexual activity, is exceedingly rare in nonhumans" (p. 3252). However, clients who seek change-allowing talk therapists may often operate with other conceptions of normality that are equally valid and which prompt them to explore their potential for change in same-sex attractions and behaviors. Apart from statistical definitions of normal, many religious clients who pursue change operate under a natural law model where "normal is that which functions according to design." Change-allowing talk therapy clinicians are sensitive to these nuances of terminology and values, which cannot be resolved by psychology, and they do not pressure clients toward adopting *either* their vision of normal *or* that of their professional associations.

12. Licensed therapists who engage in change-allowing talk therapies know that real therapy by definition does not include coercion but must promote client autonomy and self-determination. Where this exists, and with proper informed consent, such freedom should include the freedom to explore their heterosexual potential. As such, these clinicians are not "imposing outcomes" on clients but simply allowing them to pursue their self-determined goals with an understanding that change is not guaranteed. The Glassgold Declaration asserts (p. 35) that bedrock ethical practices of informed consent and client self-determination are not practiced in or do not apply to change-allowing talk therapies and again trots out a caricature of "conversion therapy" to justify such a conclusion. Beyond the false portrayals of professional SOCE, such statements represent a remarkably low view of human agency, particularly when a significant minority of nonheterosexual persons report experiencing some choice in their sexual orientation (Herek, Norton, Allen, & Sims, 2010). Moreover, research seems to indicate that although changes in sexual orientation are more difficult to achieve than changes in depression or personality, they are more likely to occur than achieving long-term change in weight loss or criminality (Turkheimer, 2011), implying a role for agency and the applicability of self-determination for consumers of change-allowing talk therapies.

13. The Glassgold Declaration also creates a false dichotomy by contrasting the demonized portrayal of "conversion therapy" with supportive therapies, which help families understand their child's conflicts and concerns, assist them in loving and open communication, and reassure youth of their worth. An accurate representation of change-allowing talk therapies provided by licensed clinicians would describe them as encompassing all of these important goals with the additional goal, where clinically appropriate, of exploring the client's potential for experiencing change and fluidity in their unwanted same-sex attractions and behaviors. Licensed clinicians who provide change-allowing therapies know the value of providing safety and

protection from bullying, discrimination, and harassment, as well as providing accurate information about sexual orientation. Contrary to the declaration's portrayal (p. 25), such provision of care is regularly provided in professional change-allowing talk therapy.

14. The Alliance for Therapeutic Choice and Scientific Integrity (ATCSI), the largest association of licensed clinicians engaged in change-allowing talk therapy, has developed practice guidelines for their members that underscore the Defendant's mischaracterization of these clinicians and their psychotherapeutic practices (ATCSI, 2018; Appendix A). In the present context, it should be noted that these guidelines recognize the heightened caution and sensitivity that must be exhibited by any therapist when working with sexual minority youth.

B. Recent Research Is being Used to Advance an Agenda, Not the Science of SOCE.

15. Recently, as the Glassgold Declaration points out, some additional research has reported an elevated risk of harm for SOCE (e.g., Bradshaw, Dehlin, Crowell, & Bradshaw, 2015; Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2015; Flentje, Heck, & Cochran, 2013; Ryan, Toomy, Diaz, & Russell, 2018). Yet these studies share many of the same methodological limitations of the Shidlo and Schroeder (2002) study I mentioned in my initial declaration.

i. Flentje et al. (2013).

16. Flentje et al. utilized a small, non-representative sample of 38 participants who self-identified as "ex-ex-gay." The majority of the self-reported, retrospective therapy "episodes" documented were in fact provided by religious, pastoral, and peer counselors. Only 34.6% of therapy "episodes" were reported as actually being provided by licensed therapists. There is no way of knowing from this study which provider types engaged in the alleged ethically dubious interventions. However, the authors did acknowledge that *no* licensed therapist was ever described by participants as utilizing aversion therapy. Ten participants reported having attempted suicide. Of these, 6 participants reported a suicide attempt prior to their therapy, 7 reported a suicide attempt during SOCE, and one indicated suicide attempts following the conclusion of their treatment. These findings suggest a significant portion of the sample was experiencing serious emotional distress *prior to* their SOCE, and the occurrence or degree of emotional harm due to their therapy experience simply cannot be ascertained in the absence of longitudinal data. Reported costs of SOCE appear to be highly skewed by the presence of one or more outliers. For example, the costs of all SOCE per participant were $7,105 and the median costs $2,150, with a standard deviation of $11,384. These costs were reported to range between $0 and $52,000, again indicating at least one severe outlier. It is curious that when the authors attempt to make the case against SOCE in the discussion section they choose to cite the inflated mean figure for total costs rather than the more appropriate (and less dramatic) median statistic.

ii. Dehlin et al. (2015).

17. Dehlin et al. tend to tout their study as providing a large and diverse sample of Mormon SOCE participants. Although the study sample is relatively large, it lacked diversity in that only 29% of participants were still actively engaged with the LDS church. Thus, the sample consisted overwhelmingly of participants who were moderately to highly disaffected from their

church, which raises concerns about the representativeness of the sample and the response bias this disaffection may have introduced against SOCE specifically and conservative values in general. Participants were asked to rate their SOCE experiences on a 5-point scale, from 1 = *highly effective*, 2 = *moderately effective*, 3 = *not effective*, 4 = *moderately harmful*, and 5 = *severely harmful*. This is a highly unusual rating scale in that it is anchored by terms that are actually measuring different dimensions, i.e., effectiveness and harm. To be consistent with most research, Dehlin and colleagues should have provided participants with two scales, one anchored by *highly effective* on one end and *highly ineffective* on the other end and the other by *significantly beneficial* and *significantly harmful*.

18. Note also that the midpoint of the scale is *not effective*, which is far from the typical neutral rating one would expect to find at the center point of a scale. This also is hard to fathom and clearly promotes a biasing effect toward SOCE as lacking effectiveness. As it stands, the conflation of harm and effectiveness in the response scale used in this study creates significant uncertainties about what the results actually mean. Certainly, outcomes would have been more favorable had Dehlin et al. defined the midpoint as *not harmful* rather than *not effective*, which would have been an equally arbitrary methodological decision. In spite of these problems with scale definitions and their potential biasing toward ineffective SOCE ratings, therapist-led SOCE methods actually did receive mildly positive endorsements. Psychotherapy was found to have moderately or greater *effectiveness* by 44% of respondents who sought it, with respective effectiveness ratings of 48% for psychiatry and 41% for group therapy. Finally, as with Flentje et al., the study combined religious and professional SOCE providers in deriving its findings, and the vast majority of SOCE did not involve licensed therapists. It should be noted that while Bradshaw et al. (2015) analyzed a subsample of the Dehlin et al. database who reported engaging in professional psychotherapy, this study suffers from the same sample and measurement concerns.

iii. Ryan et al. (2018).

19. This study is important in that it focuses on minors and concludes with the implication their research supports legislative and professional regulatory efforts to prohibit licensed therapists from engaging any minor in change-allowing talk therapies. This is a highly questionable conclusion for several reasons. Ryan et al. did not disentangle participants' retrospective perceptions of the effects of licensed therapists from that of unregulated and unaccountable religious counselors, so it is impossible to rule out the common-sense suspicion that negative effects were an outcome far more attributable to the practices of the latter group, as the Dehlin et al. (2015) data suggest. Participants were asked if they were involved in attempts to "cure, treat, or change" their sexual orientation. The concept of "cure, treat, or change" is also quite nebulous. This language may not only have served as a prompt for more negative responding, but presumably was elastic enough in participants' minds to include anything from simple prayers for healing ubiquitous in conservative religious circles to much rarer and harmful practices like exorcisms for which no change-allowing talk therapist advocates.

20. The Glassgold Declaration acknowledges that many children and adolescents "experience their sexual orientation as fluid" (p. 27). By limiting their sample to LGBT identified young adults recruited through LGBT venues who self-identified in adolescence and who did not report experiencing any sexual orientation fluidity, Ryan et al.'s sample excludes by definition those sexual minorities who may have felt some benefit from religious and professional

experiences that could be viewed as non-affirming. Thus, the nature of the sample may overestimate harm.

21. There is also growing evidence that constructs and conclusions derived from LGBT-identified samples such as Ryan et al.'s may not be easily transferrable to non-LGBT identified sexual minorities with primary religious identities (Hallman, Yarhouse, & Suarez, 2018; Lefevor, Sorrell, Kappers, Plunk, Schow & Rosik, 2019). For example, there is evidence of differences in conceptions of and pathways to happiness and life satisfaction between religious and secular cultures/worldviews (Joshanloo, 2018; Pawar, 2017; Tamir Schwartz, Oishi, & Kim, 2017). This may further complicate straightforward generalizations from religiously disaffiliated or unaffiliated LGB-identified research participants to conservatively religious non-LGB-identified sexual minorities.

22. The Glassgold Declaration points to higher suicide rates in the Ryan et al. study among those who have experienced "conversion therapy." In addition to the above methodological limitations, it is worth noting in this regard the author's own acknowledgements:

> Third, the design is retrospective, and thus causal claims cannot be made. We cannot rule out the possibility that those who were most maladjusted as young adults retrospectively attribute parental behaviors during adolescence as attempts at changing their sexual orientation; we also cannot rule out the possibility that well-adjusted LGBT young adults may be less likely to recall experiences related to SOCE. (p. 12)

Ryan et al. argue that the alternatives are less plausible than SOCE undermining health and well-being, but this remains scholarly *speculation*. Such speculation is not a substitute for clear and unambiguous data when justifying laws such as Ordinance 2017-47 that curtail the speech of licensed clinicians engaged in change-allowing talk therapies. Indeed, the APA (2009) Task Force Report contains an entire subsection highlighting the unreliability and limitations of retrospective reports (APA, 2009, p. 29). Although the Report applies this conclusion only to SOCE efficacy studies, there is no scientific rationale for not also applying it to research on SOCE harm such as Ryan et al.

iv. General Critique of Recent SOCE Research.

23. Licensed therapists on all sides of the debate over SOCE are agreed in the commitment to do no harm to their clients. The question is whether the harms attributed to change-allowing talk therapies are unambiguously grounded in scientific data sufficient to justify legal bans or whether what we are witnessing is the triumph of advocacy interests over sober science. As noted above, the more recent SOCE research all contain serious methodological limitations, including sample bias favoring negative SOCE accounts, measures defined in a manner that inflates estimates of harm, and the confounding of professional and religious SOCE providers and interventions. The findings of this body of research cannot therefore be generalized beyond the samples employed and provide an insufficient scientific basis for justifying therapy bans.

24. However, the fatal flaw these studies all evidence is their inability to control for pre-SOCE levels of distress, which is a key component for disentangling distress attributable to a psychotherapeutic intervention and distress experienced by clients prior to ever engaging in therapy. Without this data, the actual degree of harm attributable to therapy is unknowable. This is a critical fact of basic research methodology, particularly when the population under study is known to have high levels of adverse childhood experiences (Andersen & Blosnich, 2013). To cite only one example, non-heterosexual persons report much higher levels of childhood sexual abuse (CSA) than heterosexual persons (Friedman et al., 2011; Rothman, Exner, & Baughman, 2011: Xu & Zheng, 2015), and CSA has been linked to later suicidality (Bebbington, et al., 2009; Bedi et al., 2011; Eskin, Kaynak-Demir, & Demir, 2005). Hence, without pre-SOCE assessment of participants' suicidality, claims attributing frequent suicidal thoughts and behaviors to be the direct result of change-allowing talk therapies constitute empirically unfounded speculation.

25. It is also worth evaluating these more recent studies using the same methodological standards the APA (2009) Task Force utilized to discard most of the SOCE literature. As summarized by Beckstead (2012):

> Methodological errors in SOCE research included the following: (1) results are based on restricted, self-selected samples that represented a socially stigmatized population who affirmed heterocentric biases; (2) methods did not account for participants' interests to manage self-impressions and potential to promote their beliefs and lifestyles and misreport ''successes''and ''failures''; (3) some results were based on therapists' subjective impressions; (4) researcher biases or lack of expertise were not managed or addressed; (5) comparison or control groups were not used; and (6) longitudinal methods were not utilized to determine the duration or process of any positive changes. (p. 124)

With the possible exception of #3, all of these "errors" the Task Force found in the research purporting SOCE effectiveness could equally be applied to the recent research alleging SOCE harms. This double standard in scientific evaluation was noted at the time of the Report (Jones, Rosik, Williams, & Bird, 2010) and apparently continues into the present, suggesting the enduring influence of advocacy interests over scientific humility.

26. To summarize, a proper conclusion regarding the recent research is that these studies cannot provide a scientifically sound basis for restricting the rights of individuals to engage in and licensed therapists to provide change-allowing professional psychotherapy. In fact, due to the sampling problems, utilizing this research to evaluate the provision of change-allowing talk therapies makes no more sense than studying a sample of former marital therapy patients who have subsequently divorced to determine the effectiveness and harm of marital therapy in general.

C. Spitzer's Reassessment of His 2003 Study on SOCE.

27. Finally, proponents of talk therapy bans such as Ordinance 2017-47 have understandably pointed out that Robert Spitzer, M.D., author of one of the primary studies conducted on SOCE (Spitzer, 2003), changed his assessment of the study and came to believe that

it did not provide clear evidence of sexual orientation change (Spitzer, 2012). It appears that he may have originally wished to retract the 2003 study, but the editor of the journal in which the study was published, Kenneth Zucker, Ph.D., denied this request. Zucker has been quoted regarding his exchange with Spitzer as observing:

> You can retract data incorrectly analyzed; to do that, you publish an erratum. You can retract an article if the data were falsified—or the journal retracts it if the editor knows of it. As I understand it, he's [Spitzer] just saying ten years later that he wants to retract his interpretation of the data. Well, we'd probably have to retract hundreds of scientific papers with regard to interpretation, and we don't do that. (Dreger, 2012)

What Zucker is essentially saying is that there is nothing in the science of the study that warrants retraction, so all that is left for one to change is the interpretation of the findings, which is what Spitzer appears to have done. Spitzer's change of interpretation hinges on his new belief that reports of change in his research were not credible. Others made such assertions at the time of the study, and Spitzer defended the integrity of the study then. Now, however, he now asserts that participant's accounts of change may have involved "self-deception or outright lying" (Spitzer, 2012).

28. It is curious that Spitzer's (2012) apology seems to imply that he earlier claimed his research proved the efficacy of SOCE. As was understood at the time, the design of Spizter's study ensured his research would not definitively *prove* that change-allowing talk therapies can be effective. Certainly it did not prove that all gays and lesbians can change their sexual orientation or that sexual orientation is simply a choice. The fact that some people inappropriately drew such conclusions appears to be a factor in Spitzer's reassessment. Yet the fundamental interpretive question did and still does boil down to one of plausibility: Given the study limitations, is it *plausible* that some participants in SOCE reported actual change?

29. Since nothing has changed regarding the scientific merit of Spitzer's study, the interpretive choice one faces regarding the limitations of self-report in this study also remains. Either *all* of the accounts across *all* of the measures of change across participant and spousal reports are self-deceptions and/or deliberate fabrications, or they suggest it is possible that some individuals actually do experience change in the dimensions of sexual orientation that may be assisted by licensed therapists. Good people can disagree about which of these interpretive conclusions they favor, but assuredly it is not unscientific or unreasonable to continue to believe the study supports the plausibility of change for some individuals.

30. In fact, the reasonableness of this position was bolstered by the willingness of some of the participants in Spitzer's research to speak up in defense of their experience of change (Armelli, Moose, Paulk, & Phelan, 2013). They expressed clear disappointment in Spitzer's new claims:

> Once thankful to Spitzer for articulating our experience and those of others, we are now blindsided by his "reassessment," without even conducting empirical longitudinal follow-up. We know of other past

> participants who also feel disappointed that they have been summarily dismissed. Many are afraid to speak up due to the current political climate and potential costs to their careers and families should they do so.

It seems clear, then, that unless one postulates initial and ongoing self-deception and fabrication by participants to an incredulous degree, Spitzer's study still has something to contribute regarding the possibility of change in sexual orientation.

D. The Limited Understanding of the Dynamics of Stigma and Discrimination.

31. Proponents of change-allowing talk therapy bans typically frame a significant degree of their arguments concerning harm and SOCE on the negative consequences of stigma and discrimination (e.g., SAMHSA, 2015). The Glassgold Declaration is no different. While these factors certainly can have deleterious consequences for those with non-heterosexual sexual orientations, this possibility must be placed within a broader context and balanced by additional considerations.

32. From an overall perspective, the meta-analytic research (which summarizes results over multiple studies) on the association between perceived discrimination and health outcomes indicates that the strength of this relationship is significant but small (Pascoe & Richman, 2009). Schmitt, Branscombe, Postmes, and Garcia's (2014) updated meta-analysis found LGB-related discrimination (i.e., heterosexism) explained less than 9% of the relationship between discrimination and well-being and discrimination and psychological distress. Furthermore, research into what influences this association has most typically found no significant role for theoretically linked factors such as various coping strategies, social support, concealing one's LGB identity, and identification with one's group (i.e., claiming a gay identity) (Denton, Rostosky, & Danner, 2014; Schmitt et al., 2014). For example, data suggest that the impact of "internalized homophobia" for understanding risk behavior among men who have sex with men (MSM) is now negligible and, "The current utility of this construct for understanding sexual risk taking of MSM is called into question" (Newcomb & Mustanski, 2011, p. 189). By contrast, poly drug use by these men continued to be a strong predictor of risky sexual behavior. Similarly, a meta-analysis of studies examining the higher substance use rates among LGB youth compared to their heterosexual peers concluded that internalized homophobia was not a significant predictor (Goldbach, Tanner-Smith, Bagwell, and Dunlap, 2014). Such findings should be sufficient to indicate that there is a great deal left to be understood about this entire field of study.

33. Other lines of inquiry suggest that sexual orientation stigma and discrimination alone are far from a complete explanation for greater psychiatric and health risks among non-hetersexual orientations. Goldbach et al. (2014) discovered that the factors having the greatest relationship to substance use in LGB youth were not distinct from those reported by teens in the general population, regardless of sexual minority status. Victimization that was not specifically gay-related had the strongest association with substance use for these youth. Mays and Cochran (2001) reported that discrimination experiences attenuated but did not eliminate associations between psychiatric morbidity and sexual orientation. The associations between non-heterosexual orientation and poorer mental health have persisted over time with recent studies showing the same effects as older studies despite a more accepting culture (Branstrom & Pachankis, 2018; Sandfort,

de Graaf, ten Have, Ransome, & Schnabel, 2014; Semlyen, King, Varney, & Hagger-Johnson, 2016).

34. The issue of suicide among non-heterosexual persons is worthy of great concern. Yet contrary to a singular reliance on minority stress theory to explain sexual orientation disparities, research is discovering that suicide related ideation and behavior disparities are not uniformly decreasing with the greater social acceptance of LGB people, both among minors and adults (Peter, Edkins, Watson, Adjei, Homma, & Saewyc, 2017; Wang, Ploderl, Hausermann, & Weiss, 2015). Men with same-sex attractions and behaviors were found to have a higher risk for suicidal ideation and acute mental and physical health symptoms than heterosexual men in Holland, despite that country's highly tolerant attitude towards homosexuality (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006; de Graaf, Sandfort, & ten Have, 2006). Even in a highly tolerant country such as Sweden, same-sex married individuals evidenced a higher risk for suicide than other married persons (Bjorkenstam, Andersson, Dalman, Cochran, & Kosidou, 2016). Wang et al. chastised researchers studying suicidality among non-heterosexual persons for their failure to consider other common factors in the general suicide literature: "It is notable, however, that certain areas of mainstream suicide research—e.g., consideration of biologic factors, psychological factors (e.g., personality traits), and stressful life events—have not been addressed in suicide research among sexual minorities to date" (p. 499). They reported neither mental disorder nor discrimination has been shown to explain the excess risk of suicide attempts among non-heterosexual people. A study by Skerrett, Kolves, and De Leo (2014) discovered that while LGB people who died by suicide had a higher incidence (65.7%) of interpersonal problems prior to death than their heterosexual counterparts (33.3%), they actually had *lower* levels of family conflict (5.7% to 17.1%).

35. Studies outside of Western culture appear to indicate that culture may play a significant role in this literature as well. Using an LGB sample from China, Shao, Ching, and Chen (2018) found that minority stress was not related to psychological maladjustment, whereas respect for parents and perceived parental support were associated with positive adjustment. The authors conclude that the minority stress model cannot be generalized to individuals living in cultural contexts that emphasize family connections over one's sexual identity. This may have relevance for non-heterosexual persons who identify with conservative religious communities, many of which adhere to less individualistic cultural values.

36. Research in this area is almost entirely reliant upon self-reports of *perceived* discrimination, and the relation of this to objective discrimination is not well understood. Self-report data make it difficult to tell how much of the association between perceived discrimination and well-being or psychological distress reflects the effects of perceptions of discrimination per se and how much is the effect of actual encounters with discrimination and negative treatment (Schmitt et al., 2014). Burgess, Lee, and van Ryn (2007) found that although perceived discrimination was associated with almost all indicators of poor mental health, adjusting for discrimination did not significantly reduce mental health disparities between heterosexual and LGBT persons, indicating that discrimination did not account for the disparity. Also supporting the notion that perceptions of discrimination may play a more prominent role than actual discrimination is research indicating minority stress theory can explain distress even among numerically and socially dominant groups, such as Christians (Parent, Brewster, Cook, & Harmon, 2018).

i. Alternatives to Minority Stress Theory.

37. The relationship of sexual orientation related stigma and discrimination to psychological and physical well-being among LGB persons is undoubtedly complex, and no single theory is likely to provide a universal explanation. Lick, Durso, and Johnson (2013) observed that the mechanisms linking sexual orientation-related stigma to physical health outcomes remain poorly articulated and causality cannot be inferred. In spite of these uncertainties, minority stress theory (Meyer, 2003) has assumed a favored status in academic and policy discussions, including discussion related to prohibiting professional SOCE. This theory posits that experiencing or even fearing stigma specifically related to one's LGB identity arouses feelings of distress that can have profound consequences for the well-being of LGB persons. As is evident from the Glassgold Declaration, opponents of change-allowing talk therapies often view them as inherently stigmatizing and discriminatory (and thus responsible for subsequent emotional and physical distress), but this is a dubious assertion given the substantial uncertainties surrounding minority stress theory.

38. Indeed, as Savin-Williams (2006) has observed, evidence for the causal pathway of this theory (i.e., sexual orientation to discrimination to mental and physical health disparities) are "more circumstantial than conclusive" (p. 42). McGarrity (2014) reported that LGB individuals are more highly educated than the general population, a finding not consistent with an unqualified minority stress position. She also indicated that the lower income levels of gay and bisexual men may not stem from discrimination but from their tendency to pursue "typically female" fields of study in college. Another study found that components of minority stress predicted no more than 5% of non-heterosexual drug and alcohol usage (Livingston, Oost, Heck, & Cochran, 2014). Even if it were to be (and it clearly has not been) proven that change-allowing talk therapies with minors were a form of stigma, Wald (2006) asserted that, "While the presence of stigma is clear, the research does not find that it has a significant harmful impact on the children's mental health" (p. 399). Important alternative theories have been proposed to challenge or supplement the causal assumptions of the minority stress view.

39. **Mediation theories**. Some theories with empirical support suggest that other factors indirectly mediate the pathways linking discrimination and stigma with disparities in LGB psychological health (Hatzenbuehler, 2009). Other theories assert that LGB discrimination and stigma may itself mediate the relationship between other factors that result in such disparities. In other words, specific sexual orientation discrimination or stigma may be minimally or unrelated to psychological distress and physical health in the absence of certain intra- or interpersonal processes (Schumm, 2014). While many theoretically favored factors thought to influence LGB health disparities have been questioned (as noted above), several examples of other mediating factors can be provided.

40. Recent literature also finds that particular emotion/avoidant-based coping mechanisms used by people reporting same-sex attractions can almost entirely account for the effects of this perceived discrimination (Whitehead, 2010). For example, the inability to regulate one's negative emotions was found to be a primary contributor to the pathway from sexual minority stressors and physical health symptom severity (Denton et al., 2014). In addition, differential rates of health problems resulted from sexual orientation-related differences in coping styles among men, with an emotion-oriented coping style mediating the differences in mental and

physical health between heterosexual and homosexual men (Sandfort, Bakker, Schellevis, & Vanwersenbreeck, 2009). Passive coping style has been found to mediate mental health disparities between LGB and heterosexual youth (Bos, van Beusekom, & Sandfort, 2014) while emotion-focused coping (the ability to regulate negative emotions) mediated physical health disparities between adult LGB and heterosexual individuals (Denton et al., 2014). Rumination (the tendency to passively and repetitively focus on one's distress and distress-related circumstances) has also been found to mediate the relationship between stigma and distress (Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009).

41. Worries among sexual-minority youth concerning friendships and never finding a romantic partner have also been observed to mediate such disparities (Diamond & Lucas, 2004). Health disparities between gay and heterosexual men may also be mediated by the emotional and physical stresses of living with HIV/AIDS or other related physical ailments (Lick et al., 2013). In one study, disparities in heart disease, liver disease, digestive problems and urinary incontinence disappeared after accounting for HIV status (Cochran & Mays, 2007).

42. **Nonheterosexual lifestyle theory**. This perspective posits that LGB lifestyles are inherently riskier than those of heterosexuals because of certain features of LGB social communities (Vrangalova & Savin-Williams, 2014). Schumm (2014) has suggested that differences in conduct between non-heterosexuals and heterosexual persons rather than sexual orientation identity may lead to or reinforce discrimination. These behaviors may include antisocial behaviors, unsafe sexual practices, and drug use. For example, Hatzenbuehler, Keyes, & Hasin (2009) found that drug use as a psychiatric disorder increased over time for LGB persons in states that had *more* protective policies. Higher substance use may be due to many LGB communities being structured around bars and clubs (Trocki, Drabble, & Midanik, 2005, 2009).

43. **Common factors theory**. This theory asserts that the elevated health problems among nonheterosexuals could be directly or indirectly due to genetic or environmental "common causes" of both health risks and nonheterosexuality (Vrangalova & Savin-Williams, 2014; Zietsch, 2012). Gender nonconformity, and divergence in behavior, personality, and identity from those typical of one's sex are likely influenced by the same genetic and neurodevelopmental factors as non-heterosexuality, and therefore may be linked to both victimization and mental health regardless of sexual orientation. Other personality traits may be implicated as common causes as well. Increased internalizing (e.g., self-harm) and externalizing risk behaviors (e.g., sexual risk taking) may be due to direct or indirect shared genetic effects between non-heterosexuality and neuroticism or sensation seeking, rather than non-heterosexuality per se. Common causes could also be environmental. For example, to the extent the same environments (e.g., large cities, college campuses, night clubs) that provide opportunities for exposure to sexually arousing stimuli also provide opportunities for engagement in various risk behaviors or carry other health risks, this could be a common cause for both health risks and nonheterosexuality.

44. The review article by Vrangalova and Savin-Williams (2014) is particularly intriguing in that they focused on psychological and physical health disparities among mostly heterosexual individuals. The mostly heterosexual (MH) orientation is characterized by a strong presence of other-sex sexuality and a slight amount of same-sex sexuality. MH may comprise about 4% of men and 9% of women in the general population (Savin-Williams & Vrangalova, 2013). Because MH persons tend to view themselves and are viewed by others as essentially

heterosexual in their sexual orientation and lifestyle, they are plausibly exposed to much less sexual orientation discrimination and stigma than LGB identified persons. One study reviewed indicated that only 8% of MH teenagers reported experiencing sexual orientation-based discrimination. Yet Vrangalova and Savin-Williams (2014) reported that MH individuals are closer to bisexuals than heterosexuals in their health risks (see also Rosario et al., 2016). These authors further noted that people with exclusive opposite-sex or same-sex attractions may have less elevated health risks than individuals who experience any proportion of sexual attraction to both sexes. They concluded that, "This raises the possibility that it is something about nonexclusivity in sexual attractions or lifestyles that is linked to negative health outcomes" (p. 437).

45. The existence of such variant theories to explain the relationship (or lack thereof) of stigma and discrimination to psychological and physical health disparities between LGB and heterosexual persons argues strongly for the exercise of legislative and judicial restraint when making public policy that rests in part on such disparities. The pathways to elevated health risks among nonheterosexuals may certainly include discrimination and stigma, but the extent, causal direction, and mediation of such a relationship is currently far from understood. Moreover, there is no direct empirical basis for linking SOCE with such health disparities. It is therefore both simplistic and unscientific for proponents of Ordinance 2017-47 to imply a causal link between the practice of professional change-allowing talk therapies and health disparities among youth.

ii. Some Health Outcomes Are Likely Based in Anatomy More Than Stigma.

46. In addition, some health risks, such as sexually transmitted diseases (including HIV) among gay men, may be influenced by stigma but are ultimately grounded in biological reality. One comprehensive review found an overall 1.4% per-act probably of HIV transmission for anal sex and a 40.4% per-partner probability (Beyer, et al., 2012). The authors noted, "The 1.4% per-act probability is roughly 18-times greater than that which has been estimated for vaginal intercourse" (p. 5). Swartz (2014) found sexually transmitted infections other than HIV/AIDS in 35.6% of men who had sex with men compared to 6.6% of matched population sample of heterosexual men. CDC statistics indicate the rate of new HIV diagnoses in the United States among men who have sex with men has been more than 44 times that of other men (CDC, 2011). Young gay and bisexual men age 13-29 accounted for 27% of all new HIV infections in 2009 and were the only group for whom new HIV infections increased between 2006 and 2009 (Prejean et al., 2011). In 2017, gay and bisexual men disproportionally accounted for 66% of all HIV diagnoses and 82% of HIV diagnoses among males (CDC, 2019). Oswalt and Wyatt (2013) surveyed college students and found that while 69.5% of heterosexual males had never engaged in anal sex only 10.8% of gay males had not engaged in this sexual behavior. Sharing such information with prospective SOCE clients is not inherently manipulative but rather, when balanced with other considerations, constitutes an ethically obligated aspect of informed consent.

iii. SOCE Not a Proxy for Stigma or Discrimination.

47. The lessening of stigma associated with "coming out" need not imply an affirmation of a gay, lesbian, or bisexual identity or the enactment of same-sex behavior. Licensed SOCE practitioners often encourage the client's acceptance of his or her unwanted same-sex

attractions and the disclosure of this reality with safe others as a means of shame-reduction and a potential aid in the pursuit of change or, in cases where change does not occur, behavioral management of sexual identity. This typically occurs when clients desire to live within the boundaries of their conservative religious values and beliefs. While it is often assumed that conservative religious environments are stigmatizing and harmful for sexual minorities by definition, this is by no means a universal finding (Barringer & Gay, 2017). One study of black lesbian, gay, and bisexual young adults, 86% of whom were open about their sexual identity, found that, "Participants who reported lower religious faith scores and lower internalized homonegativity scores reported the lowest resiliency, while those reporting higher religious faith scores and higher internalized homonegativity reported the highest resiliency scores" (Walker & Longmire-Avital, 2013, p. 1727).

48. Referral for change-allowing talk therapies therefore cannot be designated as a proxy for harm-inducing family rejection and stigma, as the proponents of Ordinance 2017-47 seem to assume. Only a few studies have directly examined the link between family rejection and health risk among minors (Saewyc, 2011) and the derived findings can be contrary to expected theories, such as the discovery that same-sex attracted boys who participated in more shared activities with their parents were *more likely* to run away from home and use illegal drugs than those who participated in fewer shared activities (Pearson & Wilkinson, 2013). The Ryan et al. (2018) study is the first of its kind in this arena, but with serious aforementioned limitations that make it little more than a non-generalizable pilot study. Thus, Ordinance 2017-47 would unnecessarily and without scientific warrant eliminate the potential role of conservative religious values and social networks for ameliorating the effects of stigma in the context of change-allowing talk therapy. This would prevent clients from one means of prioritizing their religious values above their same-sex attractions when these factors are in conflict. The contention that a desire to modify same-sex attractions and behaviors can only be an expression of self-stigma reflects a serious disregard for and misunderstanding of conservative religious and moral values (Jones, et al., 2010).

iv. Encouraging Same-Sex Behavior May Result in Risk-Justifying Attitudes.

49. Finally, some research has raised the possibility some widely accepted theories germane to the discussion of stigma, discrimination, and health outcomes may in fact have gotten things backwards. A longitudinal study of gay and bisexual men by Heubner, Neilands, Rebchook, and Degeles (2011) found that,

> … in contrast to the causal predictions made by most theories of health behavior, attitudes and norms did not predict sexual risk behavior over time. Rather, sexual risk behavior at Time 1 was associated with changes in norms and attitudes at Time 2. These findings are more consistent with a small, but growing body of investigations that suggest instead that engaging in health behaviors can also influence attitudes and beliefs about those behaviors. (p. 114)

50. Thus, safe-sex norms and attitudes did not lead to reduced unprotected anal intercourse; rather, participants' engagement in such HIV risk behavior appeared to change how they thought and felt about the behavior and enhanced their willingness to engage in it. Such findings raise serious concerns about the impact of Ordinance 2017-47, in that a law which only allows for the affirmation and ultimate enactment of same-sex attractions may in fact increase HIV risk and negative health outcomes for some minors who might otherwise have sought change-allowing talk therapy. Engaging in homosexual behavior in adolescence has been linked with an elevated prevalence of many serious risk behaviors and emotional problems (Arnarsson, Sveinbjornsdottir, Thorsteinsson, & Bjarnason, 2015; Outlaw et al., 2011). In addition, experiencing rape or sexual assault before the age of 16 has been strongly associated with belonging to any non-heterosexual group (Wells, McGee, & Beautrais, 2011).

51. While stigma and discrimination are real concerns, they are not universal explanations for greater psychiatric and health risks among sexual minorities, some of which are likely to be grounded in the biology of certain sexual practices. Moreover, the effects of stigma and discrimination can be addressed significantly within change-allowing talk therapies for many clients, though this is no doubt hard to comprehend for those not sharing the religious values of SOCE consumers. There is no longitudinal research involving consumers of change-allowing talk therapies that link the known effects of stigma and discrimination to the practice of SOCE. SOCE is simply *ipso facto* presumed to constitute a form of stigma and discrimination. This is in keeping with the persistently unfavorable manner in which change-allowing talk therapies are portrayed by the mental health associations. Change-allowing talk therapy practitioners and consumers are associated with poor practices as a matter of course (Jones, et al, 2010; APA, 2009, 2012). This arguably is a form of stigma and discrimination toward licensed practitioners of SOCE, who ironically, as noted earlier, have developed their own set of practice guidelines that, when followed, can be expected to reduce the risk of harm to consumers of change-allowing talk therapies (ATCSI, 2018; Appendix A).

E. Understanding the Dramatic SOCE Prevalence Numbers of the Williams Institute Survey.

52. Statistics from the Williams Institute are being widely disseminated regarding the prevalence of "conversion therapy" (CT) and are unsurprisingly cited in the Glassgold Declaration (Mallory, Brown, & Conron, 2018, 2019). This survey claims that nearly 700,000 adults have received CT, 350,000 who were adolescents when they experienced CT. Furthermore, they claim that between 16,000 and 20,000 youths ages 13-17 will receive CT from a licensed therapist before turning 18. These are stunning statistics, but the study methodology raises some serious questions about their validity as applied to change-allowing talk therapies. The study utilized questions from the Generations Study, in particular the question, "Did you receive treatment from someone who tried to change your sexual orientation (such as try to make you straight/heterosexual)?" followed by an option for indicating whether the provider of treatment was a health care professional. Not only is the retrospective self-report nature of the survey problematic given the likely need for participants to recall events from decades earlier, but "treatment" is left undefined and is so nebulous that one can gain no idea about the frequency or seriousness of the treatment techniques (encompassing anything from a felt sense that the therapist preferred heterosexuality on the one end to the application of electroshock aversive procedures on the other end). Furthermore, the survey included only LGBT identified persons, which by definition would include a preponderance

of individuals who had not experienced change. Although one might reasonably surmise these individuals would be less likely to have experienced positive benefits from their therapy, this question was not asked. The degree of distress attributable to these treatments is not known and assertions to the contrary are mere speculation. It is much more plausible that the non-LGBT identified persons with same-sex attractions and behaviors who were excluded from the survey would have reported benefit from their change-allowing therapy, but again, we cannot ultimately know from the study what degree of harm or benefit any non-heterosexual participant experienced.

53. If the Williams Institute's numbers are not in some manner inflated, and even if only 1% of the tens of thousands of minors the Williams Institute indicates have undergone or are undergoing SOCE with a licensed therapist have been subjected to the aversive practices suggested by the study—"…practitioners have also used 'aversion treatments, such as inducing nausea, vomiting, or paralysis; providing electric shocks…."—it is incomprehensible that some of these clinicians would not have been brought before their state licensing boards for such egregiously unethical child abuse. Strikingly, however, Drescher et al. (2016) noted, "To our knowledge, there have been no formal actions by a regulatory body against a provider for engaging in conversion therapy." The most probable means of understanding the disconnect between the Williams Institute's numbers and the lack of any therapist having lost a license for unethical SOCE related conduct is that licensed practitioners of change-allowing therapies (whatever their number) are conducting themselves in an ethical and professional manner. This conclusion strongly suggests bans such as Ordinance 2017-47 are a 'solution' to a problem that does not exist for licensed therapists.

54. The Glassgold Declaration raises the concern that it would be difficult for minors to file complaints against their licensed care provider to state regulatory boards. Two points are worth making in response. First, surely it would be equally challenging for a minor to make a complaint under Ordinance 2017-47. Second, it is inconceivable that a minor with a verifiable complaint of misconduct against a licensed therapist would not find considerable administrative guidance and financial support from groups such as Equity Florida in filing a complaint with a state regulatory agency. Hence, this line of argument does not provide a compelling reason to usurp existing state regulatory board oversight.

F. The Limits of Appeals to Authority.

55. Ordinance 2017-47 and the Glassgold Declaration rely heavily on appeals to the authority of mental health organizations. Uncritical assessment of such appeals may be justified in areas of social science that do not intersect with significant political, legal, and advocacy interests. However, to do so in the arena of professional SOCE would be a serious and naïve mistake. In assessing such appeals, it is critical to consider the cultural and ideological climate of organized psychology. What is undeniable is that both academic and organized psychology (particularly associational leaders) are essentially politically and ideologically homogeneous, left-of-center groups. Below I add a few further examples to the evidence provided in my earlier declaration.

56. Consistently in the social sciences generally and in organized psychology specifically, self-identified liberal/progressives and Democrats outnumber self-identified conservatives and Republicans by ratios of 8:1 to 11:1 (Duarte, Crawford, Stern, Haidt, Jussim, &

Tetlock, 2015; Jussim, Crawford, Anglin, & Stevens, 2016; Martin, 2016). Al-Gharbi (2018) examined extensive survey data for Heterodox Academy and concluded, "In other words, the lack of ideology diversity seems to be vastly more pronounced in social research fields than underrepresentation in terms of gender, sexuality and race." In other words, conservative perspectives are much less present among contemporary psychology faculty than even racial (Hispanic and Black), gender, and sexual minority viewpoints.

57. Within mental health associations, and most severely among their leadership bodies, left-of-center ideological homogeneity also appears to be entrenched. Former APA President Cummings reflected on his decades within APA leadership and observed (Cummings & O'Donahue, 2008):

> The APA has more than 100,000 members, associates, and affiliates, yet less than 200 elitists control its governance. They rotate year after year through its offices, boards, Council of Representatives, and its plethora of committees, in a kind of organizational musical chairs that ensures the perpetuation of political ideology and essentially disenfranchises the thousands of psychologists who might disagree. (p. 216)

58. Exacerbating this ideological dominance is the general lack of connection by APA leaders with the membership at large. For example, in the most recent vote for apportionments to determine the composition of the APA's 2020 main governing body, the Council of Representative, only 9,490 of the APA's 118,000 members casts ballots (APA, 2019a, 2019b). If such a level of membership involvement is indicative of general participation, this means APA resolutions, reports, and policy statements are approved by officials representing approximately 8% percent of the membership. There are no minority reports solicited for such documents, and no polling of the entire membership concerning such pronouncements is conducted. These dynamics help explain, for example, how the Council in 2011 voted 157-0 to support same-sex marriage initiatives (Jayson, 2011), which in a representative governing structure implies no one in the membership disagreed with this proposal, which I know in talking to many APA colleagues was not the case.

59. These sorts of structural problems are not limited to psychological associations. Recently the American Academy of Pediatrics (AAP) released a policy statement, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Raffery, 2018). While a vast majority of clinics and professional associations world-wide encourage the "watchful waiting" approach to helping gender dysphoric children, the AAP statement repudiated that consensus and encouraged only gender affirmation. James Cantor, a gay psychologist and well know sexologist, was struck by this disconnect, carefully examined all of the statement's references, and was led to conclude, "…AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did the AAP fail to provide *extraordinary* evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence" (author's emphasis)(Cantor, 2018, p. 4; Appendix B).

60. Examination of the AAP statement indicated that a maximum of 36 members of the association (24 pediatricians and 12 members of the board of directors) directly approved the

policy, which translates to a startlingly minute .05% of the AAP's 67,000 members (Kearns, 2018). Similar to the APA, the AAP statement was not presented to all members for a vote, and a minority report was not solicited. These considerations raise questions about the AAP's treatment of other subjects where there is inherent ideological and advocacy investment, including "conversion therapy."

61. These concerns are not even limited to a North American context. The Academy of Science of South Africa (ASSA) published a report, *Diversity of Sexuality*, in order to influence policy in Africa (ASSA, 2015). However, Diamond and Rosky found the report's claim of immutability of sexual orientation to be in error: "The authors deployed the same exaggerations of scientific evidence that have long characterized immutability debates, concluding that 'all sexual orientations are biologically based, largely innate and mostly unchangeable' (p. 22)." (p. 10)

G. Terminology Creep Suggests Political Not Scientific Motives and These Can Harm Therapists.

62. It is important to recognize that until very recently, "conversion therapy" bans referenced only sexual orientation. The inclusion of gender identity in Ordinance 2017-47 and the Glassgold Declaration was not found in earlier ban legislation or mental health association resolutions. It is very likely that motives other than those guided by science are at play, as the science relative to gender identity and "conversion therapy" does not exist. As Cantor (2018) observed regarding claims made by the aforementioned AAP policy statement, "These claims struck me as odd because *there are no studies of conversion therapy for gender identity*. Studies of conversion therapy have been limited to *sexual orientation*—specifically, the sexual orientation of *adults*—not *gender identity*, and not *children* in any case" (p. 1; author's emphasis).

63. How might such terminology creep be explained given the complete absence of research examining "conversion therapy" for gender identity? One possible reason is that ban supporters have been very effective at promoting their demonized version of "conversion therapy" and now wish to extend that demonization to any care for gender identity that does not meet their definition of affirmation. What the AAP did, for example, was "simply relabeling non-gender affirmation models as conversion clinics" (Cantor, 2018, p. 3). This is a brilliant political strategy, but it has left science behind.

64. Such expansion in the scope of what "conversion therapy" covers can have real world consequences for therapists. In one particularly striking example, publicity leading up to the passage of a ban on SOCE for minors in the province of Ontario, Canada, in the summer of 2015 helped fuel allegations against world renowned psychologist Kenneth Zucker and his heretofore highly respected Child and Youth Gender Identity Clinic in Toronto. Zucker and his clinic received this scrutiny in large part due to their openness to helping young gender dysphoric children attempt to feel more comfortable in their own biological bodies. In response to years of pressure by activists, intensified by the professional climate fomented by the SOCE ban, a review was instigated by the hospital which housed Zucker's clinic. This external review was commissioned in February of 2015 and the subsequent document included claims of Zucker providing "conversion" or "reparative" therapy and linked the clinic's approach to youth suicide. Though Zucker denied these claims, none of the accusations appear to have been fact checked by the hospital's reviewers. Finally, on December 15, 2015, Zucker was unceremoniously fired and

his clinic closed down (Anderssen, 2016; Singal, 2016). Zucker subsequently filed a lawsuit against the hospital and in October of 2018 the hospital acknowledged wrongdoing and settled out of court for $586,000 (Rizza, 2018).

65. While there at least is research whose significance can be debated concerning professional SOCE pertaining to same-sex attractions and behaviors, the complete lack of any studies specific to "conversion therapy" for gender identity raises serious questions for supporters of Ordinance 2017-47. How can they in good conscience place licensed therapists and physicians in legal jeopardy for providing alleged non-affirmative models of conversational care in the absence of any research on the subject? Either they remove entirely gender identity as a focus of the law or admit that their employment of the "conversion therapy" terminology was a sloppy attempt to prejudice public and judicial opinion.

H. Overstated Claims Suggest Advocacy and Not Science.

66. The Glassgold Declaration repeatedly makes claims about the literature framed in absolute and misleading terms. "…current scientific evidence…confirm *unequivocally* that conversion therapy in *any* form is ineffective and harmful" (p. 5). There is not "*any* valid scientific evidence of lasting change in sexual behaviors" (p. 19). "Research shows that *all* forms of CT also poses [sic] a significant risk of harm to gender diverse people" (p. 22). There is "*no* credible link between same-sex sexual orientation and sexual abuse" (p. 33). "There is *no* safe form of CT; *all* CT poses significant risk to health and well-being of minors" (p. 37; my emphases). Such unequivocal pronouncements make good advocacy but reflect poor science.

67. Below I will address these statements as overstatements, but it is worth asking what may motivate such advocacy? Jussim, Crawford, Stevens, Anglin, and Duarte (2016) highlight one factor that seems consistent with the passion often displayed by therapy ban proponents in advancing such inflated claims:

> If scientists believe that it is their moral obligation to marginalize their ignorant and immoral ideological opponents, they put themselves at risk for purveying invalid scientific claims. Because strongly held ideological beliefs subjectively feel like objective truths, it is possible that such scientists are unaware of the biased nature of their science, squashing their ideological opponents may be subjectively experienced as a core component of advancing science (p. 184).

68. I have documented on numerous occasions in my declarations that the science pertaining to change-allowing talk therapies is very limited and a non-advocacy motivated reading of this literature would adopt a much more circumspect and nuanced interpretation. It is telling that the Glassgold Declaration in support of the claim of unequivocal evidence regarding "conversion therapy" cites only a qualitative study, a methodology which at best can serve as a source for generating hypotheses for later empirical research but simply cannot reach generalizable conclusions about any literature as a whole.

69. Regarding validity of studies on change, an extraordinary standard of what qualifies as valid is likely at play. As noted in my earlier declaration, the APA (2009) Report provided extremely rigorous methodological standards (e.g., random controls and longitudinal design) that conveniently eliminated all studies of contemporary professional SOCE. In fact, the Report's methodological standards eliminated from consideration all but six studies of SOCE generally, studies conducted between 1969 and 1978 using samples of men mostly in court-ordered or other mandated treatment for psychiatric and sexual concerns, sometimes facing criminal or legal penalties. This is a far cry from modern professional SOCE participants, who tend to be motivated by religious conviction. It must be said in this context that by these standards, there are also no valid studies of harm from professional change-allowing talk therapies. As Jones et al. (2010) noted, "The standard with regards to efficacy is to rule out substandard studies as irrelevant. No such standards appear to be used with regard to studies of harm" (p. 9).

70. As for research showing all forms of "conversion therapy" pose a serious risk of harm to gender diverse people, this is a curious conclusion of certainty given Cantor's (2018) detailed assessment that "*there are no studies of conversion therapy for gender identity.*" He later observes, "…in the context of GD [gender dysphoric] children, it simply makes no sense to refer to external 'conversion': The majority of children 'convert' to cisgender or 'desist' from transgender *regardless* of any attempt to change them." (p. 2; author's emphasis).

71. As outlined in my earlier declaration, there is an abundance of studies that are consistent with the possibility of nonheterosexuality being causally influenced by childhood sexual abuse for some individuals. These studies are correlational and not longitudinal and hence cannot "prove" a causal pathway in either direction. My statements accurately reflect this reality. However, asserting such studies provide "no credible evidence" is to speculate beyond what the research can tell us. Again, good therapists *listen* to their clients, some of whom have determined sexual abuse in childhood contributed to the development of their same-sex attractions. The pertinent research gives us no reason to dismiss these clients' beliefs even when political and legal advocacy may make such dismissals an enticing practice.

72. To cite just one further example, Walker, Archer, and Davies (2005) studied 40 men who had been raped by men between the ages of 16 and 25. Among their findings they reported, "Several men reported changes in their sexual behavior after the assault…One described his sexual experience after his assault as one of promiscuity and sexual compulsion:

> Before the assault I was straight; however, since the assault I have begun to engage in voluntary homosexual activity. This causes me a great deal of distress as I feel I am not really homosexual but I cannot stop myself having sex with men. I feel as if having sex with men I am punishing myself for letting the assault happen in the first place." (p. 76)

Should such a person, be he a minor or adult, be prohibited from exploring same-sex attraction and behavior fluidity in change-allowing talk therapies provided by a licensed therapist? Is such a therapist's only legal option to be to tell this person that psychological experts and their associations have determined sexual abuse cannot cause his same-sex behavior in any way and

thus he must affirm the behavior he finds distressful? This is not *listening* to the client. This is the situation Ordinance 2017-47 appears to create.

73. Finally, declaring there is *no* safe form of "conversion therapy," *all* of which pose significant health risks, wildly overstates the reality for licensed change-allowing talk therapists who do not engage in the caricature of "conversion therapy" portrayed in the Glassgold Declaration. As I have stressed before, there is no scientific way to establish the degree of harms specific to professional SOCE in the absence of studies which control for pre-therapy levels of distress. Furthermore, what is really in question here is not a form of therapy but a particular client goal, i.e., exploring the degree to which change in unwanted same-sex attractions and behaviors may be assisted through talk therapy provided by licensed clinicians. The Defendant's claim more accurately can be translated as saying there is no safe way for a client to explore the possibility of change in psychotherapy, even when voluntarily sought and only involving speech (p. 37), despite the fact change-allowing talk therapies employ mainstream therapeutic approaches to address this goal. While psychotherapy in general can lead to some increased distress for a minority of clients (Lambert, 2013), such confident overstatements implying a universal lack of safety and a certitude of harm, when applied to change-allowing talk therapies, is not scientifically justifiable and appears based in advocacy rather than an objective examination of the literature.

I. Confirmation Bias: A True Danger When the Science Behind Social and Legal Policy Making is Produced by Ideologically Homogeneous Communities.

74. Confirmation bias is the well-documented tendency of people to search for evidence that will confirm their existing beliefs while also ignoring or downplaying disconfirming evidence. Similarly, confirmation bias leads people to have a less rigorous standard of critical evaluation for information with which they agree than for information with which they disagree. As Duarte et al. (2015) observe:

> Indeed, people are far better at identifying the flaws in other people's evidence gathering than in their own, especially if those other people have dissimilar beliefs. Although such processes may be beneficial for communities whose goal is social cohesion (e.g., a religious or activist movement), they can be devastating for scientific communities by leading to widely accepted claims that reflect the scientific community's blind spots more than they reflect justified scientific conclusions. (p. 8).

75. Certainly, confirmation bias is a characteristic of human reasoning across the sociopolitical spectrum. However, in the current context, as I have repeatedly shown, mental health associations and the community of academic researchers are currently lacking the ideological diversity needed for the public to have confidence their pronouncements regarding change-allowing talk therapies are not tainted by such bias. The field of psychology is shifting evermore leftward, with the ratio of liberals to conservatives now being greater than 10:1 and hardly any conservative students in the pipeline (Duarte et al., 2015). Bailey (2019) puts this even more starkly, "…there can be no doubt that sex research is among the most ideologically suspect of disciplines" (p. 1010). He cites the alleged progress surrounding transgender issues as an example:

> But this "progress" has nothing to do with scientific advances and everything to do with ideology. Considering any of the following is ideologically off limits for the progressive: Whether a male who says he is a woman may differ importantly from natal women; whether an adolescent girl who decides she is transgender might be wrong; whether gender dysphoric children should be required to wait before "gender affirmation;" or whether transgender males who dislike autogynephilia theory may be in denial…I have never been as worried about the future of sex research specifically, and social science generally, as I have been in recent years. (p. 1010).

Thus, the most dangerous risk from confirmation bias in the current professional and legal debates over change-allowing talk therapies is the premature foreclosing on what we may learn from science in order for some to achieve political and legal advocacy goals.

76. In the study of sexual orientation, confirmation bias has likely contributed to several conclusions that were politically expedient at the time but later turned out to be inaccurate. For example, Schumm (2018) noted that, "For decades some, if not most scholars have denied any relationship between parental and child sexual orientation" (p. 113). He concluded, "I think this has to be one of the better examples of how scientists can get their science or facts very wrong. There are now dozens of studies that appear to refute the 'no difference' hypothesis with only a few studies that do not essentially refute it" (p. 135). A recent example of studies refuting the "no difference" conventional wisdom (Gartrell, Bos, & Koh, 2019) concluded, "Our findings suggest that being raised by sexual minority parents may lead to more diverse sexual expression for both female and male offspring, and a greater likelihood of same-sex attraction and sexual minority identity" (p. 8).

77. The professional and academic environment within which professional SOCE is being debated is ripe for confirmation bias, with ideologically left-of-center dominance of professional mental health association leadership and the community of academic psychology. For example, confirmation bias is a probable factor in the APA's 2009 Report, given the exclusion of conservative psychologists from the task force. This helps explain how such different evidentiary standards were utilized for determining efficacy of and harm from SOCE. "The Report," notes Jones et al. (2010), "goes to some lengths to argue that only the most rigorous methodological designs can clearly establish a causal relationship between SOCE methods and resulting change, yet the Report makes such causal attributions consistently regarding harm while repudiating any such claims for efficacy" (p. 10).

78. When the focus is on subject matter where the APA has a vested interest in downplaying harm, the rigorous standards that were used to evaluate SOCE efficacy suddenly become utilized to evaluate potential harms. Consider the subject of abortion. In 2008, the APA released its *Report of the APA Task Force on Mental Health and Abortion* (APA, 2008). This report reviewed the literature on psychological harms attributed to abortion and noted many of the same methodological limitations noted by the APA 2009 Task Force review of SOCE. These included small sample sizes, retrospective reports, uncertain reliability and validity of outcome measures, lack of longitudinal designs, and lack of controls for pre-existing and co-occurring conditions. However, the 2008 APA Task Force applied these rigorous methodological standards

to the literature purporting mental health *harms* from abortion while the 2009 APA Task Force applied them only to the issue of SOCE *efficacy* and not to alleged harms. Adler, David, Major, Roth, Russo, and Wyatt (1992), foreshadowed the 2008 APA task force by using similarly stringent methodological criteria to eliminate from their review studies that suggested psychological harms from abortion.

79. This contrast, wherein the standards for methodological acceptability are applied in an extremely rigorous manner to dismiss studies suggesting SOCE efficacy and abortion harms, but applied in a very lax manner to the studies on alleged SOCE harms, is consistent with the influence of confirmation bias among left-of-center social scientists. The 2008 APA Report regarding the mental health problems attributed to abortion concludes in a fashion that would have been equally applicable to purported professional SOCE harms had the APA been consistent in its application of its methodological critique:

> This report has highlighted the methodological failings that are pervasive in the literature on abortion and mental health. This focus on methodological limitations raises the question of whether empirical science is capable of informing understanding of the mental health implications of and public policy related to abortion. (p. 92)

The same scientific humility should be appropriately applied to the research alleging harms from change-allowing talk therapies, but this would not be in keeping with the dictates of confirmation bias, not to mention APA and academia's advocacy interests.

80. Even the Glassgold Declaration citing the APA's criticism of "conversion therapy" studies seems to be influenced by confirmation bias. For example, consider how the declaration's following analysis can be turned on its head but remain equally accurate when substituting the struck through terms with the bracketed terms:

> ….subjects in studies purporting to validate CT [harms] were often referred by ~~CT practitioners~~ [anti-SOCE advocates] or were referred by ~~"ex-gay"~~ [LGBT] organizations. This "sampling bias" runs counter to the scientific standard of trying to find a broad range of participants, and renders the results unreliable. When working with small communities or ~~faith~~ [sexual minority] groups, participants should be randomly selected from as many potential participants to avoid bias. Selecting only participants who have been "chosen" by ~~pro-SOCE practitioners~~ [anti-SOCE advocates] or that are selected from ~~a specific program~~ [an LGBT venue or network] risks selecting only those who are biased ~~in favor of~~ [against] a particular result, or avoiding those who have been ~~harmed~~ [helped] or feel the experience is a ~~failure~~ [success]. (APA, 2009, p. 32-33)

81. These examples underscore the potential for confirmation bias to shape scientific and professional perspectives and this must be acknowledged in the debates over politically and morally contentious subjects such as professional SOCE. Therefore, the science concerning

change-allowing talk therapies is very likely to be incomplete and should not be prematurely foreclosed by legal intrusions such as Ordinance 2017-47. Ideologically diverse research teams should be encouraged as a check on confirmation bias (e.g., Lefevor, Beckstead, Schow, Raynes, Mansfield, & Rosik, 2018) or, in their absence, ideologically diverse perspectives on SOCE should be solicited. The truly science-based response to important professional practice questions imbued with intense political ramifications should be further research. In the absence of an extensive and unambiguous base of scientific evidence relative to professional SOCE, ideologically diverse science, not the political process, should settle controversies over change-allowing talk therapies. However, this can only occur if the normal process of science is allowed to run its course and is not derailed by legal prohibitions such as Ordinance 2017-47.

III. Summary.

82. The Glassgold Declaration notwithstanding, there is good reason to reject Ordinance 2017-47 as a scientifically unjustified prohibition on the goals of those minor clients who, after careful professional screening, are judged to be making self-determined choices to purse change-allowing talk therapy with a licensed therapist. As I noted in my earlier declaration, the same mental health associations, academic researchers, and politicians that wish to prohibit professional change-allowing talk therapies for minors without exception also are willing to allow for circumstances whereby gender dysphoric minors can voluntarily choose to risk sterility and other serious health complications through the administration of puberty blockers and cross-sex hormones (Hembree et al., 2017; Nota et al., 2019) and, given parental consent, even have healthy body parts altered or removed despite a significant possibility of eventually identifying with their biological sex without such interventions (Murphy, 2019; Olson-Kennedy, Rosenthal, Hastings, & Wesp, 2016; Ristori & Steensma, 2016). Ordinance 2017-47 promotes such options for minors by explicitly excluding from their definition of "conversion therapy" "…counseling that provides support and assistance to a person undergoing gender transition…" (p. 5). Science is the window dressing for this pursuit to ban professional SOCE, but, as the evidence presented in my declarations suggest, science is not the driving force.

83. The Glassgold Declaration does not seriously engage the concerns I outlined in my initial declaration. Instead, the declaration relies on false portrayals of professional change-allowing talk therapies as provided by licensed mental health providers, greatly overstates what can be concluded from more recent SOCE studies, unjustifiably links contemporary change-allowing talk therapies with the literature on stigma and discrimination, relies heavily on appeals to ideologically homogeneous and advocacy-invested sources of authority, and displays in its one-dimensional presentation of the literature the likely presence of confirmation bias.

84. Licensed mental health professionals who sometimes engage in change-allowing talk therapies are ethical providers who understand the need for client self-determination in the context of what current science can and cannot authoritatively say about therapy assisted sexual attraction and behavior fluidity. These therapists are willing to *listen* to clients, both minor and adult, some of whom make self-determined choices to explore change in same-sex attractions and/or behaviors. They do not pressure or otherwise coerce such clients to adopt their views. They understand that in truly ethical psychotherapy the causes of same-sex attractions, the goals of clients, and the religious and moral beliefs concerning same-sex behavior should not be dictated by *either* the therapist *or* their professional associations. Likewise, these sacred freedoms to

believe and act upon those beliefs in the context of professional therapy should not be dictated by the politicians behind Ordinance 2017-47.

I declare under penalty of perjury under the laws of the United States that the foregoing statements are true and accurate.

Executed this July 17, 2019.

Christopher Rosik, Ph.D.

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Guidelines for the Practice of Sexual Attraction Fluidity Exploration in Therapy[1]

Alliance for Therapeutic Choice and Scientific Integrity

Task Force on Guidelines for the Practice of

Sexual Attraction Fluidity Exploration in Therapy (SAFE-T)[2]

Salt Lake City, Utah

Many significant developments have occurred in the field of same-sex sexuality in the decade since the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) introduced the first edition of its Practice Guidelines (ATCSI, 2010). These developments necessitated that the guidelines be updated to address the professional and legal realities that face therapists who assist individuals in exploring the fluidity of their unwanted same-sex attractions and behavior. The revised Guidelines incorporate the now preferred language of sexual attraction fluidity exploration in therapy[3] (SAFE-T) as the most accurate description of contemporary professional clinical intervention with these individuals. Therapists are therefore encouraged to adopt this new language in their work as an umbrella term for a variety of specific mainstream approaches utilized by individual clinicians (Rosik, 2017a).

Clinical intervention with individuals who wish to explore the degree of fluidity of their unwanted same-sex attractions and behavior continues to generate controversy. Within the left-of-center sociopolitical environment, which currently dominates academia and mental health associations (Al-Gharbi, 2018; Cummings, O'Donahue, & Cummings, 2009; Duarte, Crawford, Stern, Haidt, Jussim, & Tetlock, 2015; Honeycutt & Freberg, 2017; Inbar & Lammers, 2012; Jussim, Crawford, Anglin, & Stevens, 2015; Redding, 2001, 2013; Wright & Cummings, 2005), individuals who pursue and/or report enhanced heterosexual functioning through psychotherapy may have their experiences of change marginalized or invalidated. One development which has tended to marginalize the clinical exploration of sexual attraction fluidity has been the production by professional psychological associations of resolutions, position statements, and practice guidelines related to therapeutic approaches to sexual orientation (e.g.,

American Psychological Association, 2009, 2012; Gamboni, Gutierrez, & Morgan-Sowada, 2018). While there is much helpful information in these documents with which clinicians should be familiar, they are nonetheless limited by their lack of diverse professional perspectives (Ferguson, 2015; Yarhouse, 2009). Specifically, they often appear to be produced by partisan committees whose members do not generally share the goals, values, or worldviews of many clients who seek assistance in exploring the degree to which their unwanted same-sex attractions and associated feelings, fantasies, and behaviors may be subject to psychotherapy-assisted fluidity.

This document is intended to provide educational and treatment guidance to clinicians who affirm the right of clients to explore the fluidity of their unwanted same-sex behavior and attractions. The specific goals of these guidelines are twofold: (a) promote professional practice that maximizes positive outcomes and reduces the potential for harm among clients who pursue SAFE-T regarding their unwanted same-sex attractions and behavior and (b) provide information that corrects stereotypes or mischaracterizations of SAFE-T and those who seek it.

Given that the very right of clients to pursue SAFE-T continues to be questioned within mental health associations (American Psychological Association, 2009, 2012; Gamboni et al., 2018; Kaplan et al., 2009; Yarhouse & Throckmorton, 2002) and is increasingly the focus of legislative and other legal prohibitions (Dubrowski, 2015; Rosik, 2017b), the ATCSI Board determined that an update to their earlier practice guidelines (ATCSI, 2010) was warranted. Members of the original task force were contacted and invited to participate in this revision. Those able to participate were joined by others invited to participate in this reconstituted task force due to their specific areas of expertise. A revised draft document of the original guidelines was completed and then sent out for review to the ATSCI board and selected members of the association's professional membership. Subsequent feedback was then considered and, where deemed beneficial, incorporated into the final version of the revised SAFE-T practice guidelines.

The term *guidelines* refers to statements which suggest or recommend specific professional behavior, endeavors, or conduct for clinicians. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. By contrast, guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by clinicians. Thus, practice guidelines are not mandatory, exhaustive, or applicable to every professional and clinical situation. These guidelines should not be construed as replacing accepted principles of psychotherapy but rather as supplementing them. Nor are these guidelines intended to serve as a standard of clinical care. Instead, they are meant simply to reflect the state of the art in the practice of psychotherapy with same-sex attracted clients who desire to engage in SAFE-T. These guidelines are organized into three sections: (a) attitudes toward clients who pursue SAFE-T, (b) treatment considerations, and (c) education.

Attitudes Toward Clients Who Pursue SAFE-T

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

The standard opinion in the field of the behavioral sciences is that the causes of human behavior are multifactorial (Jannini, Blanchard, Camperio-Ciani & Bancroft, 2010; Rutter, 2006). Similarly, there is a general consensus that the etiology of homosexuality is multifactorial (e.g., Gallagher, McFalls, & Vreeland, 1993; Kleinplatz & Diamond, 2014; Otis & Skinner, 2004; Rosario & Schrimshaw, 2014; Sanders et al., 2014) as are the reasons that cause some people to view their same-sex attractions and behaviors as unwanted (cf. Guideline 3). Historically, a large variety of approaches to intervention have been followed, and there have been vastly different individual theories of etiology. This arose because many approaches yielded sufficiently adequate outcomes for counselors, therapists, and their clients and hence tended to be adopted as the sole and sufficient explanation of origin. The strongest childhood correlate of an adult same-sex orientation is that of clinical Gender Dysphoria, which has been associated with subsequent homosexuality in 50% or more of cases in longitudinal studies (e.g., Zucker & Bradley, 1995). However, the low prevalence of full-fledged Gender Dysphoria among those who experience same-sex attractions means that this explanation only applied in a minority of cases, although subclinical gender identity concerns may be more common.

Sociological research has not shown any one environmental, family, or social factor as predominant in production of same-sex attractions for the majority of gay- and lesbian-identified people. The exhaustive work of Bell, Weinberg, and Hammersmith (1981) considered all known factors to that date and concluded each could only be numerically responsible for a small fraction of the causation. This was confirmed by the work of Van Wyk and Geist (1984). However, the sociological factors taken together were statistically significant (Whitehead, 2011a), and this was mostly not an artifact of presumed stability of same-sex attractions from adolescence to adulthood. Deliberate choice also seems to be another quite minor factor (Whitehead, 2013).

Biological research does not show one predominant cause; indeed most influences have been numerically minor, though many individual correlations have achieved statistical significance (Abbott, 2010; Bogaert, 2007; James, 2006; Martin & Nguyen, 2004; Meyer-Bahlburg, Dolezal, Baker, & New, 2008; Lalumiere, Blanchard, & Zucker, 2000; Rahman, Kumari, & Wilson, 2003; Sanders et al, 2014; Whitehead, 2014). The degree of concordance of sexual orientation in twins is the result of multiple influences, whether known to researchers or not, and twin studies suggested that multiple individualistic responses predominate to a degree that had not been expected (Bailey, Dunne, & Martin, 2000; Bearman & Bruckner, 2002; Hershberger, 1997; Langstrom, Rahman, Carlstrom, Lichtenstein, 2010; Santtila, Sandnabba, Harlaar, Varjonen, Alanko, & von der Pahlen, 2008; Whitehead, 2011b). A general context for the biological causes is the strong academic emphasis on plasticity of

neural processes (Pascual-Leone, Amedi, Fregni, & Merabet, 2005), in which the brain is constantly reprogramming itself, partly in reaction to environmental events. Although this should not be presented as making any desired behavioral change easy, it can certainly be legitimately presented as an argument against the impossibility of fluidity and change.

Therefore, there is a particular need and responsibility for clinicians to take client histories seriously and to not impose on all clients' particular etiological theories even if they have been clearly applicable in individual cases (c.f. Guideline 6). On the other hand, a client may deny for psychological reasons events or processes which to the clinician are obvious causes, and it may be legitimate to confront the client if this is present. A balance must therefore be struck between taking clients' histories very seriously, and retaining therapeutic objectivity. There is also a special need for peer consultation and broadening one's understanding by collating influences which clients have found important. Although no overwhelmingly predominant factors are likely to be found, several broad themes are already known, which may contribute to the endpoint of same-sex attraction and behavior. In no particular order these include, but are not limited to, sexual abuse (Jones, 2006; Mustanski, Kuper, & Greene, 2014), conditioning from childhood sexual experience (Beard et al., 2013; Hoffman, 2012; O'Keefe et al., 2014; Pfaus, 2012), relationships with parents (Francis, 2008; Frisch & Hviid, 2005; Udry & Chantala, 2005), relationships with same-sex peers (Bem, 1996), political solidarity (Rosenbluth, 1997; Whisman, 1996), and atypical gender characteristics (mental or physical/biological) (Zucker & Bradley, 1995).

Discretion is thus necessary in comprehending the etiology of same-sex attractions in any particular client, as is suggested by leading mental health organizations now being noncommittal on the issue (APA, 2008a; Rosario & Schrimshaw, 2014). Nevertheless, a broad but unified understanding of these diverse influences might be found in viewing same-sex attractions and behavior as a developmental adaptation to less-than-optimal biological and/or psychosocial environments, possibly in conjunction with a weak and indirect genetic predisposition.[4] Furthermore, this adaptation may be distressful to some individuals in light of their values and/or because it frequently results in behavioral practices that place participants at risk for mental illness and physical disease (cf. Guidelines 3, 8, and 12). Given the complexity of this topic, clinicians who work with clients reporting unwanted same-sex attractions and behavior must be even more concerned about, and committed to, contributing data for research, subject to the usual confidentiality requirements. This would help broaden our understanding of the etiology of same-sex attractions and behaviors.

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

When individuals enter into psychotherapy and express conflicted feelings, thoughts, or values about their

same-sex attractions, or any other issues, clinicians engage them from their own values and biases. These values inform the choice of theories, techniques, and attitudes clinicians utilize in their efforts to help these clients explore their presenting issues (Blow, Davis, & Sprenkle, 2012; Jones, 1994; Meehl, 1993; Midgley, 1992; O'Donohue, 1989; Redding, 2001).

Professional mental health associations have historically recognized this principle in their ethical guidelines, which call upon clinicians to be aware of their own belief systems, values, needs, and limitations and how these factors affect their work (e.g., American Association of Marriage and Family Therapy, 2015; American Psychological Association, Ethical Principles, 2017). In this context, the professions have encouraged clinicians to exercise reasonable judgment and ". . . take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices" (e.g., American Psychological Association, 2017, Ethical Principles, Principle D, p. 4). In addition, mental health associations have also recognized that sexuality and religiosity are important aspects of personality (American Psychological Association, 2008b). Clinicians are encouraged to be aware of and respect cultural and individual differences, including those pertaining to religion and sexual orientation, when working with clients for whom these dimensions are particularly salient (American Psychological Association, 2017, Ethical Principles, Principle E; cf. Guideline 3). This is particularly pertinent because surveys suggest that those who come for therapy tend to be much more religious than average (Santero, Whitehead, & Ballesteros, 2018).

Clinicians are encouraged to be aware that their meetings with clients, wherein the clients' presenting problem is their need to clarify conflicted attitudes toward the same-sex attractions they experience, represents a microcosm of the conflicts which are being played out in culture within the spheres of morals, laws, and psychological definitions about the nature and position of homosexuality in our society. Clinicians need to be aware that historically, same-sex attractions and behavior were thought of as a moral issue (i.e., sin) by theologians and laypersons, as a legal problem by legislators (i.e., a crime), and only later as a psychological phenomenon (i.e., a psychic disturbance) (Katz, 1976). Same-sex attractions and behaviors were, and to a significantly lesser extent are still, seen or experienced in our culture as moral failures to be judged (Gallup, 2018), criminal acts to be prosecuted (Posner & Silbaugh, 1996; Rubenstein, 1996), often stigmatized and discriminated against (Eskridge & Hunter, 1997; Herek, 2010; Rubenstien, 1996), and until 1974, as a disorder in and of itself to be treated (American Psychiatric Association, 1972).

The last few decades have brought about accelerating changes in the moral valuation, legal status, and psychological description of homosexuality (Twenge, Sherman, & Wells, 2016). The latter was reflected by the removal of homosexuality in and of itself from the category of a pathological condition from the DSM in 1973 by the American Psychiatric Association (APA, 1973). At this time the legitimacy, effectiveness, and ethicality of change-oriented intervention also came into question.

This, in turn, led to most mental health associations asserting that homosexual orientation and/or attractions could never be modified (e.g. American Psychological Association, 2008a). Within this exclusively gay-affirmative position, the presumed and prescribed optimal outcome of therapy for clients ambivalent about their attractions to the same gender is developing and achieving acceptance of and identification with their sexual desires.

Clinicians who continue to practice SAFE-T believe change in terms of sexual attraction fluidity is possible and available for many highly-motivated clients, for whom the goal of therapy is the lessening of their same-sex attraction, the development and increase of their opposite-sex attractions and identification, or, short of that, achieving a stable identification with an abstinence-based life (ATCSI, 2009; Byrd & Nicolosi, 2002; Santero et al., 2018). Other clinicians can identify with both of these positions. They look at the goals of change and the goals of the gay affirmative stance as possible and ethical without an exclusive value commitment to either one as they counsel a client with ambivalence about same-sex attractions as the presenting problem (Throckmorton & Yarhouse, 2006).

As clinicians attempt to approach the task of assessment, informed consent, and goal-setting, an additional obstacle needs consideration: to define the complexities of sexual orientation and its development. Many social scientists share an interactionist perspective, which postulates that sexual orientation is shaped for most people through the complex interaction of biological, psychological, and social factors (cf. Guideline 1). There is a lack of consensus about how best to measure and what constitutes the central components or dimensions of sexual orientation (e.g., attractions, behavior, fantasies, identification, or some combination of these elements) (Beaulieu-Prevost & Fortin, 2014; Kinnish, Strassberg, & Turner, 2005; Moradi, Mohr, Worthington, & Fassinger, 2009; Sell, 1997; Throckmorton & Yarhouse, 2006). This leads to further problems with measuring reliability and estimating prevalence rates (Byne, 1995; Laumann, Gagnon, Michael, & Michaels, 1994; Stein, 1999). In addition, after December 1973, when homosexuality in and of itself was no longer categorized as a disorder, the research on the possibility of changing unwanted same-sex attractions substantially decreased from the professional literature (Jones & Yarhouse, 2007).

Along with considering the above, clinicians are encouraged to reflect on the following potential biases they may encounter as the exploration of a client's issues begins (Rosik & Popper, 2014). Clinicians who have adopted a primarily gay-affirming stance tend to focus on that portion of the research literature which emphasizes a lack of difference in pathology between individuals with same-sex attractions and the rest of the population, attributing most symptomology that differentiates the two populations to internalized negative messages about homosexuality and external minority stressors (Gonsiorek, 1991; Hatzenbuehler, 2009; Meyer, 2003), although the direct effects of perceived discrimination generally account for less than 10% of the variance in health differences (Pascoe & Richman, 2009). They may ignore the possible etiological significance of social and developmental factors, such as a

higher incidence of childhood sexual abuse, particularly for men (Eskin, Kaynak-Demir, & Demir, 2008; Fields, Malebrance, & Feist-Price, 2008; Friedman et al., 2011; James, 2005; Stoddard, Dibble, & Fineman, 2009; Tomeo, Templer, Anderson, & Kotler, 2001; Wilson & Widom, 2010; Xu & Zheng, 2015). They may also ignore the potential for discrimination to occur within LGB communities (Matsick & Rubin, 2018). They might emphasize mostly the methodological limitations in the research literature, which indicate the possible efficacy of change intervention (Gonsiorek, 1991, American Psychological Association, 2009), even though there appears to be no satisfactory measure of sexual orientation (or its change) in the literature (Jones & Yarhouse, 2007; Moradi et al., 2009). They are likely to dismiss the research into psychodynamic and other theories which can be used to support change interventions (American Psychological Association, 2009; Bell et al., 1981) based on methodological limitations, ignoring the fact that the quality of these studies, although not impressive by contemporary standards, was nevertheless "state of the art," sufficient to merit publication in respected professional journals. Moreover, the early research that supported the possibility of fluidity and change is comparable to other studies on homosexuality in the literature of the time that are still held in good repute (Jones & Yarhouse, 2007) and referenced uncritically in contemporary discussions about change-oriented treatment (cf. American Psychological Association, 2009), most likely because they support a favored sociopolitical point of view.

Furthermore, clinicians holding strong gay-affirming positions may tend to emphasize clinical literature which describe examples of harm (e.g., disappointment in not achieving complete elimination of unwanted same-sex attractions) in the course of SAFE-T and may take a position that conducting such therapy is clearly unethical and harmful (Drescher et al., 2016; Gonsiorek, 2004; Mahler & Mundle, 2015; Murphy, 1992; Tozer & McClanahan, 1999; Worthington, 2004). They may maintain this view even when clients explicitly desire to change their unwanted same-sex attractions and/or behavior (Gonsiorek, 2004). These clinicians may take the position that clients cannot establish realistic therapeutic goals for themselves nor make a truly voluntary decision to develop their heterosexual potential, assuming that such a desire can only be a reflection of an oppressive and prejudicial society (Tozer & McClanahan, 1999). They may discount the reality that many clients who want to explore the possibility of fluidity in their unwanted same-sex attractions and behaviors experience significant conflict between their religious beliefs and their sexual attraction to members of the same sex (Beckstead & Morrow, 2004; Haldeman, 1994, 2004; Yarhouse & Tan, 2004) and that some of these clients perceive their religious affiliation as the most stable aspect of their identity (Johnson, 1995; Koening, 1993). Some clinicians have even equated agreeing to help someone develop their heterosexual potential as analogous to agreeing to help an anorexic lose weight (Green 2003) or having sex with clients (Drescher et al., 2016). They may tend to espouse the immutability of sexual orientation, basing this conclusion on

unsubstantiated biological research as its foundation, a conclusion that is rapidly becoming scientifically untenable (Byrd, 2010; Diamond & Rosky, 2016; Garnets & Peplau, 2001; Hu, Xu, & Tornello, 2016; James, 2005; Manley, Diamond, & van Anders, 2015; Stein, 1999; Yarhouse & Throckmorton, 2002).

Some clinicians who engage in SAFE-T for unwanted same-sex attractions and behaviors may overly interpret the likelihood of the possibility and extent of probable fluidity, oversimplifying or overselling the process of change according to their preferred (often psychodynamic) theory (Rosik & Popper, 2014; cf. Guideline 6). They may not take into account sufficiently the uniqueness of a particular client's history of same-sex or opposite-sex interest/arousal/behavioral patterns and underestimate the possible harm that may result from such oversimplification (Rosik & Popper, 2014), such as causing clients to feel misunderstood and misrepresented (Beckstead, 2001; Drescher et al., 2016; Haldeman, 2002; Shildo & Schroeder, 2002; Shildo, Schroeder, & Drescher, 2001). They may be tempted to ignore the reality that only a minority of clients with unwanted same-sex attractions achieve complete change towards heterosexual capacity and functioning, even though they face enormous social sanctions throughout their lives (Green, 2003; Santero et al., 2018).

SAFE-T clinicians might also minimize the research on the effect of social pressures and internalized societal attitudes toward homosexuality as possibly contributing to the symptomatology of the client (Di Placido, 1998; Maylon, 1982; Mays & Cochran, 2001; Meyer & Dean, 1998; Newcomb & Mustanski, 2010; Shildo, 1994; Szymanski, Kashubeck-West, & Meyer, 2008) as well as research suggesting that gay-identified men and women identifying as lesbians who report lower internalized homophobia will present with less symptomatology (Meyer & Dean, 1998; Szymanski et al., 2008). Some clinicians who engage in SAFE-T might automatically assume that the outside pressures experienced by clients to move away from their unwanted same-sex attractions are congruent with clients' value systems and should be honored, without a deeper exploration of the issues (Green, 2003; cf. Guideline 9). Some of these clinicians may suggest fluidity and change in unwanted same-sex attractions to clients as potential relief from a pathological condition when it would be more helpful to look at it as a "clinical problem" (Engelhardt, 1996; cf. Guideline 6), especially for clients who are leaning towards integrating a gay identity and who experience a focus on pathology as unhelpful (Liddle, 1996) or as harmful in various ways (Shildo & Schroeder, 2002), or for clients who have been made vulnerable by repetitive, traumatic anti-gay experiences (Haldeman, 2002).

Both gay-affirmative and change-oriented clinicians, especially if they are actively involved in the cultural debate surrounding the moral, legal, and psychological position of homosexuality in our society, may be vulnerable to dismissing the need for referring clients. This may be a risk particularly when, during the goal setting process, it becomes clear that the value position of the counselor is in clear conflict with the client's goals (Haldeman, 2004; Liszez & Yarhouse, 2005). A need to refer may arise due to a counselor's inability to identify with religiously based identity

outcomes (Throckmorton & Welton, 2005) or with the less sexually monogamous norms of a significant portion of the gay culture (Levine, Herbenick, Martinez, Fu, & Dodge, 2018; Bepko & Johnson, 2000; Bonello & Cross, 2010; Laumann et al., 1994; Martell & Prince, 2005; Mercer, Hart, Johnson, & Cassell, 2009; Prestage et al., 2008; Shernoff, 1999, 2006; Spitalnick & McNair, 2005). Or they may find it objectionable to refer clients to a needed supportive community whose values they do not accept (Yarhouse & Brooke, 2005).

Clinicians who adopt a primarily more flexible position than either gay-affirmative or SAFE-T clinicians are less likely to have their therapeutic interactions be influenced by the above potential biases during the initial phase of assessment, informed consent, and goal setting (Throckmorton & Yarhouse, 2006). Yet these therapists also may tend to wait too long to encourage a client to move out of contemplative ambivalence, thus losing opportunities to help a client experiment with new behaviors, attitudes, and adaptations (Rosik & Popper, 2014). This could be due to a clinician's own ambivalences toward the possibility of therapy-assisted fluidity or to not being able to fully identify with the sexual value system of the gay or conservative religious subcultures (Bepko & Johnson, 2000; Rosik, 2003a).

Clinicians who are not engaged in offering SAFE-T may not appreciate fully the experience of clinicians who are such providers, who often find that effective working alliance can come into play only when the counselor and client both view unwanted same-sex attractions from similar value positions (Blow et al., 2012). From this perspective, their more flexible position of addressing the therapeutic needs of both change-seeking and gay-affirmative clients can dilute the power of the alliance and leave the client feeling incompletely understood and incompletely supported (Nicolosi, Byrd, & Potts, 2000; Rosik, 2003a, 2003b). When working with adolescents, in addition to the above considerations, gay-affirmative and SAFE-T clinicians may need to exercise extra caution, being aware that at this developmental stage the experience of sexual identification is more fluid, and therefore adolescents may experience pressure towards resolution as unhelpful (Cates, 2007; McConaghy, 1993; Remafedi, Resnick, Blum, & Harris, 1992; Savin-Williams, 2005; cf. Guideline 11).

Mental health professionals are in conflict on how best to help the unique individual who enters psychotherapy expressing conflicted feelings, thoughts, or values about their same-sex attractions and behavior (Rosik & Popper, 2014). Since conservative and traditional views are presently underrepresented in the mental health profession (Duarte et al., 2015; Redding, 2001), there is serious risk that a counselor's response to clients wanting to explore potential fluidity will be negative. Therefore, there is merit in clinicians being familiar with a range of therapeutic options for clients who experience religious and sexual identity conflicts, including those that validate a client's decision to develop heterosexual potential (Beckstead & Morrow, 2004; Haldeman, 2004; Rosik, 2003a; Throckmorton & Yarhouse, 2006). It is recommended that clinicians consider these options as part of a reflective, ethical practice.

Guideline 3. ***Clinicians are encouraged to respect the value of clients' religious faith and refrain from making disparaging assumptions about their motivations for pursuing SAFE-T.***

Research indicates that the majority of individuals who present to clinicians with unwanted same-sex attractions are motivated in part by deeply held religious values (Jones & Yarhouse, 2007; Nicolosi et al., 2000; Santero et al., 2018; Spitzer, 2003). However, studies consistently report that mental health professionals are less religious than the general population across several dimensions of participation and belief (Bergin & Jensen, 1990; Delaney, Miller, & Bisono, 2007; Neeleman & King, 1993; Shafranske & Cummings, 2013). A lack of familiarity with religious beliefs and values in general—and those of the client in particular—can negatively affect the course and outcome of interventions with clients whose faith motivates the pursuit of SAFE-T for unwanted same-sex behaviors and attractions (Ruff & Elliott, 2016). Respect for religion as a dimension of diversity within psychology underscores the need for attention to this risk (Benoit, 2005; Rosik & Popper, 2014; Yarhouse & Burkett, 2002; Yarhouse & VanOrman, 1999).

While religious motivations should not be immune from scrutiny in the context of psychotherapy, clinicians need to be extremely cautious about pathologizing the religious values which may prompt a client to pursue SAFE-T. A lack of conservative and religious representation among mental health professionals relative to general population estimations (Delaney et al., 2007; Redding, 2001; Shafranske & Cummings, 2013) suggests that the danger of clinicians misinterpreting or invalidating the motives of religious and conservative clients is considerable (Ruff & Elliott, 2016). One way in which such therapeutic misattunement occurs is when religious beliefs that motivate clients to pursue SAFE-T for unwanted same-sex attractions are too quickly and uniformly labeled as internalized homophobia (Herek, Gillis, & Cogan, 2009; Sowe, Taylor, & Brown, 2017). Persons who prioritize their traditional religious identities above their sexual attractions can and do experience many benefits from such faith commitments, which may outweigh the challenges (Barringer & Gay, 2017; Walker & Longmire-Avital, 2013). Differences in moral values between therapists, counselors, and their religiously identified clients concerning sexuality can easily become the object of clinical suspicion, with the tacit and inappropriate assumption that the counselor's values are superior to and should override those of the client (Haidt & Hersh, 2001; Kendler, 1999; Miller, 2001; O'Donahue & Caselles, 2005; Rosik, 2003a, 2003b, 2007a, 2007b).

Clinicians can benefit by examining the role that worldview similarity, particularly with regard to moral epistemology, plays in their attitudes toward clients who request assistance in developing their heterosexual potential. For example, six domains of moral concerns have been identified across cultures: 1) concerns for the suffering of others; 2) concerns about unfair treatment, inequality, and justice; 3) concerns about having liberty restricted; 4) concerns related to obligations of group membership (e.g., religious identification); 5) concerns related to social cohesion and respect for tradition and authority; and 6) concerns related to

physical and spiritual purity and the sacred (Graham et al., 2013; Graham, Haidt, & Nosek, 2009; Haidt, 2012; Haidt & Graham, 2007, 2009; McAdams, Albaugh, Fauber, Daniels, Logan, & Olson, 2008). The first three moral domains focus on the individual as the center of moral value, with an aim of protecting the individual directly and teaching respect for individual rights. The other three domains emphasize the value of groups and institutions, attempting to bind individuals into roles and duties for the good of society.

The research of Haidt and his colleagues has indicated that conservative persons tend to utilize all six of these domains in their moral thinking, whereas liberal/progressive persons tend to rely much more on the first two concerns for their moral intuitions. These differences can lead liberally minded people to misunderstand the moral concerns of conservative individuals more than the latter misconstrue those of the former (Graham, Nozek, & Haidt, 2012). Furthermore, the moral concerns of conservative individuals regarding group loyalty, respect for authority and tradition, and purity/sacredness tend to be rejected by liberal persons (including mental health professionals) and deemed immoral when perceived to be in conflict with their emphasis on harm, rights, and justice. Respectful awareness of such differences can promote a positive therapeutic environment for clients pursuing SAFE-T for their unwanted same-sex attractions and behavior due to religious or other morally motivated reasons.

Another means of marginalizing religious belief within the general practice of psychology has been to bifurcate psychology and religion, to deem religiously motivated SAFE-T as essentially a religious pursuit which has no place in a science-based clinical practice (Silverstein, 2003; American Psychological Association, 2009). This perspective creates a strict demarcation which is not supportable given the enormous overlap between the fields in their philosophical and anthropological areas of inquiry, e.g., theories of human nature (Auger, 2004; Bain, Kashima, & Haslam, 2006; Jones, 1994; O'Donahue, 1989). Furthermore, it may represent some degree of philosophical naivety or professional hubris in that the empirical methods of psychology contain their own "innate" values and are also influenced by the value assumptions of researchers (Fife & Whiting, 2007; Slife, 2006, 2008; Slife & Reber, 2009, 2012; Slife, Starks, & Primosch, 2014). These methods are not theologically or philosophically neutral nor do they enable research to proceed without the application of interpretive biases of some sort, particularly when investigating value-laden subjects such as the pursuit of SAFE-T. As noted by Chambers, Schlenker, & Collisson (2013), "To the extent that social scientists operate under one set of assumptions and values, and fail to recognize important alternatives, their scientific conclusions and social-policy recommendations are likely to be tainted" (p. 148). Conversely, established religious and theological traditions are not bereft of a degree of objective and empirical validation, in that when they have not become corrupted by power they have displayed practical validity and utility for understanding and directing human behavior for hundreds if not thousands of years (e.g., Stark, 2005).

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

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

Professional clinicians ascribe to the general ethical principle of individual autonomy and self-determination (e.g., Principle E: Respect for People's Rights and Dignity; American Psychological Association, 2017). Clinicians are encouraged to avoid viewing individuals who pursue SAFE-T for their unwanted same-sex attractions, same-sex behaviors, or sexual identity as an exception to this general ethical principle. Likewise, professionals strive to view clients as fully capable of pursuing self-determination or able to respond in an autonomous manner to the source of their distress (Byrd, 2004). Clinicians act in an ethical and humane manner and provide a valued service to clients when they respect a client's right to self-determination and autonomy to select SAFE-T for unwanted same-sex attractions and behavior (Benoit, 2005).

A focus on self-determination and autonomy does not relegate this ethical consideration above others in addressing the provision of change-oriented interventions (APA, 2009; Drescher et al., 2016). However, this ethical issue is often stressed in the literature relevant to SAFE-T precisely because it is the ethical guideline most directly impacted by the threat of professional and legal restrictions on such care. Restricting client self-determination to pursue SAFE-T on the basis of a lack of empirical efficacy, even if accurate, should in fairness commence a professional prohibition on many other experimental and unsupported treatment modalities that are currently practiced (Barnett & Shale, 2013; Pignotti & Thyer, 2009). A significant case in point is "recovered memory therapy" (RMT), with which the APA dealt in a vastly more lenient and nonpartisan manner than it did with so-called "sexual orientation change efforts," in spite of RMT having more clearly established harms and much less empirical basis than SOCE (Rosik 2017c). Nor does the limiting of client autonomy appear to be warranted by the potential for harm in exploring the fluidity of unwanted same-sex attractions. No harm has been definitively linked to such exploration as a whole (APA, 2009; Santero et al., 2018), and harms that could be imagined can likely be resolved by suitable practice guidelines such as those offered here.

Clients enter therapy with values that guide their goals for therapy. Whether religious or personal, such values may lead individuals to seek change interventions for unwanted same-sex attractions and behavior. In treatment settings, professionals respect the autonomy and right of self-determination of individuals who pursue SAFE-T for unwanted same-sex attractions and

behavior as well as those individuals who do not desire such goals. Clinicians refrain from persuading clients to select goals and interventions that are contrary to their personal values (American Psychological Association, 2008a; Haldeman, 2004).

Professionals support the principle that individuals are capable of making their own choices in response to same-sex attractions and promote autonomy and self-determination by: a) acknowledging a client's choice or desire to pursue SAFE-T for unwanted same-sex attractions and behavior, b) exploring why these attractions and behaviors are distressing to the client (Jones & Yarhouse, 2007), c) addressing the cultural and political pressures surrounding choices in response to same-sex attractions, d) discussing the range of professional therapies and resources that are available (Jones & Yarhouse, 2007), e) providing understandable information on outcome research related to change interventions (ATCSI, 2009), and f) obtaining informed consent for treatment (Rosik, 2003a; Yarhouse, 1998a; cf. Guideline 5).

Value conflicts with the broader culture may be experienced by consumers who opt for gay-affirmative interventions. However, the more sociopolitically liberal and secular worldview of licensed clinicians heightens the probability that value conflicts in the clinical setting are more likely to occur among clients who desire that SAFE-T be a therapeutic option. The clinician's commitment to respecting client autonomy and self-determination may be especially tested when working with individuals reporting unwanted same-sex attractions and behavior. Clinicians risk violating the client's right to autonomy and self-determination when they attempt to deny a client the opportunity to engage in SAFE-T, view the client as incapable of making choices among intervention options, or withhold information about a full range of therapeutic choices. Such violations of client rights may risk harm to the client (Byrd, 2004).

Treatment Considerations

Guideline 5. ***At the outset of treatment, clinicians strive to provide clients with accurate information on SAFE-T processes and outcomes, sufficient for informed consent.***

Clinicians from all the mental health professions provide clients with informed consent at the beginning of treatment (e.g., American Psychological Association, 2017, Ethical Standards 3:10 & 10.01; American Association for Marriage and Family Therapy, 2015, Ethical Standard 1.2; National Association of Social Workers, 2017). Ethically, those who serve clients with unwanted same-sex feelings and behaviors—or any psychological, behavioral, or relational concerns—offer accurate information both about the process of SAFE-T and the kinds and likelihood of changes that may be possible.

Adequate informed consent is an important part of therapeutic "Beneficence and Nonmaleficence," whereby clinicians ". . . strive to benefit those with whom they work and take care to do no harm . . . [and] seek to safeguard the welfare and rights of those with whom they interact professionally . . ." (APA, 2017, General Principle A, p. 3). Informed consent also encourages and expresses clinical "competence," in

which clinicians "provide services . . . with populations and in areas only within the boundaries of their competence." Clinicians inform their clients about their clinical "education, training, supervised experience, consultation, study, or professional experience," through which competence was developed (APA, 2017, Ethical Standard 2.01, p. 5).

Clinicians engaged in SAFE-T with clients may properly acknowledge that the perspective of the therapist's professional association regarding same-sex attractions and behaviors, and therapy to address them, may be different from, or opposed to, the perspective of the therapist and the perspective of the client. As appropriate, clinicians may want to discuss the specifics of those differences with the client and include a statement regarding them as part of their consent process.

Since 1973, homosexuality itself has no longer been diagnosed formally as pathological (American Psychiatric Association, 1973; APA, 1975). Although most professional associations no longer consider homosexuality to be a diagnosable or treatable condition (American Psychiatric Association, 2013), related co-occurring conditions with theoretical and empirical links to non-heterosexuality remain valid foci of diagnosis and therapeutic care. As even gay-identified scholars have asserted, "The developmental issues that contribute to 'the persistent and marked distress' about one's sexual orientation are valid areas of investigation" (Morin & Rothblum, 1991, p. 3). This also holds true when examined within the context of SAFE-T for unwanted same-sex attractions and behavior. Contrary to current attitudes explicit or implicit in the professional and lay media, "regardless of pathology, cultural trends, or current political rhetoric, mental health issues for homosexuals remain clinically significant and, like all others, must be addressed by the clinician with competence" (Monachello, 2006, p. 56). When clinicians help clients distressed about their same-sex attractions and behavior, they are being ethically responsible, respecting "the dignity and worth of all people, and the rights of individuals to . . . self-determination" (American Psychological Association, 2017, General Principles, Principle E, p. 4).

In helping clients resolve unwanted same-sex behavior and attraction, clinicians are mindful that the phenomena of male and female homosexuality and the related concept of "sexual orientation" (i.e., the gender(s) of the persons to whom one is sexually and/or affectionately attracted and experiences love and/or sexual arousal) are not universally defined, fixed, discrete, one-dimensional constructs (Beaulieu-Prevost & Fortin, 2014; Weinrich & Klein, 2002; Worthington & Reynolds, 2009). A person's perceived or self-declared sexual orientation may or may not be consistent with actual sexual behaviors, thoughts, or fantasies (Korchmaros, Powell, & Stevens, 2013; Schneider, Brown, & Glassgold, 2002). Moreover, clients' responses to unwanted same-sex experiences may vary from obsessive anxiety that they—or a dependent family member—may develop same gender sexual attractions, to feeling but never having acted upon such attractions, to having gratified them in a single, occasional, habitual or even addictive manner.

Clinicians will assess the nature of their clients' actual experience of unwanted same-sex feelings, thoughts,

and behaviors as part of informing the clients of possible treatment outcomes and developing a mutually agreed-upon plan for intervention. Such assessment will explore the possible presence of many co-occurring medical, psychological, behavioral, and relational difficulties which either contribute to and/or may be consequences of a client's unwanted same-sex attractions or behaviors (cf. Guideline 8). Some research findings indicate the average client will have three difficulties within these domains to some extent (Santero et al., 2018). Unlike other therapeutic settings, there is a tendency for more substance-related issues for the women, and more mood-related issues for the men. (Whitehead, 2010). Evidence is that self-esteem, social functioning, depression, self-harm, suicidality, substance abuse will all move in positive directions during SAFE-T, and most do so markedly. Religiosity among clients who engaged in SAFE-T remains at very high levels even several years after therapy has concluded (Santero et al., 2018).

Clinicians also will assess the nature of their clients' spiritual and religious involvement and motivation in order to respect their clients' rights, dignity, and need for self-determination (cf. Guidelines 3 and 4). Appropriate referrals for allied medical, mental, and/or pastoral healthcare may be an appropriate component of informed consent and goal setting (cf. Guidelines 8 and 12). The therapist should consider whether support groups are available or desirable. Other recommendations for client involvement may include non-erotic same-sex friendship and spiritual support. Clients involved in SAFE-T have found strongly positive benefits in these activities with almost no negative effects. (Santero et al., 2018).

When discussing the possibilities for change, it is important to explain that as with any intensive course of intervention, achievement of significant fluidity and change in unwanted same-sex attractions and behaviors requires sufficient motivation, hard work and patience, with no guarantees of "success" (Haldeman, 1991, 1994, 2001). The mean number of hours engaged in SAFE-T reported by Santero and colleagues (2018) was 80. But when discussing the possibilities of successful changes, it is heartening to note that successful intervention has been reported in the clinical and scientific literature for the past 135 years. In over 150 reports spanning the end of the 19th century through the beginning of the 21st, successful change(s) in sexual attractions, thoughts, fantasy, and/or behaviors from same-sex to opposite-sex have been documented (ATCSI, 2009; Byrd & Nicolosi, 2002; Phelan, 2014; Santero et al., 2018). One rule of thumb which continues to be supported by research and experience over many decades is that among individuals who pursue psychological care with a clinician skilled in SAFE-T, one third experience no change, one third experience some change, and one third experience profound change. But of those exclusively same-sex attracted, two thirds experienced some attraction to the opposite sex for the first time (Santero et al., 2018).

Reports of change range in size from single client case studies to group studies with hundreds of clients. The various therapeutic paradigms used for the purposes of SAFE-T have included psychoanalysis (Bieber, Dain, Dince, Drellich, & Grand, 1962; MacIntosh,

1994) and experiential or other psychodynamic approaches (Berger, 1994; Nicolosi, 2009; Pela, Sutton, & Nicolosi, 2018; Santero et al., 2018); hypnosis; behavior and cognitive therapies (Bancroft, 1974; Birk, Huddleston, Miller, & Cohler, 1971; Throckmorton, 1998); sex therapies (Masters & Johnson, 1979; Pomeroy, 1972; Schwartz & Masters, 1984); group therapies; religious-mediated interventions (Jones & Yarhouse, 2007, 2011); pharmacology; combinations of therapies (Karten & Wade, 2010; Pela et al., 2018; Santero et al, 2018); and others. A number of meta-analyses also demonstrate that intended fluidity and change in feelings and behaviors is a realistic goal for persons with unwanted attractions to the same sex (Clippinger, 1974; James, 1978; Jones & Yarhouse, 2000; Byrd & Nicolosi, 2002). This list is not exhaustive (cf. ATCSI (2009) for a comprehensive list of reports for each paradigm). In addition, SAFE-T clinicians frequently provide orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices.

As part of fully informing clients and obtaining informed consent, SAFE-T clinicians are encouraged to emphasize in their discussions with clients and in their consent forms that their therapeutic work does not include practices such as aversion therapy, "shock" therapy, any form of physical or emotional intimidation, therapist-imposed goals, or other similar practices or methods, regardless of what label may be attached to them. Advocates of proposed legal prohibitions on therapy have attempted to portray such practices as widespread and suggest that they are somehow necessarily or unavoidably involved in any professional therapy that may address unwanted feelings of same-sex attraction or unwanted behaviors. Such portrayals are untruthful. No SAFE-T clinician would engage in any such practice, and clinicians should leave no question or room for doubt in the client's mind in this regard (cf. Guideline 7).

Clinicians who engage in SAFE-T are further encouraged to communicate to clients that they do not practice so called "conversion therapy," sexual orientation change efforts (SOCE), or any other therapy that is purported to focus on orientation change. SAFE-T clinicians do not attempt to change the client's sexual orientation or gender identity; however, they uphold clients' rights to pursue fluidity and change of any aspect of their identity, attractions, behaviors, or personality. Throughout the therapy process, therapists involved in SAFE-T provide acceptance, support, and understanding to clients and facilitate clients' coping, social support, and identity exploration and development.

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

It is not uncommon that clients who report and/or are assessed as having made a significant transition from same-sex to opposite-sex attraction, cognition,

fantasy, and behavior, may re-experience same-sex feelings or thoughts, albeit at a less intense level than before SAFE-T. Of course, there may be exceptions. Even when clients have not achieved all they had hoped for when beginning therapy, many report satisfaction with what they have achieved (Nicolosi et al., 2000, 2008; Santero et al., 2018; Spitzer, 2003), and some clients who describe their experiences in therapy as "harmful" also may characterize them as "helpful" (Shildo & Schroeder, 2002). Also, as with therapy in general (Lambert & Ogles, 2004), along with documented intervention success, some recidivism during or following the treatment of compulsive or addictive sexual and/or other disorders co-occurring with unwanted same-sex attractions may be expected (cf. Guidelines 7 and 12). However, the percentage of clients who believe they have benefitted is very similar to outcomes in other fields of psychotherapy (Santero et al., 2018), and statistical effect sizes are similar. Similarly, the low degree of alleged harm is comparable. Therapists should nevertheless judge carefully the ability of clients to withstand hostile attitudes from others regarding their pursuit of SAFE-T, and may need to recommend limited exposure to such environments. Activists opposed to SAFE-T clients' goals may aggressively interrogate them to a degree rarely seen in other therapy fields.

Critics of the clinical and scientific literature documenting successful SAFE-T outcomes—or the lack thereof—accurately point out the absence of truly randomized outcome studies. Another criticism of the literature is the lack of clear definition of the meaning of terms like "sexual orientation," "homosexuality," "heterosexuality," and "change." As noted previously, since the American Psychiatric Association's 1973 decision to no longer diagnose homosexuality as a mental disorder, there have been fewer reports of research on the development of and interventions for unwanted same-sex attractions and behavior. However, as Spitzer (2003) noted, a truly randomized study with controls is probably logistically impossible.

Such criticism does not negate that for over a century, clinical and scientific evidence has persistently demonstrated that fluidity of unwanted same-sex attractions and behaviors can be facilitated within a therapeutic setting and that clients who seek such exploration are not invariably harmed when doing so. A substantial number of persons who have sought SAFE-T from professionals representing various theoretical paradigms and psychotherapeutic approaches to address unwanted same-sex attractions have successfully pursued their goals of diminishing the frequency and strength of these attractions, reducing or eliminating same-sex behaviors, and enhancing their experience of opposite gender sexual attractions (Nicolosi et al., 2000; Phelan, 2014; Santero et al., 2018). Reduction in frequency may be about an order of magnitude overall (i.e., about 10 times less than original levels), but many achieve far greater reductions (Santero et al., 2018).

Lambert & Ogles (2004) observed that "helping others deal with depression, inadequacy, anxiety, and inner conflicts, as well as helping them form viable relationships and meaningful directions for their lives, can be greatly facilitated in a therapeutic relationship characterized by trust, warmth, understanding, acceptance, kindness and

human wisdom" (pp. 180–181). As with therapy for all presenting concerns, giving satisfactory informed consent when beginning to counsel persons who want to resolve unwanted same-sex attractions and behavior not only is ethical but also may be expected to facilitate the development of more effective, therapeutic relationships.

Guideline 6. ***Clinicians are encouraged to be aware of the legal environment in their state or local jurisdiction with respect to the presence of therapy bans and to seek competent legal counsel as appropriate under the circumstances.***

Since 2012 various state and municipal governments have enacted statues or promulgated ordinances or regulations aimed at prohibiting at least some clients from pursuing fluidity and change of unwanted same-sex attractions and behaviors within a psychotherapy setting (Dubrowski, 2015; "List of jurisdictions banning conversion therapy for minors," 2018; Rosik, 2017b; Sandley, 2014). Despite claims of egregious and widespread harms that are the purported motivation for such bans, there have been no formal actions against any licensed therapists by any regulatory authorities in these or other jurisdictions (Drescher et al., 2016). This suggests that the primary aim of these laws or regulations may be to intimidate clinicians who would assist a client in the client's personal goal to explore the potential fluidity of unwanted same-sex attraction and behaviors. Further, clinicians in these jurisdictions should be aware that these bans have handed a potential weapon to activists who are looking for disgruntled clients who are willing to make an example of their former therapists. Therefore, while excellence in practice should be the goal of all therapists who engage in SAFE-T, those in jurisdictions that have therapy bans may also need to obtain the assistance of competent local legal counsel to evaluate the effect and implications of any restrictions that have been enacted or promulgated.

The SAFE-T concept and approach offers an accurate description of therapies that allow for fluidity of unwanted same-sex attractions and behaviors. The practice of SAFE-T is, by definition, one that only utilizes contemporary mainstream therapeutic modalities in assisting clients who request assistance in identifying and resolving issues that might prevent a greater heterosexual adaptation (cf. Guideline 7). Clients with unwanted SSA often present with their own understandings about the origins of their same-sex attractions, and it is best to utilize the moral, religious, and psychological language of clients in initial discussions about their same-sex attractions and behaviors. SAFE-T needs to be client-centered, and clinicians must exercise care not to pressure clients toward adopting the etiological and moral perspective of either the therapist *or* the therapist's professional association (Benoit, 2005; Rosik & Popper, 2014).

Clients who believe, for example, that their history of childhood trauma or relational disruption may have contributed to their nonheterosexuality can be reassured there is research evidence consistent with their experience (Beard et al. 2013; Bickham et al. 2007; O'Keefe et al. 2014; Roberts, Glymour, & Koenen, 2013; Wells, McGee, & Beautrais, 2011; Wilson & Widom, 2009). They can also be informed that fluidity of sexual attractions and

behaviors is common rather than atypical, especially for women but also for men (Diamond, 2008a, 2016; Dickson, Paul, & Herbison, 2003; Dickson, van Roode, Cameron, Paul, 2010; Far, Diamond, & Boker, 2014; Hu, Xu, & Tornello, 2016; Katz-Wise, 2015; Katz-Wise & Hyde, 2015; Katz-Wise, Reisner, Hughto, & Keo-Meier, 2016; Moch & Eiback, 2012; Ott, Corliss, Wypij, Rosario, & Austin, 2011; Ott et al., 2013; Savin-Williams & Ream, 2007). Moreover, there is evidence that such fluidity is influenced by relational and environmental contexts that are commonly addressed in the therapeutic process (Manley, Diamond, & van Anders, 2015; Santero et al., 2018). It is no small irony that the APA and other professional organizations acknowledge that no single factor or set of factors is known to definitively determine same-sex attraction (APA, 2008a) while simultaneously maintaining that they are certain all of these factors are simply normal and positive (APA, 2009; Mustanski, Kuper, & Greene, 2014).

Clinicians engaged in SAFE-T recognize that therapist-initiated recommendations for superficial external alterations of the client's gender presentation and role behavior are unlikely to address deeper emotional, relational, and/or identity issues (Santero et al., 2018). SAFE-T is a process that recognizes addressing deeper issues may (or may not) affect a particular client's unwanted same-sex attractions. For example, sufficient resolution of underlying attachment wounds may promote client-initiated interest in such adjustments of gender presentation.

Another important aspect of SAFE-T practice is the clinician's regular acquisition of client feedback about their therapy experience. This review can be done in session and client perceptions should be documented in the progress notes, whether of satisfaction or dissatisfaction. Occasional use of more objective measures of client satisfaction and progress are also recommended (e.g., the OQ-45 survey; Lambert et al., 2004). Points of perceived dissatisfaction would need to be addressed and documented, including adjustments in the therapy process and goals or even referral to a different therapist if requested.

Clients with nonheterosexual identities who enter therapy may have done so for reasons unrelated to their sexual orientation and may have no interest in SAFE-T. Therapists therefore do not inject a discussion of SAFE-T or the fluidity of same-sex attraction and behaviors into their clinical work without an explicit client-initiated request and the undertaking of a fully informed consent process. Therapists are also encouraged to educate clients concerning their clinical approach to unwanted same-sex attractions and behaviors through both written consent forms and in-session discussions. A similar educative process may be utilized to address possible benefits and risks of SAFE-T as well as the range of potential outcomes with and without treatment (Rosik & Popper, 2014).

SAFE-T clinicians do not promise or guarantee, whether explicitly or implicitly, a change in sexual orientation or even shifts in unwanted same-sex attractions and behaviors. Therapists should exercise caution to make sure clients do not feel blamed if they do not experience their desired level and direction of sexual attraction fluidity. This is particularly important in religious settings where there may be implicit or

explicit expectations for change that may be unrealistic. Meichenbaum and Lilienfeld (2018) offer 19 signs of psychotherapy "hype" that are good reminders of ways therapists may undermine their credibility. Indicators of hype may include exaggeration of claims of treatment effectiveness, excessive appeal to authorities or "gurus," and claims that treatment "fits all people." For these reasons, a thorough and scientifically grounded discussion concerning the occurrence of fluidity and change combined with a regular review of the therapy process is very important.

In therapeutic practice, SAFE-T clinicians are encouraged not to specifically target same-sex attractions or sexual orientation generally as a focus of treatment. In fact, large majorities of male clients who pursue SAFE-T reported their pursuit of fluidity and change was most benefited by developing non-erotic relationships with same-sex peers, understanding emotional needs and issues, meditation and spiritual work, and learning to maintain appropriate boundaries (Santero et al., 2018).

Guideline 7. ***Clinicians are encouraged to utilize accepted psychological approaches to psychotherapeutic interventions that minimize the risk of harm when serving clients with unwanted same-sex attractions.***

Every counselor uses psychotherapeutic approaches which may be reasonably expected to offer clients help in dealing with their presenting problems (beneficence) and to avoid or minimize potential harm (nonmaleficence). Professional clinicians who utilize SAFE-T in their work with clients to address unwanted same-sex attractions and behaviors are trained in one or more of the theoretical approaches and techniques practiced currently in the mental health professions. Clinicians use accepted psychological approaches to help clients deal with common co-presenting problems, including depression, anxiety, shame, unresolved distress originating from family of origin, sexual and emotional abuse, relationship difficulties, lack of assertiveness, and compulsive and addictive habits. Clinicians also seek supervision and additional training as dictated by their clients' needs and their own professional development (cf. Guideline 13).

It has been suggested by critics that one possible outcome of SAFE-T for unwanted same-sex attraction has been the development of a negative attitude towards homosexuality or gay and lesbian persons (e.g., Drescher et al., 2016; Haldeman, 1991, 1994). This caution about potential harm or criticism of reported harm must be understood in the context of any therapeutic process. Such intervention often leads a client to become more aware of depression, anxiety, and other emotions leftover from the recent or distant past. In the short-term, as clients are helped to practice sexual or other (e.g., substance use) sobriety, they may experience an increase in their "feeling" of depression, anxiety, etc.

An increase in unpleasant feelings may not be an indication of "harm," but an opportunity to deal with feelings formerly numbed by mood-altering behaviors (e.g., sexual gratification), relationships (e.g., codependency), substances (e.g., alcohol or drugs), or other paraphernalia (e.g., pornography). Clients who terminate any therapy

before underlying emotional issues or compulsive behavior patterns are effectively resolved will undoubtedly feel worse than when they began therapy. Also, to the extent that persons with same-sex desires are engaged in sexual compulsions or experience other psychological or relational difficulties, a high recidivism rate, such as is found when treating substance abuse and other habits, may not be unrealistic.

In general, SAFE-T for unwanted same-sex attractions and behavior has been shown to be helpful for a number of clients and has not been shown to be invariably harmful (Santero et al., 2018). Authors who clearly oppose such intervention and who caution that it sometimes is, can, or may be harmful, nonetheless recognize that it is not always so (Haldeman, 2001; Schroeder & Shildo, 2002; Shildo & Schroeder, 2002). Even when disappointed with not changing their same-sex thoughts, feelings, fantasies, and/or behaviors as much as they had hoped, clients have reported satisfaction with the changes they did achieve and that the counseling process was at least somewhat helpful (e.g., Nicolosi et al., 2000; Santero et al., 2018; Shildo & Schroeder, 2002; Spitzer, 2003). While a client's dissatisfaction is a possible and unfortunate consequence of any therapy, such dissatisfaction is not inherently "harmful" and may be minimized by the responsible practice of timely and accurately informed consent (cf. Guideline 5). Such practices would include a discussion that fluidity and change in unwanted same-sex attractions, thoughts, and behavior during therapy occur on a continuum. Some clients seem to experience profound fluidity and change, other's a moderate amount, and still others little or none (ATCSI, 2012).

Regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences appear to be unavoidable for a small percentage of clients. As Lambert (2013) writes, while psychotherapy has proven to be highly effective "for many clients," "psychotherapy can and does harm a portion of those (adults and children) it is intended to help" (p. 192). Clients who are especially more likely to "deteriorate while participating in treatment" (p. 192) commonly begin therapy with a severe "initial level of disturbance," e.g. borderline personality disorder (Lambert & Ogles, 2004, p. 177). "[C]lients with comorbid problems (also) are less likely to do well." Depending on the primary diagnosis, comorbidity for personality disorders, depression, substance abuse, and psychiatric diagnoses all have been shown to negatively impact treatment outcomes (Bohard & Wade, 2013, p. 227). In addition, clients whose clinicians may lack empathy, underestimate the severity of their problem, or who experience significant, negative countertransference may also be at greater risk for deterioration (Mohr, 1995).

Finally, in light of current research and professional ethics, some long outdated interventions for unwanted same-sex attractions and behavior are not recommended. These include shock therapy and other aversive techniques, so-called reparenting therapies, and coercive forms of religious prayer (including exorcisms). Overall, research to date has shown that clients participating in SAFE-T to address

unwanted same-sex attractions or behaviors are not invariably harmed by doing so (APA, 2009; Pela et al., 2018; Santero et al., 2018). Any negative consequences attributed to engaging in SAFE-T have not been shown to outweigh the benefits claimed by those who have found such exploration helpful. Unfortunately, most mental health associations like the APA, both in the United States and in Europe, unfairly warn the general public that clients who pursue fluidity and change in their unwanted same-sex attractions and behaviors through professional therapy have the potential to be harmed. This happens even though the mental health associations themselves admit that historical and recent research does not support their warning (APA, 2009; Sutton, 2014).

Guideline 8. ***Clinicians are encouraged to be knowledgeable about the psychological and behavioral conditions which often accompany same-sex attractions and offer relevant treatment services to help clients manage these issues.***

In the psychological care of clients with unwanted same-sex attractions and behavior, it is strongly encouraged that clinicians fully assess each with a detailed history and examination, paying particular attention to the potential presence of associated psychopathological conditions. While often limited by restricted samples, lack of controls, and/or indeterminate causal pathways, studies of mental health morbidity among adults reporting same-sex partners consistently suggest that lesbians, gay men, and bisexual individuals may experience excess risk for some mental disorders by comparison with heterosexual individuals (Cochran & Mays, 2009; King et al., 2008; Semlyen, King, Varney & Hagger-Johnson, 2016). Cochran, Sullivan, and Mays (2003) indicate that gay-bisexual men showed higher prevalence of depression, panic attacks, and psychological distress than heterosexual men; lesbian-bisexual women showed greater prevalence of generalized anxiety disorder than heterosexual women in the same study. Other comparisons may be found in Whitehead (2010). Quantitative estimates of length of relationship (Whitehead, 2015/16) suggest a mean length of 4.7 (±2) years, which itself leads to depression that is also associated with frequent short heterosexual relationships (Davila et al., 2009). In addition, several studies have suggested that bisexuals often have even worse health outcomes than gay and lesbian persons (Ross, Salway, Tarasoff, MacKay, Hawkins, & Fehr, 2018), although this conventional wisdom has been challenged of late (Savin-Williams & Cohen, 2018). This excessive risk of co-occurring psychopathology needs to be at the forefront of the clinician's mind when working with individuals with same-sex attractions, whether wanted or not.

A key issue in the area of health is the assessment of risk and its subsequent management. In mental health terms, this invariably involves a risk assessment for self-harm and suicide. Research has demonstrated evidence of a strong association between suicide risk and same-sex attractions and behavior (Arnarsson, Sveinbjornsdottir, Thorsteinsson, & Bjarnason, 2015; Eskin et al., 2005; Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016; King et al., 2008; Ploderl & Fartacek, 2005; Ploderl

& Tremblay, 2015; Remafedi, French, Story, Resnick, & Blum, 1998). Using data from the *National Comorbidity Survey*, Gilman, Cochran, Mays, Hughes, Ostrow, and Kessler (2001) found that people reporting same-sex partners have consistently greater odds of experiencing psychiatric and suicidal symptoms compared with their heterosexual peers. This finding has been consistent in studies of young people (Rimes, Shivakumar, Ussher, Baker, Rahman & West, 2018; Russell & Joyner, 2001) and adults (Remafedi et al., 1998) and has also been noted in Holland and Sweden, countries with a comparatively tolerant attitude to homosexuality. Dutch men with same-sex attractions and behaviors and Swedes in same-sex marriages are still at a much higher risk for suicidality than their heterosexual counterparts (Bjorkenstam, Andersson, Dalman, Cochran, & Kosidou, 2016; de Graaf, Sandfort, & ten Have, 2006; Sandfort, de Graaf, Bijl, & Schnabel, 2001).

Often sex addiction co-occurs with same-sex behavior (Bothe et al., 2018; Dodge, Reece, Herbenick, Fisher, Satinsky, & Stupiansky, 2008; Guigliamo, 2006; Kelly, Bimbi, Nanin, Izienicki, & Parsons, 2009; Parsons, Kelly, Bimbi, DiMaria, Wainberg, & Morgenstern, 2008; Quadland & Shattls, 1987), and it has been defined as follows: "Contrary to enjoying sex as a self-affirming source of physical pleasure, the addict has learned to rely on sex for comfort from pain, for nurturing or relief from stress" (Carnes, 1992, p. 34). This often has roots in childhood and adolescence with up to 60% of people who present with sex addiction having been sexually abused before reaching adulthood (Griffin-Shelley, 1997). Individuals reporting same-sex attractions and behavior also appear to have a higher prevalence of sexual abuse, particularly among women (e.g., Bebbington et al., 2009; Doll, Joy, Bartholow, & Harrison, 1992; Eskin et al., 2005; Friedman et al., 2011; Mustanski, Kuper, & Greene, 2014; Paul, Catania, Pollack, & Stall, 2001; Tomeo et al., 2001; Wilson & Widom, 2010; Xu & Zheng, 2015). It is therefore imperative that clinicians take a full and detailed history from each client. Since clients with same-sex attractions commonly report other addictive behaviors, a thorough history should include assessment of other common addictive behaviors such as pathological gambling (Granta & Potenzab, 2006) and substance misuse (Branstrom & Pachankis, 2018; Goldbach, Fisher, & Dunlap, 2015; Ploderl & Tremblay, 2015; Roth et al., 2018; Ueno, 2010), both for prescribed, illicit and over-the-counter medicines, in addition to sex addiction.

When clinicians have completed a full assessment which screens for active psychopathology, they must also take care not to practice in a clinical area where they are not competent (APA, 2017, Ethical Standard 2). If active psychopathology is detected, then where clinically necessary it should be addressed through multidisciplinary consultation or by referral to an appropriate service (cf. Guideline 12).

Guideline 9. ***Clinicians strive to understand the difficult pressures (e.g., culture, religious community) which clients with unwanted same-sex attractions confront.***

The societal pressures that surround clients who present with unwanted same-sex attractions cannot be

understated. Clinical intervention will benefit from a careful appraisal of the multiple contexts from which these clients come and the normative attitudes toward homosexuality found in each milieu. The cultural context of these clients includes their ethnic heritage, and differences in perspectives on homosexuality by ethnic background must be considered. For example, clients coming from African-American or Hispanic backgrounds often live in communities that have traditional and more uniformly negative views of homosexuality (Greene, 1998; Herek & Gonzalez-Rivera, 2006; Martinez & Sullivan, 1998; Schulte & Battle, 2004; Vincent, Peterson, & Parrott, 2009).

Another critical dimension is the religious background of these clients, since many who seek interventions for unwanted same-sex attractions and behavior often come from conservative faith communities (Haldeman, 2002, 2004; Nicolosi et al., 2000; Rosik, 2003a; Schulte & Battle, 2004; Santero et al., 2018; Spitzer, 2003). Most of these individuals will have previously adopted a value framework from their religious background which views homosexual behavior as immoral. Some religiously conservative clients will have grown up hearing theologically based condemnatory remarks about homosexuality from some religious authorities whom may—or may appear to—lack compassion for their struggle, or even assert they have deliberately chosen their attractions and/or are totally irredeemable.

A third environment worthy of careful evaluation is the family context of clients (Yarhouse, 1998b). The attitude of parents and heterosexual spouses toward clients' same-sex attractions is perhaps the most immediate factor that can exert influence on the mindset of those seeking change. Clients may receive a variety of messages from family members, ranging from gay affirmation to loving disapproval to outright rejection and distancing (Freedman, 2008; Pachankis, Sullivan, & Mora, 2018; Ryan, Huebner, Diaz, & Sanchez, 2009). The extent to which clients have disclosed their unwanted same-sex attractions to family members will also affect clients' clarity concerning how their loved ones might respond. The effects of ethnicity and religious identity certainly can overlap with family considerations and may intensify a sense of reluctance to acknowledge, explore, and seek therapy for unwanted same-sex attractions. Clients' proximity to these contexts should also be considered, as clients coming immediately from non-affirming backgrounds may not have been as reflective about their decision to pursue change as clients who report having once lived a gay identity but now wish to dis-identify with it.

The early assessment of these contexts is important in evaluating clients' preparedness to enter into SAFE-T. The more clients come from ethnic, religious, and family backgrounds which are non-affirming of homosexuality, the greater the burden is upon clinicians to ensure that clients are acting in a reasonably self-determined manner as they seek intervention. This important precaution is not to assert, as some have done (Davison, 2001; Drescher et al., 2016; Murphy, 1992), that clients from these backgrounds can never autonomously enter into SAFE-T with the goal of modifying unwanted same-sex attractions and behaviors. In fact, Santero and colleagues (2018) found societal pressures were quite

minor. However, while individuals do make rational and free choices to identify with the moral values and behavioral codes of conduct for sexual expression inherent in homosexually non-affirming contexts (Yarhouse & Burkett, 2002), it cannot be assumed that this is always the case. Exploring with clients the attitudes and beliefs toward same-sex attractions and behavior that dominate their particular cultural and family situation is therefore essential in evaluating the extent to which they have genuinely taken ownership of their decision to explore the degree to which their attractions may be subject to fluidity and change.

Guideline 10: ***Clinicians are encouraged to acknowledge and accommodate the unique experiences of women who experience SSA***.

Most of what has most recently been written about women's same-sex attraction experiences are conclusions drawn from research with self-selected, openly identified lesbian and bisexual women (Diamond, 2003, 2017). Despite these limitations, there are some conclusions that can be drawn from the research, particularly in contrasting the experiences of men and women with SSA. Men and women experience different neurobiological, cultural, and political influences on their sexual development (Savin-Williams & Diamond, 2000; Diamond, 2003a, 2017). These differences result in contrasts between men and women in their accounts of the development of SSA (Diamond, 2003a) and the differences in the exploration and experience of sexual attraction fluidity.

Women's romantic attractions start with emotional and relational intimacy more consistently than men (Diamond, 2003a; Diamond, 2003b; Diamond, 2008a; Savin-Williams & Diamond, 2000). While men may also experience increased sexual attraction as the result of emotional intimacy, women's same-sex attraction experiences almost always move from emotional bonding to sexual attraction, and are sometimes followed by sexual behavior (Diamond, 2000). Although women may have an earlier awareness of attractions and admirations for other women, they tend to "come out" only after they become sexually involved with another woman (Diamond, 2008a). Also, in contrast to men, women's first same-sex attraction experiences are virtually never with a stranger, while men report that 25% of the time their first same-sex sexual experience is with a stranger (Diamond, 2000). These findings about the differences between SSA men and women parallel the differences between men and women's sexuality, in general.

Women have a larger range of sexual attraction fluidity potential (Diamond, 2016; Katz-Wise & Hyde, 2015; Savin-Williams & Diamond, 2000). Most women who experience SSA also experience OSA (Diamond, 2017). Diamond (2003b) found that 2/3 of lesbian-identified women have had male partners within the last 5 years. Additionally, she reports that 27% of the lesbian-identified women in her study had dis-identified as lesbians. Some women who reject a lesbian identity choose to live heterosexually, while others have simply chosen to reject an erotic-attraction identity altogether (Savin-Williams & Diamond, 2000). Such dis-identification should not be presumed to be an indication of shame or incomplete psychosocial development, particularly for

conservatively religious women (Hallman, Yarhouse, & Suarez, 2018; see Guideline 3). Sexual attraction identities limit and distort the complexities of sexuality and may result in a forced identity that is rejected during developmental maturity. Many more mature women see themselves and their sexuality as more complex than the current cultural narrative of an essential, immutable identity based on erotic attractions.

Historical clinical accounts of women experiencing distress related to their SSA are grounded in a Classical Psychoanalytic understanding of the development of women's sexuality. This view frames the development of SSA in women in terms of unresolved penis envy or, more moderately, as maternal attachment issues (Siegel, 2015). However, these limited conclusions regarding the etiology of SSA in women have proved to be inadequate as reflected in recent research that has found the development of same-sex attraction to vary widely from woman to woman (Diamond, 2017). Consequently, SAFE-T clinicians addressing the distress of women with unwanted SSA are encouraged to recognize that clinical intervention will require a more individualized and informed client-centered approach.

Guideline 11. ***Clinicians are encouraged to recognize the special difficulties and risks which exist for youth who experience same-sex attractions.***

Research suggests that first attraction to the same or opposite sex has occurred by age 10 for 50% of the population (Hamer, Hu, Magnuson, Hu, & Patterson, 1993; Whitam & Mathy, 1986), but there is an unusually wide range, and some are still essentially asexual until their late teens in spite of the highly sexualized cultural climate in the West. Adolescents still have developing neurology (Sisk & Zehr, 2005), including brain development, and lack mature judgment, although they are at or near their physical peak in late teenage years. This period is occupied by finding what mature possibilities may exist for them and evolving an identity by experimenting with a wide range of experiences. Sexual initiation is usually during this time (Floyd & Bakeman, 2006).

For adolescents, the simple mature, accurate estimate of risk is often not perceived to be real. They tend to underestimate familiar risks and overestimate the possibility of remote risk. The risk of HIV is clearly underestimated by mature people, but adolescents' estimation of risk is less realistic still, although their risks are not much less than those of adults (Lock & Steiner, 1999). Unfortunately, teenagers may be reluctant to listen to input about this. In view of the above, responsible clinicians will offer more directive guidance to youth than to more mature clients, particularly when estimates of risk are unrealistic. This may involve more mentoring than for a mature client or referral to those who can mentor.

Statistical surveys show there is considerable sexual experimentation of types which are mostly not followed up in adulthood and are therefore far from definitive (Laumann et al., 1994). Change of various types continues to take place even as adults (Diamond, 2016; Diamond, Dickenson & Blair, 2017; Katz-Wise & Hyde, 2015; Katz-Wise et al., 2016; Kinnish et al., 2005). Clinicians should be aware that

adolescents may prematurely decide they have a particular sexual orientation and hence should be warned against hasty conclusions. A very significant proportion of young women are most comfortable with the "unlabelled" sexual orientation category (Diamond, 2008b). Conversely, they might be told that with strong motivation, experiencing fluidity and change may be easier than as an adult.

Annually, about 42% of youth are exposed, willingly or unwillingly, to Internet pornography. Hence, over a few years this exposure is almost universal (Wolok, Ybarra, Mitchell, & Finkelhor, 2007), so its effects should be monitored. Quite unrealistic ideals may be absorbed by these youths. Alternatively, compulsive or addictive use of gay pornography may lead a young person to assume that he is gay when he is merely compelled or addicted to sexual gratification.

Surveys show that some adolescents reach a conclusion about their sexuality, are distraught about what they perceive be the consequences, and are at highest risk of suicide immediately before disclosure to anyone (Paul, Catania, Pollock, Moskowitz et al., 2002; Wang, Ploderl, Hausermann, & Weiss, 2015). Therapists should be particularly aware of the fragility of such clients, who tend to be those without social support. Suicide risk among youth with same-sex attractions decreases 20% each year self-labeling as gay is delayed (Remafedi, Farrow, & Deisher, 1991). Although causal links are not clear, it is prudent to encourage the deferring of self-labelling (Rimes et al., 2018). Clinicians should also consider carefully whether disclosure of the client's struggle to unaware family and friends is in the client's best interests (Rosario, Schrimshaw, & Hunter, 2009; Ryan et al., 2009; Wang et al., 2015; cf. Guideline 9). Many who disclose their homosexuality to unsympathetic family join the ranks of the homeless and are further at risk for drug use, prostitution, and violence (Tyler, Whitbeck, Hoyt, & Cauce, 2004). The reactions of peers at this age can be brutal (brutality tends to peak in the adolescent years) probably because they have less empathy than younger or older groups. There is still intense pressure from peers to conform to stereotypical gender roles.

The male client (but not so much the female client) will probably report rejection and discrimination as central elements of intervention by others (Friedman et al., 2011; Hershberger & D'Augelli, 1995). Fathers can be a primary and potent focus of reported rejection, particularly among men (Pachankis et al., 2018). Therapists should be aware that this experienced rejection may be more perceived than actual but, nonetheless, have real effects for clients (Burgess, Lee, Tran, & van Ryn, 2007). The literature suggests emotional and avoidance coping styles may account for perceived rejection, perhaps more than objective circumstances in some cases (Burgess et al., 2007; Gold, Feinstein, Skidmore, & Marx, 2011; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2009). Thus, an individual's coping style may need examination by therapists. Co-occurrence of standard DSM conditions is much higher for such clients than in others and should be assessed (Fergusson, Horwood, & Beautrais, 1999). Among conditions which should be checked are substance abuse (Branstrom & Pachankis, 2018; Ploderl & Tremblay, 2015; Ross et al., 2018; Sandfort et al., 2001; Trocki, Drabble, &

Midanik, 2009; Ueno, 2010), antisocial behavior (Fergusson et al., 1999), depression (Cochran et al., 2003; Gonzales & Henning-Smith, 2017; Ploderl & Tremblay, 2015; Ross et al., 2018), impulsivity (Puckett, Newcomb, Garofalo, & Mustanski, 2017), compulsivity (Dodge et al., 2008), and borderline personality disorder (Marantz & Coates, 1991; Sandfort et al., 2001).

Education

Guideline 12. ***Clinicians make reasonable efforts to familiarize themselves with relevant medical, mental health, spiritual, and religiously oriented resources that can support clients in their pursuit of attraction fluidity and change.***

Unwanted same-sex attractions and behaviors often co-occur with formally diagnosable or otherwise evident medical, psychological, behavioral, and relational difficulties (cf. Guideline 8). Therefore, clinicians make reasonable efforts to familiarize themselves with relevant medical, psychological, behavioral, and relational approaches to healthcare. Clinicians keep their knowledge current about health psychology and related issues of behavioral health. They refer clients to specialists when the care of co-occurring influences is outside of their scope of practice. These include general health habits (e.g., diet, exercise, relaxation, sleep, etc.), relevant psychotropic medications and their interactive effectiveness with psychotherapy (Forand, DeRubeis, & Amsterda, 2013; Preston & Johnson, 2018), ways to enhance compliance with medical directives, and the timeliness of partial and inpatient hospitalization (Creer, Holroyd, Glasgow, & Smith, 2004; Thase & Jindal, 2004).

At times, addressing clients' co-occurring medical or psychiatric difficulties may have greater priority than serving their intentions to address unwanted same-sex attractions or behaviors. Psychological care may become an important support to enable clients to comply with other medical directives. At other times, treating medical or psychiatric difficulties may enable clients to engage in psychological and spiritual interventions more effectively. Additional adjunctive interventions may include referring for psychoeducation (e.g., individual or group substance abuse counseling) and to couple, family, and group therapy, as well as peer-support groups, when clients need and are able to benefit from therapeutic relational and group interaction. Referrals also may be expedient for helping clients deal with co-occurring sexual, substance abuse, eating disorders, or other compulsive or addictive behaviors (Forand et al., 2013; Lambert & Ogles, 2004).

When helping parents respond to concerns about children with gender confusion, incongruence and distress, including gender dysphoria or unwanted same-sex attractions, the practice of—or referral for—parent education and family therapy especially may be indicated (Lundy & Rekers, 1995; Rekers, 1988, 1995; Zucker & Bradley, 1995). Therefore, clinicians are prepared to make referrals to other healthcare professionals to obtain primary, sequential, alternative, combined, or adjunct medical or mental health assistance in a timely way.

In addition, clinicians serving clients who seek to address unwanted same-sex attractions and behaviors also prepare

themselves to offer their clients directly or to refer them for pastoral care. Such clients often have religious or spiritual beliefs, practices and social interactions which offer motivation and support for their desired changes (cf. Practice Guidelines 3 and 4). Therefore, clinicians make reasonable efforts to assess their clients' religious beliefs, moral values, and spiritual practices to support clients' utilization of appropriate spiritual and religiously oriented resources to achieve intended changes (Collins, 2006; Richards & Bergin, 2000; Wilson, 1988[5]).

Clinicians wisely recognize that, in general, religion can be beneficial to psychological and interpersonal health, more "intrinsic" ways of being religious appear to be healthier, and clients who are more religiously devout tend to "prefer and trust clinicians with similar beliefs and values" (Gregory et al., 2008; Richards & Bergin, 2005, p. 307). Also, the use of spiritual or religious-inspired aides such as prayer (Wright, 1986), meditation (Benson, 2015; Benson & Stark, 1997; Proctor & Benson, 2011), forgiveness (Enright, 2012; Enright & Fitzgibbons, 2014), and twelve step groups based on spiritual principles (Burlingame, Strauss, & Anthony, 2013; Friends in Recovery, 2009; Hemfelt, Minirth, Fowler, & Meier, 1991; Marich, 2012) have been shown to be therapeutically effective as part of or as an adjunct to clinical intervention (Richards & Bergin, 2004, 2005).

Studies of clients with unwanted same-sex attractions and behavior who have used spiritual aides, religious activities, and pastoral counseling, whether as adjuncts to psychotherapy or apart from therapy, often report positive results (Jones & Yarhouse, 2007, 2009, 2011). Even when clients did not change as they had intended, research designed to elicit reports of intervention failure, harm, or dissatisfaction from religiously mediated efforts to change nevertheless yielded a few participants who asserted that the process was helpful (Shildo & Schroeder, 2002). Research designed to elicit reports of intervention success or satisfaction with their participation yielded substantially more favorable reports (Nicolosi et al., 2000, 2008; Santero et al., 2018; Spitzer, 2003). The more rigorous the research design, the more clearly results have shown that spiritual/religious/pastoral counseling approaches by themselves have been able to reduce or eliminate unwanted same-sex attractions and behaviors for some individuals (Jones & Yarhouse, 2007, 2011; Yarhouse, Burkett, & Kreeft, 2002). Clients tend to try a wide variety of methods and find almost all helpful (Santero et al., 2018).

Guideline 13. ***Clinicians are encouraged to increase their knowledge and understanding of the literature relevant to clients who request SAFE-T, and seek continuing education, training, supervision, and consultation to improve their clinical work in this area.***

The literature on homosexuality is at first sight an academic field like any other, even though it might be thought slightly more active than many as a few new references accumulate almost every day. However, this is deceptive. Same-sex attraction is not an isolated clinical entity. A very wide range of conditions are co-occurrent with it, and it is necessary for clinicians to have a reasonable knowledge of these conditions, or at least be able to recognize them readily and refer clients

on as necessary (cf. Guideline 8). This greatly increases the responsibility of clinicians to become and keep current with the literature.

Research has generally shown that persons reporting same-sex attractions and behavior (mainly the male representatives) have much greater prevalence of pathology than the general population. The consistency of these findings counterbalances to some degree the methodological limitations. Prevalence disparities have been reported or can be inferred in several areas: depression (Ross et al., 2018), suicidal risk-taking in unprotected sex (van Kesteren, Hospers, & Kok, 2007), violence (Coxell, King, Mezey, & Gordon, 1999; Friedman et al., 2011; Owen & Burke, 2004), antisocial behavior (Fergusson et al., 1999), substance abuse (Branstrom & Pachankis, 2018; Pakula, B., Shoveller, J., Ratner, P. A., & Carpino, R., 2016; Rhodes, McCoy, Wilkin, & Wolfson), injury (Batejan, Jarvi, & Swenson, 2015), rumination (Timmins, Rimes, & Rahman, 2017; Wang & Borders, 2017), suicidality (de Graaf et al., 2006; Hottes et al., 2016; King et al., 2008; Peter et al., 2017; Ploderl & Tremblay, 2915; Rimes et al., 2018), more sexual partners (Laumann et al., 1994; Mark, Garcia, & Fisher, 2015; Mercer et al., 2009; Parsons, Starks, Gamarel, & Grov, 2012; Pawlicki & Larson, 2011; Rhodes et al., 2009), paraphilias (fisting) (Crosby & Mettey, 2004), being paid for sex (Schrimshaw, Rosario, Meyer-Bahlburg, Scharf-Matlick, Langstrom, & Hanson, 2006), sexual addiction and hypersexuality (Bothe et al., 2018; Dodge et al., 2004; Parsons et al., 2008; Satinsky et al., 2007), personality disorders (Zubenko, George, Soloff, & Schulz, 1987), and psychopathology (Gonzales & Henning-Smith, 2017; Sandfort et al., 2001). It is difficult to find a group of comparable size in society with such intense and variable co-occurring pathology.

As a rule of thumb, many of these characteristics have prevalence rates about three times those reported in the general population, sometimes much more. A check of any medical database shows that articles dealing with conditions which co-occur with homosexuality are far more frequent than those restricted to homosexuality alone. The former may outnumber the latter by nearly ten times. This means it is not enough to read about homosexuality alone, but the much greater number of co-associated articles must also be read. Thus, the other fields add to understanding significantly. In addition, the references to HIV are extensive, and it is quite possible this condition will co-occur. Even if HIV infection is under control, the prevalence of various cancers in AIDS patients is about 20 times greater than in the general population (Galceran et al., 2007). A clinician may well encounter clients with such medical needs and discover therapeutic issues which must be addressed.

SAFE-T for unwanted same-sex attractions and behavior is controversial in a manner that is seldom experienced today for other types of presenting concerns. As a result, there is a potentially increased risk for the clinician of unanticipated legal consequences (Hermann & Herlihy, 2006; Rosik, 2017b; cf. Guideline 6), a greater potential complexity of therapy, and therefore a greater need than average to stay current in the field and be aware of the latest implications of research and good practice. Clearly, it may be

necessary to understand the consequences on the client's psyche of having one of the associated medical conditions, or one of the common political attitudes, such as strong rejections of society's attitude toward homosexuality.

This need is also greater because the therapeutic modalities though which SAFE-T is provided are numerous and there is no consensus on the best approach. This again means an unusual need to be aware of other intervention strategies and theoretical approaches, as well as a willingness to adopt useful insights and previously successful techniques (cf. Guideline 7). Alongside this, the varieties of experience in clients are significantly diverse (e.g. Otis & Skinner, 2004; Santero et al., 2018). This readily demands a greater versatility of response from the clinician and more reading of the clinical and research literature than usual.

Much of the literature pertaining to homosexuality is at risk of being irrelevant because it is associated with the political and advocacy aspects of the topic. The remainder of the relevant literature involves many widespread fields, including genetics, physiology, sociology, urban anthropology, and of course psychotherapy. Thus, clinicians must strive to locate relevant material in unusually diverse fields. This material is also often unusually attention-grabbing for the media, and clients are more likely than usual to read it and require comment. Their clinicians should be prepared. It is probably worthwhile that clinicians use a service on the Internet to alert them when relevant material is published (e.g., PubMed).

Focused events such as seminars, conferences, etc. are more important than usual because SAFE-T approaches for unwanted same-sex attractions and behavior are not as widely known and practiced as counseling for other conditions, which increases the need for collegial consultation. It is assumed in all the above that clinicians attempt to keep current in the psychological disciplines in general, with the usual accompanying need for continuing education.

Applications and Conclusion

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

Second, these guidelines inform consumers who currently are receiving or considering the pursuit of SAFE-T for their unwanted same-sex attractions and behaviors. The guidelines provide a broad evaluative framework which these clients can utilize to help determine if the clinical services they receive are being provided in a sufficiently professional and ethical manner. Consumers of SAFE-T may find value in

discussing these guidelines with their clinicians. Discussing them early in treatment as part of the informed consent process may facilitate planned short-term and long-range goals for the psychological care they are going to receive.

The social scientific and medical information made available through these guidelines may also benefit consumers as they weigh the benefits and risks of SAFE-T in comparison to therapeutic approaches that endorse the embracing of a gay or lesbian identity. In this way, these guidelines can contribute to a more fully informed and autonomous decision-making process by clients regarding what clinical approach—if any—they may choose for responding to their unwanted same-sex attractions and behavior (Rosik & Popper, 2014). Periodically and at the end of a course of treatment, clinicians may also use these guidelines to assess the therapeutic progress that has been achieved by clients and to review and renegotiate any remaining goals. As is true for all approaches to psychological care for any presenting problem, an initial and ongoing clarity of purpose and goals shared by clients exploring fluidity and their clinicians enables the therapeutic alliance to be more cooperative and effective.

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

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

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Endnotes

[1]The original guidelines were adopted by the Board of Directors of the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) on October 25, 2008. This updated version was adopted by the ATCSI Board on June 22, 2018, and replaces the earlier guidelines document.

[2]These revised guidelines were developed by the Alliance Practice Guidelines Task Force (PGTF). The PGTF chair was Christopher H. Rosik, Ph.D. (Link Care Center & Fresno Pacific University). The PGTF members included Shirley Cox, DSW (Brigham Young University); Carolyn Pela, Ph.D., LMFT (Arizona Christian University & Fuller Theological Seminary); Paul Popper, Ph.D. (independent practice, San Francisco, CA); Phil Sutton, Ph.D. (independent practice, South Bend, IN); and Neil Whitehead, Ph.D. (research scientists, Lower Hutt, New Zealand). Others who contributed to the development of these guidelines were Julie Hamilton, PhD, LMFT (independent practice, West Palm Beach, FL); Geoff Heath, J.D. (U.S. Department of the Interior, Washington, D.C. (Retired)); Joseph Nicolosi, Jr. (The Breakthrough Clinic, Westlake Village, CA); David Pruden, MA (Utah State University); and Robert Vazzo, LMFT (independent practice, Culver City, CA, and Las Vegas, NV).

Requests for copies of these guidelines should be addressed to the Alliance for Therapeutic Choice and Scientific Integrity, 307 West 200 South, Suite 3001, Salt Lake City, UT 84101, or can be ordered by phone at 1-888-364-4744, or online at http://therapeuticchoice.com.

[3]SAFE-T can be defined as the client-centered exploration of sexual attraction fluidity among clients reporting unwanted same-sex attractions utilizing established psychotherapeutic modalities.

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

[5]Wilson's (1988) book is one of 28 volumes in the *Resources for Christian Counseling* series, which is edited by Gary R. Collins. The series' authors address how Christian psychotherapists and professional counselors may serve Christian clients who are dealing with a variety of issues, including self-esteem, depression, anxiety, anger, marriage and family difficulties, special needs of children, family violence and abuse, eating disorders, substance abuse and addiction, and ACOA issues. The notable, last book in this series is authored by the series' editor (Collin, 1988).

American Academy of Pediatrics and trans- kids: Fact-checking Rafferty (2018)

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The American Academy of Pediatrics (AAP) recently published a policy statement entitled, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Rafferty, 2018). It was quite a remarkable document: Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping GD children, the AAP statement rejected that consensus, endorsing only *gender affirmation.* With AAP taking such a dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. (Extraordinary claims require extraordinary evidence, and all that.) As I read the works on which they based their policy however, I was pretty surprised…rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*.

The AAP statement was also remarkable in what it left out—namely, the outcomes research on GD children. There have been eleven follow-up studies of GD children, of which AAP cited one [Wallien & Cohen Kettenis (2008)], doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis to be considered in the aggregate—It was merely disappeared. (I have presented the complete list of the outcome studies on this blog before; they appear again at the bottom of this page together with their results, for reference.) As they make clear, *every* follow-up study of GD children, without exception, found the same thing: By puberty, the majority of GD children ceased to want to transition. AAP is, of course, free to establish whatever policy it likes on whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false, as detailed below.

AAP divided clinical approaches into three types—conversion therapy, watchful waiting, and gender affirmation. It rejected the first two and endorsed *gender affirmation* as the only acceptable alternative. Most readers will likely be familiar already with attempts to use conversion therapy to change sexual orientation. With regard to gender identity, AAP wrote:

> "[C]onversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions….Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29, 39–42]

AAP's citations were:

38. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. J Consult Clin Psychol. 1994;62(2):221–227
29. Adelson SL; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. J Am Acad Child Adolesc Psychiatry. 2012;51(9):957–974
39. Byne W. Regulations restrict practice of conversion therapy. LGBT Health. 2016;3(2):97–99
40. Cohen-Kettenis PT, Delemarrevan de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. J Sex Med. 2008;5(8):1892–1897
41. Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. Sex Res Soc Policy. 2006;3(3):23–39
42. World Professional Association for Transgender Health. WPATH De-Psychopathologisation Statement. Minneapolis, MN: World Professional Association for Transgender Health; 2010. Available at: https://www.wpath.org/policies. Accessed April 16, 2017

These claims struck me as odd because *there are no studies of conversion therapy for gender identity.* Studies of conversion therapy have been limited to *sexual orientation*—specifically, the sexual orientation *of adults*—not *gender identity,* and not *children* in any case. The article AAP cited to support their claim (reference number 38) is indeed a classic and well-known review, but it is a review of *sexual orientation* research only. Neither gender identity, nor even children, received even a single mention in it. Indeed, the narrower scope of that article should be clear to anyone reading even just its title: "The practice and ethics of *sexual orientation* conversion therapy" (Haldeman, 1944, p. 221, italics added).

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AAP continued, saying that conversion approaches for GD children have already been rejected by medical consensus, citing five sources. This claim struck me just as odd, however—I recalled associations banning conversion therapy for sexual orientation, but not for gender identity, exactly because there is no evidence for generalizing from adult sexual orientation to childhood gender identity. So, I started checking AAP's citations for that, and these sources too pertained only to sexual orientation, not gender identity (specifics below). What AAP's sources *did* repeatedly emphasize was that:

(1) Sexual orientation of adults is unaffected by conversion therapy and any other [known] intervention;

(2) Gender dysphoria in childhood before puberty desists in the majority of cases, becoming (cis-gendered) homosexuality in adulthood, again regardless of any [known] intervention; and

(3) Gender dysphoria in childhood persisting after puberty tends to persist entirely.

That is, in the context of GD children, it simply makes no sense to refer to externally induced "conversion": The majority of children "convert" to cisgender or "desist" from transgender *regardless* of any attempt to change them. "Conversion" only makes sense with regard to adult sexual orientation because (unlike childhood gender identity), adult homosexuality never or nearly never spontaneously changes to heterosexuality. Although gender identity and sexual orientation may often be analogous and discussed together with regard to social or political values and to civil rights, they are nonetheless distinct—with distinct origins, needs, and responses to medical and mental health care choices. Although AAP emphasized to the reader that "gender identity is not synonymous with 'sexual orientation'" (Rafferty, 2018, p. 3), they went ahead to treat them as such nonetheless.

To return to checking AAP's fidelity to its sources: Reference 29 was a practice guideline from the Committee on Quality Issues of the American Academy of Child and Adolescent Psychiatry (AACAP). Despite AAP applying this source to *gender identity,* AACAP was quite unambiguous regarding their intent to speak to *sexual orientation* and only to *sexual orientation:* "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*. 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" (AACAP, 2012, p. 967, italics added).

Whereas AAP cites AACAP to support gender affirmation as the only alternative for treating GD children, AACAP's actual view was decidedly neutral, noting the lack of evidence: "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" (AACAP, 2012, p. 969). Moreover, whereas AAP rejected watchful waiting, what AACAP recommended was: "In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood" (AACAP, 2012, p. 969). So, not only did AAP attribute to AACAP something AACAP never said, but also AAP withheld from readers AACAP's actual view.

Next, in reference 39, Byne (2016) also addressed only sexual orientation, doing so very clearly: "Reparative therapy is a subset of conversion therapies based on the premise that *same-sex attraction* are reparations for childhood trauma. Thus, practitioners of reparative therapy believe that exploring, isolating, and repairing these childhood emotional wounds will often result in reducing *same-sex attractions*" (Byne, 2016, p. 97). Byne does not say this of gender identity, as the AAP statement misrepresents.

In AAP reference 40, Cohen-Kettenis et al. (2008) did finally pertain to gender identity; however, this article never mentions conversion therapy. (!) Rather, in this study, the authors presented that clinic's lowering of their minimum age for cross-sex hormone treatment from age 18 to 16, which they did on the basis of a series of studies showing the high rates of success with this age group. Although it did strike me as odd that AAP picked as support against conversion therapy an article that did not mention conversion therapy, I could imagine AAP cited the article as an example of what the "mainstream of traditional medical practice" consists of (the logic being that conversion therapy falls outside what an 'ideal' clinic like this one provides). However, what this clinic provides is the very *watchful waiting* approach that AAP rejected. The approach espoused by Cohen-Kettenis (and the other clinics mentioned in the source—Gent, Boston, Oslo, and now formerly, Toronto) is to make puberty-halting interventions available at age 12 because: "[P]ubertal suppression may give adolescents, together with the attending health professional, more time to explore their gender identity, without the distress of the developing secondary sex characteristics. The precision of the diagnosis may thus be improved" (Cohen-Kettenis et al., 2008, p. 1894).

Reference 41 presented a very interesting history spanning the 1960s–1990s about how feminine boys and tomboyish girls came to be recognized as mostly pre-homosexual, and how that status came to be entered into the DSM at the same time as homosexuality was being *removed* from the DSM. Conversion therapy is never mentioned. Indeed, to the extent that Bryant mentions treatment at all, it is to say that treatment is entirely irrelevant to his analysis: "An important omission from the *DSM* is a discussion of the kinds of treatment that GIDC chil-

dren should receive. (This omission is a general orientation of the DSM and not unique to GIDC)" (Bryant, 2006, p. 35). How this article supports AAP's claim is a mystery. Moreover, how AAP could cite a 2006 history discussing events of the 1990s and earlier to support a claim about the *current* consensus in this quickly evolving discussion remains all the more unfathomable.

Cited last in this section was a one-paragraph press release from the World Professional Association for Transgender Health. Written during the early stages of the American Psychiatric Association's (APA's) update of the DSM, the statement asserted simply that "The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide." Very reasonable debate can (and should) be had regarding whether gender dysphoria should be removed from the DSM as homosexuality was, and WPATH was well within its purview to assert that it should. Now that the DSM revision process is years completed however, history has seen that APA ultimately retained the diagnostic categories, rejecting WPATH's urging. This makes AAP's logic entirely backwards: That WPATH's request to depathologize gender dysphoria was *rejected* suggests that it is *WPATH's* view—and therefore, AAP policy—which fall "outside the mainstream of traditional medical practice." (!)

AAP based this entire line of reasoning on their belief that conversion therapy is being used "to prevent children and adolescents from identifying as transgender" (Rafferty, 2018, p. 4). That claim is left without citation or support. In contrast, what is said by AAP's sources is "delaying affirmation should *not* be construed as conversion therapy or an attempt to change gender identity" in the first place (Byne, 2016, p. 2). Nonetheless, AAP seems to appear to be doing exactly that: Simply relabeling non-gender affirmation models as conversion clinics.

Although AAP (and anyone else) may reject (what they label to be) conversion therapy purely on the basis of political or personal values, there is no evidence to back the AAP's stated claim about the existing science on gender identity at all, never mind gender identity of children.

AAP also rejected the watchful waiting approach, repeatedly calling it "outdated." The criticisms AAP provided, however, again defied the existing evidence, with even its own sources repeatedly calling that model the current standard. According to AAP:

> [G]ender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47]

The citations from AAP's reference list are:

45. Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Keo-Meier C. Prepubertal social gender transitions: what we know; what we can learn—a view from a gender affirmative lens. Int J Transgend. 2018;19(2):251–268

47. Olson KR. Prepubescent transgender children: what we do and do not know. J Am Acad Child Adolesc Psychiatry. 2016;55(3):155–156.e3

I was surprised first by the AAP's claim that pubertal onset was somehow "arbitrary." The literature, including AAP's sources, repeatedly indicated the pivotal importance of puberty, noting that outcomes strongly diverge at puberty. According AAP reference 29, in "*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% to 11.9% continuing to experience gender discordance" (Adelson & AACAP, 2012, p. 963, italics added), whereas "when gender variance with the desire to be the other sex is present *in adolescence,* this desire usually does persist through adulthood" (Adelson & AACAP, 2012, p. 964, italics added). Similarly, according to AAP reference 40, "Symptoms of GID *at prepubertal ages* decrease or even disappear in a considerable percentage of children (estimates range from 80–95%). Therefore, any intervention in childhood would seem premature and inappropriate. However, GID persisting *into early puberty* appears to be highly persistent" (Cohen-Kettenis et al., 2008, p. 1895, italics added). That follow-up studies of prepubertal transition differ from postpubertal transition is the very meaning of non-arbitrary. AAP gave readers exactly the reverse of what was contained its own sources. If AAP were correct in saying that puberty is an arbitrarily selected age, then AAP will be able to offer another point with as much empirical backing as puberty has.

Next, it was not clear on what basis AAP could say that watchful waiting withholds support—AAP cited no support for its claim. The people in such programs often receive substantial support during this period. Also unclear is on what basis AAP could already know exactly which treatments are "critical" and which are not—Answering that question is the very purpose of this entire endeavor. Indeed, the logic of AAP's claim appears entirely circular: If one were pre-convinced that the gender affirmation model is the only acceptable one, then watchful waiting withholds critical support only in the sense that it delays gender affirmation, the method one has already decided to be critical.

Although AAP's next claim did not have a citation appearing at the end of its sentence, binary notions of gender was mentioned both in references 45 and 47. Specifically, both pointed out that existing outcome studies have been about people transitioning from one sex to the other, rather than from one sex to an in-between or combination of masculine/feminine features. Neither reference presented this as a reason to reject

the results from the existing studies of complete transition however (which is how AAP cast it). Although it is indeed true that the outcome data have been about complete transition, some future study showing that partial transition shows a different outcome for them would not invalidate what is known about complete transition. Indeed, data showing that partial transition gives better outcomes than complete transition would, once again, support the watchful waiting approach which AAP rejected.

Next was a vague reference alleging concerns and criticisms about early studies. Had AAP indicated what those alleged concerns and flaws were (or which studies they were), then it would be possible to evaluate or address them. Nonetheless, the argument is a red herring: Because all of the later studies showed the same result as did the early studies, any such allegation is necessarily moot.

Reference 47 was a one-and-a-half page commentary which off-handedly mention's criticisms previously made of three of the eleven outcome studies of GD children, but does not provide any analysis or discussion (Olsen, 2016). The only specific claim was that studies (whether early or late) had limited follow-up periods—the logic being that had outcome researchers lengthened the follow-up period, then people who seemed to have desisted might have returned to the clinic as cases of "persistence-after-interruption." Although one could debate the merits of that prediction, AAP (and Olson) instead simply withheld from the reader the result from testing that prediction directly: Steensma and Cohen-Kettenis (2015) conducted another analysis of their cohort, by then ages 19–28 (mean age 25.9 years), and found that 3.3% (5 people of the sample of 150) later returned. That is, the childhood sample showing 70.0% desistence instead showed 66.7% desistance in long-term follow-up. It is up to the reader to decide whether that difference challenges the aforementioned conclusion that that majority of GD children cease to want to transition by puberty or represents a grasping at straws.

Reference

Steensma, T. D., & Cohen-Kettenis, P. T. (2015). More than two developmental pathways in children with gender dysphoria? *Journal of the American Academy of Child & Adolescent Psychiatry, 52,* 147–148.

Reference 45 did not support the claim that watchful-waiting is "outdated." Indeed, that source said the very opposite, referring to watchful waiting as the *current* approach: "Put another way, if clinicians are straying from SOC 7 guidelines for social transitions, not abiding by the watchful waiting model *favored by the standards,* we will have adolescents who have been consistently living in their affirmed gender since age 3, 4, or 5" (Ehrensaft et al., 2018, p. 255). Moreover, Ehrensaft et al. said there are cases in which they too would still use watchful waiting: "When a child's gender identity is unclear, the watchful waiting approach can give the child and their family time to develop a clearer understanding and is not necessarily in contrast to the needs of the child." Ehrensaft et al. are indeed critical of the watchful waiting model (which they feel is applied too conservatively), but they do not come close to the position the AAP policy espouses. Where Ehrensaft summaries the potential benefits and potential risks both to transitioning and not transitioning, the AAP presents an ironically binary narrative.

In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all. AAP claimed, "This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population" (p. 1); however, much of that evidence was about sexual orientation, not gender identity. AAP claimed, "Current available research and expert opinion from clinical and research leaders…will serve as the basis for recommendations" (p. 1-2); however, they provided recommendations entirely unsupported and even in direct opposition to that research and opinion.

AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems in Rafferty (2018), however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or missing a reference or two. Rather, AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide *extraordinary* evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence.

Appendix

All outcome studies of gender dysphoric children

Count	Group	Study
2/16	gay	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128,* 1283–1289.
4/16	trans-/crossdress	
10/16	straight/uncertain	
2/16	trans-	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 19,* 363–369.
2/16	uncertain	
12/16	gay	
0/9	trans-	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology, 4,* 29–41.
9/9	gay	
2/45	trans-/crossdress	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172,* 90–97.
10/45	uncertain	
33/45	gay	
1/10	trans-	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15,* 511–517.
2/10	gay	
3/10	uncertain	
4/10	straight	
1/44	trans-	Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.
43/44	cis-	
0/8	trans-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146,* 565–569.
8/8	cis-	
21/54	trans-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1413–1423.
33/54	cis-	
3/25	trans-	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*, 34–45.
6/25	lesbian/bi-	
16/25	straight	
17/139	trans-	Singh, D. (2012). *A follow-up study of boys with gender identity disorder*. Unpublished doctoral dissertation, University of Toronto.
122/139	cis-	
47/127	trans-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 582–590.
80/127	cis-	

*For brevity, the list uses “gay” for “gay and cis-”, “straight” for “straight and cis-”, etc.