EXHIBIT

3-A

(Deposition of Christopher Rosik, Ph.D.)

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

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

Plaintiff,

vs.

CASE NO: 8:17-cv-02896-WFJ-AAS

CITY OF TAMPA, FLORIDA,

Defendant.

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DEPOSITION OF: CHRISTOPHER ROSIK, PH.D.

TAKEN: PURSUANT TO NOTICE
COUNSEL FOR DEFENDANT
DATE: July 29, 2019
TIME: 9:00 a.m. - 3:45 p.m.
LOCATION: Burr & Forman, LLP
201 N. Franklin Street
Tampa, Florida
REPORTED BY: ELSA M. HERNANDEZ, FPR
Notary Public

APPEARANCES:

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THE COURT REPORTER: Would you raise your right hand, please. Do you swear or affirm the testimony that you are about to give will be the truth, the whole truth and nothing but the truth?

THE WITNESS: Yes.

CHRISTOPHER ROSIK, Ph.D.,

the deponent herein, being duly sworn under oath, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. WILLIAMS:

Q. Good morning, Dr. Rosik. Would you please state your full name for the record, sir.

A. Christopher Hastings Rosik.

Q. Your age, sir?

A. 61.

Q. Where do you reside?

A. Fresno, California.

Q. How long have you resided in Fresno?

A. Since 1986. I will let you do the math. 1986.

Q. Long time. How does that sound? What is your profession, sir?

A. I am a licensed clinical psychologist.

Q. And where do you work? Do you still work as a clinical --

A. Oh, yes. Oh, yes.
Q. Where do you work, sir?
A. I work at a counseling center, nonprofit, called the Link Care Center, L-I-N-K, C-A-R-E Center, three words. That's in Fresno, California.
Q. And when you say it's a nonprofit --
A. It's a -- is it a 503(c)?
Q. 501(c)(3)?
A. Yes. Religiously based.
Q. Okay. And what is the religious base, then?
A. Broadly Protestant, but -- I mean, yeah, I say Christian, tends to be more involved with the Protestant community.
Q. Is there a specific religion that supports it?
A. No. It pays for itself through counseling fees and through -- it actually had senior housing, so it's a diversified income stream.
Q. Okay. So it's a counseling center in Fresno where the professionals charge for their services, I take it?
A. Oh, sure, yes.
Q. And otherwise generates revenue to pay the expenses?
A. Yes, that would be correct.
Q. But there are no profits that go to any

shareholders. The profits are plowed back into the center itself?
A. That would be my understanding.
Q. And it's a Christian/Protestant-based center with no specific religion?
A. No specific denominational affiliation.
Q. Yes. I grew up in an Episcopal church, so I guess that includes --
A. Yeah. I did clergy evaluations for the Episcopal Diocese.
Q. All right. And you get paid a salary there?
A. I get paid a salary, and then there's -- it's kind of a two-prong system, where there's a salary and then you do get some -- after a certain base, you generate --
Q. Yeah.
A. -- a bonus based on what you generate for them.
Q. Sure. How long have you worked for Link Care?
A. Since 1986.
Q. Since '86. So you've been there the whole time you've lived in Fresno?
A. I have, indeed.
Q. I have your declaration, Doctor, and I've read it very carefully, many times, actually. So I'm very

familiar with your background, your publications, and obviously the general gist of the testimony that you are probably going to give today.
But for the record, would you describe your educational background?
A. Just higher education, I assume. I have a bachelor's degree in psychology, honors college --
Q. From where?
A. University of Oregon in 1980.
Q. University of Oregon in 1980?
A. Right. I did spend a semester at the University of Copenhagen during that time in Denmark.
Q. Let me make sure I get this correct. You got your bachelor's degree in psychology from the University of Oregon --
A. University of Oregon.
Q. -- in Eugene?
A. Correct.
Q. I was born in Portland, so I'm very familiar.
A. Oh, yeah. Okay. I have family up there.
Q. Good. All right. After your bachelor's degree, then where did you matriculate?
A. I went to Fuller Theological Seminary. They have a graduate school of psychology called Fuller Graduate School of Psychology. It's a program, a first

of it's kind in the country -- it started in the '60s -- where a student is able to study -- it's a six-year program, and you study theology alongside psychology. So it's integrative. And you take some courses in integration, which is ideally to pull the best of those two fields together.
Q. What is a course in integration? Give me a description.
A. Well, it might talk about, like, theological anthropology.
Q. Okay.
A. And how that relates to psychological understandings of human nature and Christian understandings and how those may or may not sort of interface. That would be one example.
Q. Okay. And Fuller, is that a denominational-oriented institution?
A. It tends to be Protestant, I would say, but it -- I don't think they hold themselves out -- it started back with Charles Fuller in the 1940s.
Q. I don't know who --
A. He was an evangelist at the time, and so it comes out of that tradition, but the school of psychology started in the '60s. And I think -- if I were to characterize it, I would say it's a lot of

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Presbyterian, Presbyterians go there, but I know there are Episcopalians, there are Baptists. So it's fairly broad-based Protestant, although there was Catholics in the graduate school I was at.

The graduate school of psychology, there's three schools, theology, intercultural relations, and then psychology program, which I was in. And their program was, I think, the first of its kind that was approved by the APA, back in the late '60s, early '70s.

Q. The APA being?

A. American Psychological Association. Yes. So it's --

Q. First of it's kind being the integrative?

A. Exactly. Right. Religious-oriented school.

Q. Okay. Is it Mr. Fuller or Dr. Fuller?

A. Charles Fuller are you talking about? Yeah, I imagine it's a mister. I don't know think he was a doctor. Unless it was an honorary.

Q. You said he was an Evangelical. What does that mean?

A. He was an evangelist.

Q. What does that mean?

A. It's like Billy Graham.

Q. Okay. Well, I know Billy Graham.

A. Right.

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Q. I went to the same elementary school as Billy Graham.

A. Did you really?

Q. Yes, I did.

A. Anyway, so that was his -- his ministry was evangelizing, so -- he wasn't as famous as Billy Graham, but Billy Graham was in -- I think they were compatriots in some things. They worked together sometimes. Same era.

Q. All right. You said evangelicals like Billy Graham. I certainly know who Billy Graham is. I grew up in Charlotte, so that's where Billy Graham was.

MR. MIHET: For the record, did you go the same elementary school with him at the same time as him?

MR. WILLIAMS: The answer to that is no. The answer to that is no.

MR. MIHET: Okay.

MR. WILLIAMS: But my wife and I were married in Black Mountain, North Carolina, where he was headquartered in his later years. But I did go to the same elementary school, and I'm very proud of that because he's quite and individual, I think.

A. So it kind of came out of that tradition, the founding of the school. Even though the theology

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school, the seminary was founded back in the '40s, late '40s, the school of psychology wasn't really founded until the '60s.

Q. What year did you graduate from the Fuller --

A. 1986.

Q. So you were there for six years?

A. I was there for six years.

Q. After you graduated in '86, I take it you went to Fresno?

A. I did, yes.

Q. And --

A. The rest is history.

Q. Well, let me ask the question.

A. Sorry.

Q. And you were there since, and you've been involved with Link Care since?

A. Correct.

Q. All right. Thank you for that --

A. I could add that I -- since about 2001, I have been -- so affiliated as a clinical faculty at Fresno Pacific University, so that is what I -- I do that mostly to stay balanced.

(A discussion was held off the record.)

BY MR. WILLIAMS:

Q. Have you ever been involved in any litigation

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of any kind prior to today?

A. Yes.

Q. And would you describe that for me, please.

A. I can think of two things. One, I was a plaintiff in the Pickup versus Brown suit in California, and then I also submitted -- I was asked to submit a -- what do they call it, again? -- for a case in New Jersey -- I wasn't an expert witness, but I submitted, I believe, in support of plaintiffs.

Q. You were an expert witness where, sir?

A. I wasn't an expert witness. I submitted -- I'm not quite sure what the legal term is for it when you submit comments about it.

Q. Well, we'll get to that. Don't worry.

A. Yeah. Yeah.

Q. Before we go any further, let me have this marked as Exhibit 1 do Dr. Rosik's deposition.

(Exhibit No. 1 was marked for identification.)

BY MR. WILLIAMS:

Q. Here is Exhibit 1, Dr. Rosik. I'll describe it on the record in a minute, but I want to go through some preliminaries that I probably should've gone through before we got started.

This is not a game of the foxes, today's deposition. There are no trick questions. I want you

to feel free to ask me any questions if you don't understand my questions, if you want me to repeat it, clarify. You are under oath, and so therefore I respect the fact that you have the right to make sure that you understand what we're talking about.

And if you give an answer and then later think you need to augment it or change it, let me know. We're here to get -- this is not a gotcha process. This is to get your testimony as accurately as possible.

Do you understand what I just said?

A. Yes.

Q. If you need a break, just let me know. We're going to take a break probably every hour. We're going to take a lunch break around noon-ish. I cannot provide that today, gentlemen. This is off the record.

(A discussion was held off the record.)

BY MR. WILLIAMS:

Q. Further, Doctor, it is very important to me that we communicate very clearly. So if you want me to define something that you don't understand, just let me know and I'll do my best. And I will do the same. I will do the same. Because words matter in these situations. All right?

A. Understood.

Q. All right. I'm returning to Exhibit 1 to your deposition, which is a copy of a complaint -- a copy of a declaration, I should say, that you provided in Pickup versus Brown out in California.

Do you see that?

A. Yes.

Q. And the style of that case -- by the style of the case, that's what we lawyers call this first part -- is in the United States District Court Eastern District of California, Sacramento Division. Pickup versus Brown, Case No. 2:12-cv-04297-KJM-EFB.

Did I say that correctly?

A. It looks like it, yes.

MR. GANNAN: For the record, I think the number was 02497. I think you reversed it.

MR. WILLIAMS: Not in what I have. I have 04297.

MR. GANNAN: Oh, you know what, the filing header is 02497, but the style has what you said, so I guess --

MR. WILLIAMS: That's what I'm going on.

MR. GANNAN: Okay. I'm sure the heading is correct because that's the electronic filing stamp.

MR. WILLIAMS: Could be right. I don't who prepared this, but whoever did...

BY MR. WILLIAMS:

Q. Anyway, whether it's 249 or 429, we're talking about the same document in the same case, are we not, sir?

A. Yes.

Q. All right. Do you know Mr. Pickup, David Pickup?

A. I do know David Pickup.

Q. And who is Mr. Pickup?

A. He is a therapist. He, from what I understand, has a practice in Texas, and he had a practice obviously in this municipality too.

Q. In where?

A. In this -- in Tampa.

Q. Tampa.

A. I think he had a practice in California one time. I'm not sure if he still does. So I know him in that way.

Q. Have you met him?

A. I have met him.

Q. Where did you meet him?

A. I met him at some conferences of The Alliance for Therapeutic Choice and Scientific Integrity. It's called the Alliance from here forward.

Q. What is that, the Alliance? What you just

said.

A. It's a professional organization of therapists and others that -- the mission statement is basically that we share desire to protect the rights of clients to pursue therapy of their choice when it comes to this area of same-sex attractions and the rights of therapists who provide that therapy. That is -- that is a goal, if you will.

Q. And what is the therapy? Can you tell me the name of the therapy you are referring to?

A. There is no specific therapy. There is no -- there is no specific one type of therapy. Therapists affiliated with the Alliance come from a number of different traditions in terms of therapeutic modalities, anywhere from psychodynamic, to narrative, to interpersonal, cognitive. These are all standard, mainstream therapeutic approaches.

Q. I'm familiar with the term "therapeutic modality."

A. Yeah.

Q. In fact, I've heard that quite a bit over the course of my legal career and from my wife who does that kind of stuff, so...

A. That's cool.

Q. How would you define "therapeutic modality"?

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A. It's an approach, a theoretical approach that has practical, obviously, applications towards addressing client issues.

So a cognitive therapist would look at a person's cognitions and intervene in terms of addressing those.

A psychodynamic therapist might look at the client's developmental history, attachment history, psychodynamics of what may be involved in their behavior in the present.

A narrative therapist will look at the story of the client and see about how they construct their story and will make changes, perhaps, and how they construct that story, so it's -- you know, the client brings a certain issue, a certain problem to the therapist. The therapist's modality is going to be the framework through which he or she will address that issue.

Q. So therapeutic modality or I guess the treatment process would be client specific, one size doesn't fit all. Is that a good way to put it?

A. I would say so. I mean, therapists tend to orient towards some modalities more than others, just by virtue of personality and experience and things like that.

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Q. So your colleagues there at Link Care might approach something -- a particular client differently than you might. Is that --

A. Oh, yes.

Q. Okay. So that's what you mean by therapeutic modality, a treatment process or a procedure that you choose versus what another psychologist might choose. Is that a good way to put it?

A. That would do, I think.

Q. All right. Now, we're going back to the Alliance. And I'm exploring this because I want to make sure that I understand your background.

A. Right. Right. Right.

Q. I think it's important for purposes of this litigation. So the Alliance, which you say you'll just refer to it as the Alliance, how large of an alliance of human beings, psychologists, therapists, counselors is it?

A. The last I heard I would say it's a couple of thousand.

Q. Nationwide?

A. Yeah. International.

Q. Worldwide?

A. Yeah. I mean, obviously, it's more in North America.

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Q. Sure. And does it have a headquarters?

A. Well, the headquarters is sort of -- the office is based in Utah, so I guess that would be --

Q. What part? Salt Lake City?

A. Yeah, I believe so.

Q. Okay.

A. One of the board members, our executive director is there.

Q. Okay. So it has an -- it's an organization. It --

A. Yeah, it has a board. It has an executive director, yes.

Q. And the executive director, who is the executive director?

A. David Pruden.

Q. Spell the name.

A. David Pruden, P-R-U-D-E-N.

Q. And Mr. Pruden is the executive director of the Alliance which is headquartered -- physically headquarters in Salt Lake City, Utah?

A. It's his office, but, yes, documents and things like that are stored there.

Q. Why is it in Salt Lake City?

A. Because he is there.

Q. Because that's where he lives?

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A. That's where he is. That's right.

(A discussion was held off the record.)

BY MR. WILLIAMS:

Q. So the Alliance has headquarters in Salt Lake City, has an executive director, and I assume the executive director kind of is the person who runs the operations?

A. Yeah, like the hub, yes.

Q. The hub?

A. Yeah.

Q. Does the Alliance have meetings?

A. We do.

Q. How often?

A. Well, the board meets monthly by conference call, and then we have a conference once a year, different cities, so that's -- for the most part, that's the meetings that we have.

Q. And the members of the Alliance attend those meetings, if they can, those conferences?

A. Sure. It's open to all members and nonmembers, for that matter.

Q. Really? Okay.

A. Oh, yeah. You can come.

Q. Okay. Well, maybe when you have one in Tampa, I'll take you up on that.

Does the Alliance have a mission statement?
A. We do.
Q. What is the mission statement?
A. It's -- I have to -- I'd have to see it to know exactly, but it -- certainly, it includes what I told you earlier, about defending the rights of clients to pursue their goals in therapy and the rights of therapists to provide those goals.
Q. Does the Alliance have a website?
A. We do.
Q. And would the mission statement be on the website?
A. It would be, yes.
Q. And if I wanted to know more about the Alliance without spending a lot of time in today's deposition, I could look at that website?
A. Yes.
Q. Access it, even though I'm not a member; is that correct?
A. Yes.
Q. And to your knowledge, is everything that I would find on the website accurate?
MR. GANNAN: Objection. Calls for speculation.
A. I haven't read everything on the website, so I

couldn't tell you with certainty. It's a big -- it has a lot of documents on it, some of which I don't have anything to do with. So as far as things that I have been involved in, I would say, to the best of my knowledge, yes, to your question.
BY MR. WILLIAMS:
Q. Do you feel comfortable in saying that the Alliance, in maintaining their website, makes a legitimate effort to try to make sure that it's accurate?
A. I would think so. I hope so, yes.
Q. Yes. Okay.
MR. GANNAN: I just want to say for the record that Dr. Rosik is not appearing today on behalf of the Alliance.
MR. WILLIAMS: I understand that. I'm only going into it because he raised it.
A. But, again, we are -- I tempered it just by the fact that there's a lot of information over the years, a lot of that has been, you know, evolved some, and so there may be old documents that don't represent our thinking at this point in time. But, again, I don't know that. I don't manage the website. I simply -- I contribute some information to it. But it's entirely possible that there is some things on it

that I don't agree with.
Q. And I'm sure that's the case. I'm sure I don't agree with what is on the ABA's website.
A. As well, yes.
Q. All right. I was trying to get an idea of how I can obtain information about the Alliance without spending all morning on that topic.
A. Sure.
Q. Because you are not here on behalf of the Alliance. Am I correct?
A. Correct.
Q. Are you an officer of the Alliance?
A. I am.
Q. What is your office?
A. I'm on the board. I have served as the -- I'm a former president of the organization.
Q. And you still remain on the board itself?
A. I do remain on the board, yeah.
Q. All right. How long have you been on the board?
A. Probably -- I would say at least 10 to 12 years.
Q. Were you one of the founders of the Alliance?
A. I was not.
Q. Do you know who did found it?

A. Well, the Alliance in its first -- in its infancy, it was called the National Association for Research and Therapy of Homosexuality, or NARTH.
Q. Say that again, NARTH?
A. N-A-R-T-H. And that was founded by, I believe, Dr. Bieber, Socarides -- Kaufman is the other one -- Socarides, Kaufman, and Nicolosi.
Q. How do you spell Socarides? She's gotta write this down.
A. S-A-C-A-R-I-D-E-S [sic], something like that.
Q. Is Dr. Socarides still alive?
A. No. He passed way sometime ago.
Q. Are the founders, the three gentlemen that you talked still alive?
A. Dr. Kaufman, to the best of my knowledge, is still live, but he doesn't practice anymore. He's not really involved in the organization. And Dr. Nicolosi passed away a couple of years ago.
Q. Do you know why these three professionals formed NARTH, I think you called it?
A. Yeah. It was, I believe, a reaction to their disagreement with actions taken by the mental health associations in the area, I guess, of, you know -- again, I wasn't there.
Q. I understand. I'm just asking your best

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knowledge.
A. I'm speculating here.
Q. The record will reflect that you're not -- you don't know of actual knowledge.
A. But I think they wanted to preserve the right for clients -- clients who were dissatisfied with their same-sex attractions to be able to have therapy. Originally, it was a clinical organization when it started.
Q. What do you mean by "clinical organization"?
A. Of therapists. It was almost exclusively therapists when it began. We have therapists now, but we also have others who are not therapists who are members of the Alliance.
Q. When you say "clinical organization," meaning it provided clinical --
A. Professional -- professional therapist membership organization.
Q. But they didn't provide clinical services as NARTH?
A. No. No. It's never been that.
Q. Okay. That was my question.
A. Sorry.
Q. And you said that they -- it was formed, you think, because of, I guess, dissatisfaction with

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positions taken by mental health organizations? I think you said mental health.
A. Right.
Q. What mental health organization?
A. American Psychiatric Organization and American Psychological Association.
Q. And what positions by those two organizations were the motivating factor for forming NARTH, which has evolved into the Alliance, if you know?
MR. GANNAN: Objection. Speculation.
A. Again, I'm speculating, but I know at least part of it was concern about the rights of clients to receive therapy, concerned about treatment options for individuals who were maybe dissatisfied with their same-sex attractions and behavior. And there may have -- you know, again, I don't want to speculate too much.
BY MR. WILLIAMS:
Q. Well, the record reflects that you are speculating, and this is a discovery deposition, Doctor, and the reason it's okay to speculate is because you may provide information that will --
A. Yes.
Q. -- help me do my own investigation separate and apart from this deposition.

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A. All right.
Q. So that's the reason I'm asking these questions. And the American Psychological Association, the American Psychiatric, they took positions that were, I guess, antithetical to what the three founders of NARTH, now the Alliance, believe were correct. Is that a good way to put?
A. It was certainly an argument within the psychoanalytic circles.
Q. Right. What were the positions that the American Psychiatric Association and the American Psychological Association took that were -- can you articulate those positions that led to the formation of NARTH, now Alliance?
MR. GANNAN: Objection. Speculation.
A. I wasn't privy to those conversations. My guess --
BY MR. WILLIAMS:
Q. Guess, go ahead. The objection is on the record. That's what we lawyers do.
A. Yeah. I mean, I think it probably came in the context of differing, changing views of the status of same-sex attractions behavior, sexual orientations.
Q. For example?
A. That at least in some instances it was a

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condition that could be treated, could -- a person could be helped in terms of adjusting, changing. Again, I think it all had to do with the treatment issue, being able to treat.
Q. So did the American Psychiatric Association and the American Psychological Association take the position that homosexuality was not something that was treatable? I want to make sure I understand what you're saying.
MR. GANNAN: Objection. Compound and speculation.
BY MR. WILLIAMS:
Q. Go ahead.
A. Repeat your question, please.
MR. WILLIAMS: Would you read it back to him, please.
(The question was read back as follow: "So did the American Psychiatric Association and the American Psychological Association take the position that homosexuality was not something that was treatable? I want to make sure I understand what you're saying.")
A. It's not a simple question, because it was evolution of the associations over time. Right. The DSM, it was declassified as a disorder. However, it

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was left in as a -- at least in the later DSM-III, it was still a condition that could be under sexual disorders NOS, so it wasn't officially in. And then it became egodystonic from a homosexuality. And --

Q. Say that again.

A. It was -- a later edition of the DSM, which is the Diagnostic and Statistical Manual.

Q. Yes.

A. A later edition it became -- said homosexuality -- egodystonic.

Q. Egodystonic.

A. Right. And that eventually --

Q. Spell that for the court reporter.

A. D-Y-S-T-O-N-I-C. Then it was removed altogether. Although -- yeah, so...

Q. What was removed altogether?

A. Homosexuality as a condition.

Q. As a mental illness?

A. As a mental illness.

Q. Now, DSM-III --

A. As a disorder, okay, yes.

Q. -- DSM III, if I recall, was published in 1987, if my memory is correct. Is that about right?

A. It could be. I don't know the exact date.

Q. Assume that it was published in 1987. Are you

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telling me that prior to the DSM-III, assuming it's '87, homosexuality was declassified?

MR. GANNAN: Objection. Speculation.

A. It was declassified at least by the organizations in, I think -- as a stand-alone category of homosexuality in 1973.

BY MR. WILLIAMS:

Q. Okay.

A. But it was still -- you know, you could diagnose egodystonic homosexuality. Right.

Q. Okay.

A. You can have ego-syntonic. People comfortable in it would not be considered that.

Q. What does declassified mean?

A. Taken out of the DSM. It was removed from the DSM as a category.

Q. Mental illness?

A. Yes.

Q. So sometime in the '70s --

A. My understanding is that when it was taken out it was voted on by the membership of the American Psychiatric Association. It was a very close vote. It was a very close vote to declassify it of the membership, and that's one of the reasons that it wasn't, you know -- I imagine that psychiatrists, like

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Dr. Kaufman and Dr. Socarides were psychiatrists, that's one of the reasons that they got together eventually.

Q. Sure. I'm just trying to get the chronology so I can understand it.

A. Yeah.

Q. I'm not a psychologist. I leave that to my wife. In the 1970s, homosexuality was declassified as a mental illness by the American Psychiatric Association, and that declassification was evidenced in what? Is it a resolution by it, or how do they do that?

A. I don't know for sure. I imagine they may have made some resolutions to justify, you know. I mean, obviously, the DSM is something that -- it's a book that is done by a number of committees, and so the committees related to sexual disorders probably made that decision in the end.

Q. And then in DSM-III -- tell me, again, what you said about DSM-III. And, again, I'm pretty sure I'm right that DSM-III came out in 1987. We're up to DSM-5 now, I think.

A. My recollection would be that DSM-III did not have homosexuality as a category, and it had sexual disorders NOS, which is not otherwise specified, and it

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included homosexuality that was egodystonic as a possible, you know, example for that.

Q. Just for everybody's sake, what is "egodystonic"?

A. It means that it is not -- it is unwanted, I guess, you could say that. It caused the individual distress.

Q. Homosexuality that was not wanted?

A. Right. As opposed "syntonic," which means that would be what they -- that the person was comfortable in their homosexuality.

Q. Sure.

A. It's not a problem.

Q. Sure. All right. And so in DSM-III, there was that change. It had already been declassified, and now it's either syntonic -- egosyntonic or egodystonic.

A. Uh-huh.

Q. And then when was homosexuality removed from the DSM, Diagnostic and Statistical Manual completely?

A. My guess would be it was in the DSM-IV.

Q. In IV. Okay.

So there was an evolutionary chronology, a declassification DSM-III, which you just described. And then by DSM-IV, which I think was in the '90s, it was removed altogether from DSM-IV. Am I correct?

A. I don't know about the specific years, but in general, that was the evolution.
Q. Right. And the organization which you described as NARTH, which evolved into the Alliance, you believe was started by those three gentlemen, two psychiatrists and psychologist, as a reaction to the declassification and ultimately elimination?
A. In part --
MR. GANNAN: Objection. Asked and answered. Speculation.
Q. Go ahead.
A. I suppose in part it could, yes, but it was interesting, it didn't -- I'll just say in part.
BY MR. WILLIAMS:
Q. Okay. Doctor, to become a licensed clinical psychologist in the state of California, does -- aside from the educational qualifications and requirements, does one have to have a residency or some clinical --
A. You have to have --
Q. -- practicum --
MR. GANNAN: Let him finish his question completely before you answer.
BY MR. WILLIAMS:
Q. -- before one can practice that -- provide clinical psychological treatments to clients in

California?
A. In California, at least when I was graduating, you had to have 3,000 hours of supervised training, practical experience. 1,500 of those hours could be prior to graduation, 1,500 could be after. So that's the answer to the question.
Q. How did you acquire those 3,000 hours in your evolution from a student into a clinically -- clinical practitioner?
A. My undergrad, my last year at Fuller was mostly as an intern as a student trainee at Camarillo State Hospital.
Q. Say that again.
A. I was a student in training at Camarillo State Hospital. It was an internship. My internship was at Camarillo State Hospital.
Q. Where is that hospital?
A. In Camarillo, California.
Q. Spell it, please.
A. C-A-M-A-R-I-L-L-O.
Q. Camarillo.
A. Camarillo, yes.
Q. And where is that in California?
A. It's kind of between Thousand Oaks and Ventura.

Q. Okay. So it's down in Southern California?
A. Yes.
Q. Is that a particular kind of hospital, a psychiatric --
A. It was a psychiatric hospital, yes, at that time. Doesn't exist anymore.
Q. Was it a long-term or short-term psychiatric hospital?
A. I don't know. They had different wings, different -- they had sex offenders. They had mental -- developmentally disabled. They had all sorts of different people.
Q. Was that a state hospital?
A. It was a state hospital, yes.
Q. So funded by the state, I take it?
A. Yes.
Q. So you spent a year there getting clinical?
A. Nine, ten months, yes.
Q. Okay. All right. Take me forward.
A. And the other hours were through supervision at Link Care.
Q. Through what?
A. Supervision, supervised hours at the Link Care Center.
Q. I see.

A. I had a supervisor there.
Q. While you were in school?
A. No. After graduation, 1,500 hours are prior to graduation.
Q. Yes, sir.
A. 1,500 hours are after. So my 1,500 hours after were at Link Care under the supervision of a psychologist there.
Q. Were you qualified from a licensure point of view to provide clinical therapeutic procedures or modalities, however -- whatever words --
A. Until you can get your license, you qualify under the license of your supervisor.
Q. I see.
A. That's how it works.
Q. I got you. Then once you get the 3,000 hours?
A. Then you apply, take the exam, and if you pass, then you are licensed, yes.
Q. Okay. Good enough. Is that standard throughout the country that you have that kind of --
A. I don't know about the hours piece of it, but, yes, most states have tests that you have to take to be licensed, requires certain amount of hours.
Q. Why -- do you know why you became a plaintiff in the Pickup case -- I will call it the Pickup v.

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Brown case -- that I described on the record about 30 minutes ago?
A. Sure. Sure. It's a little bit of a story. But at the time --
Q. I'm all ears.
A. -- at the time, I was the president of Alliance. And you may guess, I really don't have a great stomach for confrontational kinds of things. I don't enjoy them. However, I don't look for a fight, you know. But in a sense, here I am the president of this organization and the state I'm practicing in is threatening to take away the rights of clients and therapists.
I should say, this is -- it's important contextually to understand the Link Care Center, we work with a fairly conservative religious population, meaning we work with all people, of course, but a significant -- a significant percentage of that are Protestant, evangelical, conservative, traditional, theologically orthodox, whatever you want to call it, but they come from those backgrounds.
We have a program that we work with a lot of clergy and missionaries. It's a cross-cultural, it's -- those working a full-time Christian vocation. So I'm well acquainted with these individuals.

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Over the years in my working there, it was unusual for -- it wasn't frequent, but not unusual for some of these individuals to come to Link Care and among the issues were same-sex attraction issues. So from an early on, I was concerned, just, you know, sensing the wind, that the rights of these individuals were going to be taken away, the sincerely held religious beliefs to pursue and explore their same-sex attractions.
And so that's really why I got involved in this whole field in the first place. I mean, the suit itself was 15 years later, but I didn't feel like these individuals who I was seeing in my office had a voice, and I was afraid that their rights were going to be taken away to pursue the goals that are based on their religious beliefs.
Q. And you said this is why you got involved in the first place. It wasn't because of the change in the California law, but -- what you were talking about earlier, the Alliance --
A. I was involved -- yes, although it took some time. As I was involved with the Alliance -- again, if you read my writings, I talk about this early on in my writings in this area, long before the law was actually passed or actually, you know, was working through the

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legislature -- legislature in California.
So I sensed that this could happen, and I wanted to be a voice for these clients who don't have a voice. You know, they're not represented by, you know, I would say most of the voices that are on the other side anyway.
Q. What other side?
A. Well, I would say those who would support the bans on therapy.
Q. Who are "they"? Can you characterize them for me?
A. What are you looking for?
MR. GANNAN: Objection. Vague. Go ahead answer.
A. What are you looking for on that? I'm not quite sure.
BY MR. WILLIAMS:
Q. Well, I'll have her read back the colloquy and then probably help you out, I believe.
(A discussion was held off the record.)
(The record was read back as follows: "And you said this is why you got involved in the first place. It wasn't because of the change in the California law, but -- what you were talking about earlier, the Alliance --

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"ANSWER: I was involved -- yes, although it took some time. As I was involved with the Alliance -- again, if you read my writings, I talk about this early on in my writings in this area, long before the law was actually passed or actually, you know, was working through the legislature -- legislature in California.
"So I sensed that this could happen, and I wanted to be a voice for these clients who don't have a voice. You know, they're not represented by, you know, I would say most of the voices that are on the other side anyway.
"QUESTION: What other side?
"ANSWER: Well, I would say those who would support the bans on therapy.")
BY MR. WILLIAMS:
Q. That's the context, Doctor, when you said "the other side." And I would agree with Mr. Gannam that it is a vague reference, but that's why I'm asking the question, because I don't know what you mean by "the other side."
A. Well, I guess in the broad sense it would be those who wish to support in whatever fashion laws to take away the speech rights and the freedom to choose goals in regards to their presenting issues of same-sex

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attractions if that is something they're concerned about.
Q. All right. I think I understand what you just said when you used a phrase with the pronoun "they." Are there any particular people or organizations that you can identify for me that would come within the ambit of the word "they"?
MR. GANNAN: Objection. Vague.
You can answer.
A. I do know like California Equality was the group that sponsored the bill. We had politicians that supported the bill. There were therapists and therapeutic organizations that supported the bill after some, obviously, negotiating of it.
BY MR. WILLIAMS:
Q. What do you mean by "obviously, some negotiating of it"?
A. The original bill in California -- it's very interesting. The original bill, the way I look at it was Equality California just was throwing all sorts of things against the wall and seeing what would stick, because this was the first of its kind legislation in the country.
Q. When was that? What year?
A. 2012, right, and so the original bill talked

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about -- as it was originally crafted, it included adults, it included a statement of consent that was -- that therapists would have to read before doing therapy that could be construed as SOCE.
Q. SOCE being what?
A. Sexual Orientation Change Efforts, a term that I would say I have problems with.
Q. You have what? Problems with?
A. Problems with the term. We can talk about it later.
But this original legislation, it obviously prevented therapists from working with minors. That was part of it, but it was more expansive than that, like I say. And it allowed therapists to be sued if they didn't -- for up to $5,000 in damages if they either worked with a minor or did not present this consent form and also they had to -- therapists who would engage in SOCE would have to, under this law, as it originally constituted, they would have to report to the state. So it was very expansive.
Q. Report to the state what, sir?
A. They had to report to the state that they were doing it, how much they were charging, what dates it occur, all these sorts of things.
Q. Okay.

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A. So all of this was thrown against the wall to see what would stick and --
Q. You mean metaphorically; correct?
A. Well, okay. Yes. Yes. They were fishing to see what would be considered. I mean, the long-term goal seemed from that to be banning this for everybody in some form or making it very difficult. And after negotiating with the professional organizations, everything apart from the minor's piece was taken out and it was referred back to the Board of Psychology as possible -- that's where the penalties would come from, not from civil litigation up to $5,000. So that's what stuck in the end, and then that, of course, was taken as a template across the country.
Q. All right. So the original proposed California law -- which would be statewide, I take it. Am I correct?
A. Statewide, yes.
Q. -- had started with one version, but when it was finally enacted, it was a --
A. A very narrow.
Q. -- much more narrow version of it?
A. Yes. Yes.
Q. And you mentioned Equality California, what is that group?

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A. It's a civil rights organization that works for -- they introduced lots of legislation primarily in the area of sexual orientation-related matters, very involved.
Q. Were state psychological/psychiatric associations involved in the enactment or the promoting the enactment of that law?
A. I mean, they were negotiating with California Association of Marriage and Family Therapists, the California Psychological Association. They consulted with the APA, American Psychological Association.
Q. Who is "they"?
A. The legislators, to understand. But the APA representatives basically said that we don't do -- we don't recommend banning. Basically, we don't get involved in these things, so they did not weigh in on it.
Q. How do you know that?
A. It was a news report.
Q. From the news?
A. From the news.
Q. That's the source of your knowledge?
A. It was a quote from the --
Q. I understand that. But that is the source of your knowledge, some newspaper article?

A. It's the words that she used.
Q. I understand. The source --
A. Okay.
Q. -- of your knowledge is a newspaper article?
A. She was interviewed, apparently.
Q. Who is "she"?
A. Rhea Faberman, I think her name was.
Q. And who is she?
A. I don't remember her exact title, but she was a representative of the APA.
Q. Okay. All right. And so you -- did you volunteer to become a plaintiff in that lawsuit or were you asked?
A. I was asked.
Q. By whom?
A. By Liberty Counsel.
Q. Liberty Counsel, meaning these two gentlemen to your right?
A. Not these two gentlemen specifically.
Q. Other members of Liberty Counsel?
A. I believe so, yes.
Q. Do you remember their names?
A. I think one was Daniel Schmidt. That's the one I remember. I think I interacted with him more.
Q. And is he located in California?

A. I don't know. I don't think so, but I don't know.
Q. So Mr. Schmidt contacted you and asked you if you would be willing to be a plaintiff; is that correct?
A. It's been a while, but that's my --
MR. GANNAN: Before you get further. I just want to sort of preemptively address any privilege issues, that you are not to answer the content of any conversations you had with Mr. Schmidt other than to perhaps describe the subject matter, if that's responsive to the question.
MR. WILLIAMS: Nor will I get into that. I respect the attorney-client privilege very much.
BY MR. WILLIAMS:
Q. My question was how did you get involved in this lawsuit.
A. Right.
Q. So apparently Mr. Schmidt contacted you, and you agreed to be a plaintiff; is that correct?
A. After much deliberation with myself, yes.
Q. All right.
A. As I said, that was not something I wanted to do.
Q. Okay. And Robert Vazzo, do you know Mr. --

Dr. Vazzo or Mr. Vazzo?
A. I know Mr. Vazzo, not as well as Mr. Pickup. I don't know them really personally other than they're colleagues at the Alliance.
Q. And Dr. Nicolosi, who was a plaintiff in this case?
A. I knew Dr. Nicolosi, yes.
Q. He has since passed away, has he not?
A. He has. Yes, he has.
Q. And then the next one is National Association for Research and Therapy of Homosexuality (NARTH).
A. Right.
Q. And that's the organization that you referred to earlier?
A. Right.
Q. Which is now called the Alliance, is it not?
A. Correct.
Q. When did that change, that name change take place? Do you know?
A. Probably five or six years ago.
Q. And then you have the American Association of Christian Counselors (AACC).
A. Correct.
Q. And what is that organization or association?
A. I'm not a member of that organization, but I

assume -- I mean, it represents Christian counselors, you know, and others, I suppose. I don't think it discriminates that way, but mostly Christian counselors, 50,000.
Q. Which gets us back to something you said earlier that piqued my curiosity, I guess, as much as anything. You said that -- I think the words you used were the population was "a fairly conservative religious population," quote-unquote. I wrote it down --
A. Oh, at Link Care?
Q. Yes.
A. Uh-huh.
Q. Yeah.
A. Yeah, I mean, obviously we serve -- my license is with the state -- we serve people across the spectrum of belief, but we are known as a faith-based center by a lot of churches in the area, and so we get referrals from them. So a high percentage of clients tend to be people with sincere religious beliefs, and that's motivating their choice to seek counseling. They hope to see someone who at least understands, if not, shares their world view in significant ways.
Q. And when you say "fairly conservative religious population," tell me what you mean by

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"conservative religious." What does that mean?
A. I would say in terms of theological belief, authority of the scripture, they would probably take that seriously. That would be a primary authority for them in terms of life, in terms of -- even in terms of morality, and that would include sexual morality, if they understand it.
Q. What does sexual morality have to do with homosexuality?
A. Well, my under- -- sexual morality, I think it's what your beliefs about sexual activity, whether that's like sex, sexuality -- well, I mean, that's the broad answer to the question. Right? I mean, sexual morality is an understanding of what's -- what's within a theological belief system, what is ideal and what is not ideal.
Q. What is moral and what is immoral?
A. That's possible, yes. That is one way of looking at it.
Q. Is that one way to characterize sexual morality from a conservative religious point of view?
A. I think that would be a fair characterization.
Q. All right.
A. They're concerned with living up to their religious ideals --

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Q. It's important that I understand.
A. Yeah, sure.
-- in terms of their sexual conduct, yes.
Q. Okay. And you also -- and I'm using the terms that you used. I'm not going to dwell on this. I just want to make sure I understand this so as we talk I get a better feel for your thinking, sir.
A. Sure.
Q. You also used the word "Protestant evangelical." What does that mean?
A. It's different definitions. Like evangelical would be someone who had a high view of the scripture.
Q. What is "a high view of the scripture"?
A. That it is the utmost authority in their life. That's how they would frame it, utmost authority. Repeat the question, if --
Q. I asked you -- you used the term "Protestant evangelical."
A. Yes.
Q. Let me set the stage so the record is fair to you and clear to whoever reads it. I'm using the terms that you used in answer to some broad question that I asked ten minutes ago, probably.
And one of the phrases that you used was "Protestant evangelical." I'm asking for your

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definition of what that means. You used the phrase, so I'm just trying to understand what you meant by that.
A. Fair enough. Fair enough. I would say it would be a high view of scripture. They often are, you know, trying to live by their beliefs. I think that's the biggest thing. And there is subject to nuance and interpretation, but, yes, the scriptures are authoritative, and they try to live by them.
Q. If somebody is living by the scriptures, does that make them automatically a Protestant evangelical?
A. Not necessarily.
Q. What's the difference? That's my question.
A. You can say, for instance, if you want to put in a hierarchy. Let's look at it this way.
Q. Okay.
A. Authority of scripture; say authority of tradition; authority of, say, reason; and authority of experience. You probably find the evangelicals saying scripture, tradition, reason, maybe science, and then experience. And probably a non-evangelical might have something like experience first. Experience tells me what's true.
Q. Okay.
A. All right. And then maybe science and then maybe -- so if you want to put these in different kind

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of hierarchies, the evangelical would probably have scripture, by and large. I mean, there's always exceptions, but would have that scripture authority on top.
Q. All right. The hierarchy --
A. And they understand the others through that -- you know, in part through that lens where it speaks to it. It doesn't always speak to it, but in part through that lens.
Q. All right. I think I understand. Thank you. That's a good way to explain it.
And the last phrase you used was -- again, I'm just trying to make sure I understand this in case it becomes relevant, and it probably won't. "Theologically orthodox." What does that mean? Same hierarchy kind of thing?
A. Yeah. I mean, I guess they would -- if you want a simple answer, I would say that they would agree with the Apostles' Creed. That would be kind of a summary statement of their belief.
Q. So somebody who is theologically orthodox believes in the Apostles' Creed?
A. I think so. I think that would be fair to say. There may be other things. So you can have orthodoxy apart from -- even though there is an

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orthodox church, you know.
Q. Yes.
A. I'm not saying that only Protestant evangelicals have orthodox theology. I'm just saying, this is how they see it. They wouldn't be exclusionary of others.
Q. Well, the Apostles' Creed, you would agree with me, is not unique to any particular denomination?
A. No. That's correct.
Q. I mean, the Episcopals do it, Presbyterians say it.
A. Absolutely.
Q. Methodists say it.
A. Absolutely.
Q. I think the Latter-day Saints say it, do they not?
A. They may. I'm not an official -- I'm not totally knowledgeable about that.
Q. I have a friend who is. I'll ask him.
MR. WILLIAMS: All right. Let's do this. Let's take a short break.
(A brief recess was taken.)
BY MR. WILLIAMS:
Q. Dr. Rosik, I'm going to go through your declaration, obviously, in detail. It's a lengthy

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declaration, as you know, which I enjoyed reading. But before we get into that aspect of your involvement in this case, would you please tell me how you first became involved as an expert witness in this case?
A. I believe I was approached by Liberty Counsel, seeing if I would be willing to participate in that regard, in that capacity.
Q. Yes, sir. And is there a particular lawyer or lawyers who contacted you?
A. I think the one sitting next to me.
Q. Mr. Gannam?
A. Mr. Gannam. If my recollection is accurate.
Q. Did you know Mr. Gannam prior to him contacting you?
A. No.
Q. When did he first contact you?
A. Spring, probably, maybe early -- late winter 2019.
Q. Okay. Six months ago or so?
A. Something like that, yes.
Q. What did Mr. Gannam ask you to do?
A. He wanted to know if I was interested in serving as an expert witness in this case.
Q. And did you ask him what kind of expert witness, by any chance?

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A. Well, I knew the case, so...
Q. How did you know the case?
A. I mean, I was aware that it existed based on my affiliation with the Alliance.
Q. Well, tell me about that. How is the Alliance involved with this particular case? And by "this particular case" --
A. Alliance has nothing to do with this case. However, we have a great interest in these cases, so we have people that do follow them and what's happening with them.
Q. I see.
A. And they report on them.
Q. So as a member of the board of the Alliance, you are generally aware of these kind of cases throughout the country. Is that a good way to put it?
A. More or less.
Q. Is it more more than or more less?
A. I'm just saying I'm not aware of -- some cases I know more about, than I'm aware of others. I may not know of every case out there, because there's a lot, I guess, but by and large, yes.
Q. I'm not trying --
A. I don't take it that way.
Q. Good. Words matter, phrases matter, and when

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you read a dry record --
A. I get it.
Q. -- six months from now and you say, "What did he mean by that?" that is why I'm so picky about phrases and definitions and things like that.
As I said, I have been doing this a long time, so I know what I'm talking about when it comes to that kind of stuff.
I have in front of me, actually, a copy of -- and I'm not going to make this an exhibit to your deposition. I have a copy of the first amended verified complaint, the declaratory preliminary and permanent injunctive relief and damages that is the operative charging instrument, as I call the complaint, in this particular case, Vazzo versus City of Tampa, Florida. And that is here in the Middle District of Florida, the Tampa Division.
And I'm going to hand it to you, and just tell me if you have seen that before. Certainly Mr. Gannam and Mr. Mihet have seen it. They authored it.
A. I think I have seen it, but I don't recall.
Q. Now, the reason I ask you that question is I asked you earlier when Mr. Gannam called you to be an expert. I think what you said was you were generally familiar with the fact that this case is pending?

A. Yes.
Q. Because of your position with the Alliance; correct?
A. I learned it through that, yes.
Q. That you keep track of things more or less; right?
A. Yes.
Q. And were you generally familiar with the issues in this case that we're here on today, the Vazzo versus Tampa case?
MR. GANNAN: Objection. Vague.
A. In the sense that these cases, the legislative language is boilerplate stuff. By and large, it's boilerplate. So being familiar with California, I'm quite -- you know, the language is echoing California's law.
BY WILLIAMS:
Q. The language of the Tampa ordinance is echoing the statute in California?
A. A lot of it.
Q. You've compared the two?
A. I mean, I haven't done a detailed analysis, but, you know, typically, you know, the citation from all the different organizations and definitions of terms and those sorts of things, it's a lot of

boilerplate stuff.
Q. Okay. Again, boilerplate. Is it your belief, Doctor, that the substance wording and so forth of the Tampa ordinance is very similar to the substance and wording of te California Statute?
MR. GANNAN: Objection. Asked and answered.
A. There are similarities. I don't know if I would say "very," but there are similarities.
BY MR. WILLIAMS:
Q. All right. Do you believe that the Tampa ordinance was modeled after the California statute?
MR. GANNAN: Objection. Speculation.
A. I mean, is it in every detail, I don't -- I don't know. I certainly suspect that there is communication that goes on along these lines; otherwise, it would be hard to understand how they could spread so rapidly.
BY MR. WILLIAMS:
Q. Fair enough. And the reason I'm asking these questions is because we started out that you were generally familiar with the existence of the lawsuit here in Tampa because the Alliance keeps track of these things.
A. Sure.
Q. Were you aware of the specific allegations in

the Tampa case -- I'll just call it the Tampa case -- when Mr. Gannam called you?
MR. GANNAN: Objection. Vague.
A. I don't know. To be honest.
BY MR. WILLIAMS:
Q. You don't remember, or you don't know?
A. No, I really don't know, were -- if there were specific allegations leveled against the therapist or whether this was done at kind of a preemptive way.
Q. Okay. Fair enough.
A. I don't know the answer to that question.
Q. Fair enough. All right. Let's get back to when Mr. Gannam contacted you. Recount for me, if you can, to the best of your memory, which is about six months ago, I think we agree, what that conversation was, what he said, what you said.
A. I mean, there is no way I'm going to be able to remember a narrative account of what our conversation was. There was some e-mail contact, and I'm sure in that I was asked if I would be willing to be an expert witness. And after some deliberation with my wife and within myself and my employer, I agreed to do that, and that's the gist of it.
Q. Fair enough. And do you still have those e-mails?

A. Probably, yeah.
Q. And so you had some e-mail exchanges with Mr. Gannam --
A. Correct.
Q. -- back earlier this year?
A. Yes.
Q. Did you inquire of Mr. Gannam, once you said I'll be an expert, what am I -- what does my expert testimony, what subject matter it was going to be on?
A. Yeah. I mean, I knew what subject matter it was going to be.
Q. What did you know then?
A. Just in part the science surrounding SOCE and sexual orientation in general.
Q. SOCE -- science surrounding SOCE and sexual --
A. Or I should say science or lack thereof.
Q. Okay. Science or lack thereof surrounding SOCE and sexual orientation. Did I get that correct?
A. And therapy issues, obviously, because that's -- I'm a psychologist, so broadly speaking, you know, the issues at play here with this legislation, this bill.
Q. Delineate for me those therapy issues you are alluding to.
A. Again, whether -- I mean, again, broadly

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speaking, whether licensed professional therapists are able to speak to clients in a way that could be construed as unopeness to change, unopeness to fluidity of sexual attractions and behaviors.
Q. When you say "can," you mean legally?
A. Are you legally allowed to.
Q. Yeah.
A. Under the bill you --
Q. That's what you mean by "can"; right?
A. Exactly.
Q. Before the break, we talked about the hierarchal concepts that you described in terms of Protestant, evangelical, and theological orthodox, conservative religion?
A. Sure.
Q. And at the top was scripture, adherence to scripture, and I assume that means a literal adherence? That's the way I heard you, at least.
A. Yeah, that would be a mischaracterization.
Q. Okay.
A. Literal. "Literal" is typically used, but what you have to understand is the scripture -- and I got this from my theological training.
Q. Sure.
A. -- scripture includes many genres, right.

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Like the parables of Jesus, I don't take them as literal. Right. They're not literal in that sense. I think evangelicals would say, "Well, that the loose gospel that contains history in it, that Jesus's life, his death, his resurrection, that's historicity to that. That's literal." Right.
So you have to contextualize, you have to understand what the genre of the scripture is when you say is it literal or not. That's not a -- it's a simple question.
Q. All right. Well, I don't want to get bogged down on --
A. Okay. But it's important to understand that, because I know where this goes.
Q. Where is it going? You tell me.
A. That it's a literal -- what I meant by that is that the accusation is these are fundamentalist, literal interpretation of the scripture, as if everything -- they're made to look kind of silly by that statement.
Q. Who is made to look silly?
A. Evangelicals, conservatives, orthodox.
Q. Okay. Well, the next here, if I recall the hierarchy was science. Am I right?
A. I think I said scripture, tradition, science,

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experience.
Q. All right. So number three is science.
A. Yes.
Q. That's third on the list. Okay. Right?
A. This is a hypothetical list, but it has -- it has heuristic value.
Q. But it's your list, is it not?
A. Well, not -- I would say --
Q. It's what you testified to.
MR. GANNAN: Objection. Let him answer.
BY MR. WILLIAMS:
Q. Please.
A. Yeah, it depends on the issue. Some issues I would value tradition. Other issues I would more value science.
Q. So on some issues you might elevate science above tradition. Is that what you're saying, in hierarchy?
A. Possibly, yes, because tradition is tradition. I mean, it's not as authoritative as scripture in an evangelical context.
Q. The hierarchy that you described for me earlier was scripture, tradition, science, and I think experience; right?
MR. GANNAN: Objection. Asked and answered.

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BY MR. WILLIAMS:
Q. I want to make sure that I got that right. And the only reason I'm saying that again, because I did ask and you answered it, is to make sure that my next question makes sense. And that is, you said -- in response to one of my questions, you said, "Science or lack thereof surrounding SOCE, sexual orientation, and the therapy issues associated with all that." Something like that. Is that correct?
A. I believe so.
Q. Right. So when you say "science or lack thereof surrounding SOCE," first, define what SOCE means in lay terms. How would you describe that?
A. That's a great question.
Q. Thank you.
A. Because it's a very amorphous term. I would like to know what specific actions of the therapist are envisioned within that definition of "sexual orientation change efforts." Before I could really answer the question, I need to know what I'm being asked, because it's such a broad umbrella term. It's hard to know what I'm agreeing or not agreeing to. But if you give me specifics, this is what a SOCE therapist does specifically, that's in question, I might be able to answer that.

Q. If I brought my teenage daughter down to someone who is qualified to do SOCE therapy --
A. There's no -- it's not -- it's not certified.
MR. MIHET: Let him finish his --
A. Oh, I'm sorry.
MR. MIHET: Let him finish his question, please.
A. I'm sorry.
BY MR. WILLIAMS:
Q. Go ahead. Let me revise my question based on what you said.
SOCE stands for sexual orientation change efforts, does it not?
A. Yes.
Q. So if I brought my daughter, my teenage daughter down to you and said to you, "I'm here to make sure -- my daughter wants efforts towards not being homosexual, but rather being heterosexual," okay, would that be an example of SOCE?
MR. GANNAN: Objection. Vague. Calls for speculation.
A. I guess that -- I'm thinking that would be an example of a parent bringing their child in for therapy.
***

BY MR. WILLIAMS:
Q. I'll change the question, then.
My daughter is old enough to drive and drove down to somebody who is involved in this kind of clinical practice and said, "I would like you to exert efforts to make me nonhomosexual." Is that an example of the practice of SOCE?
MR. GANNAN: Objection. Vague. Misstates testimony. Improper hypothetical.
A. She's a minor; correct?
BY MR. WILLIAMS:
Q. My daughter is.
A. Well, in this scenario she's a minor?
Q. Yes.
A. I could not talk to her without talking to you.
Q. Okay. And would that be something that any ethical clinical psychologist would follow?
A. Absolutely. It's legally required. We have a form. We have to have a parent sign that says you may meet with my child. A minor child. So if the child comes in by themself, minor child, we have to have -- we'd have to say, "Sorry. We need to contact -- have your parents contact us."
Q. You wouldn't even talk to her, basically?

A. No.
Q. You would not; right?
A. No. The front desk would just say, "You need to have your parents contact our clinic and request counseling."
Q. All right. Well, I don't want to get too much in the weeds here, Doctor, because you used the term "science or lack thereof surrounding SOCE." That was your testimony. I wrote it down very carefully.
So let's start with the science surrounding SOCE. What is the science surrounding SOCE? Generally describe that for me.
MR. GANNAN: Objection. Vague.
A. In probably the most specific terms it would be research that has been done regarding -- in a therapy-therapist context of providing care for individuals who are, you know, looking at coming to therapy with unwanted same-sex attractions. So it's a limited literature. That's a narrow version regarding SOCE, science that's been done around that topic.
BY MR. WILLIAMS:
Q. And what do you mean by the lack thereof or a lack of science?
A. What I mean, by that, for example, is what science can and cannot say. For instance, all these

studies, most every one of them are correlational in nature.
Q. What does that mean?
A. They look at associations between variables. All right. So they can say, "This variable is related to this variable." They seem to vary together to some extent. Right? That's what a correlation is. Science would say there could be a -- there's a relationship between these those variables. Science can't say which of these variables is causative. One -- it could go either way. And that is -- again, that's the nature of this literature by and large.
Q. And when you refer to "this literature," is there something you can point me to to identify that literature?
MR. GANNAN: Objection. Vague.
BY MR. WILLIAMS:
Q. Let me help you out.
A. Yeah -- I know you're -- okay.
Q. Have you read the Tampa ordinance that is the subject matter of this litigation here in Tampa?
A. Yes. I haven't read it recently, though.
Q. But at some point in the past you have?
A. Yeah.
Q. After you were engaged as an expert in this

case did you read the ordinance?
A. I believe so.
Q. And I realize you haven't read it recently, but if you recall from your reading, there were a number of reports, studies, et cetera, et cetera, by any number of well-recognized organizations that are recited in the ordinance itself, are there not?
MR. GANNAN: Objection. Assumes facts not in evidence.
A. Yes, that's part of the boilerplate.
BY MR. WILLIAMS:
Q. Okay. Is that the science you are referring to that is correlated?
A. Those are resolutions. Those are policy statements. That's not science. They're saying it's based on science, but -- but those -- if you are talking about these different organizations and their statements, that's comment on it, that's their --
Q. Position?
A. -- position statements. Exactly.
Q. Okay. So correlate that, to use your term, with science. Are those position statements based on underlying scientific analysis by those organizations?
MR. GANNAN: Objection. Vague.
A. I would say that they are based in part. My

take on it is that -- and you've read the -- you know this already, but it's incomplete.
BY MR. WILLIAMS:
Q. What's incomplete?
A. The science is incomplete. It can't possibly be complete based on the science as it's conducted currently.
Q. How is the science conducted currently?
A. It's conducted almost exclusively on -- for instance, as an example, almost exclusively on LGBT identified participants.
Q. What does that mean?
A. When they recruit for participants, they -- I mean, this a function of just, say, the idealogical lack of diversity, but the research, if you look, they describe in the research methodology how they obtain participants. And very commonly it's through gay, lesbian, transgender networks, websites, venues, because these are the ones that researchers know and people trust. So that would be -- what's the problem with that is that it's missing the people that I work with.
Q. And who are those people?
A. Well, typically theologically conservative individuals who do not identify as LGB. They -- so

they don't -- they're not in those networks, put it that way.
Q. I got to understand this.
A. Yeah.
Q. You're really trying hard, and I appreciate it, but I'm a little confused.
The people you work with are a conservative religious population; right? Is that what you're referring to?
MR. GANNAN: Objection. Asked and answered.
BY MR. WILLIAMS:
Q. Yes?
A. By and large.
Q. Yes.
A. Not exclusively.
Q. And are you saying that people that are in that population, there are no homosexuals in it?
A. No. No.
Q. What are you saying?
A. The studies, many of them, when they recruit participants, they will, by virtue of their design, miss a good number of individuals who are not GLBT identified. And that means they cannot be generalized through that population. They can only be generalized within that population of GLB-identified individuals.

Q. What does that mean?
A. So it's incomplete.
Q. I don't know what that means, GLB identified?
A. Gay, lesbian, bisexual.
Q. I know what that means.
A. They self-identify that way.
Q. The members of this population?
A. Yes. Yes. Right. So someone in a conservative environment might say, "I have same sex attraction, but I'm not GLB --
Q. I see.
A. -- I'm not gay identified." And those people will not be sampled.
Q. I see. Okay. Now I understand what you are saying. So somebody in that population that would say, "I might be homosexual, but I'm not GLBT," what do they call themselves?
MR. GANNAN: Objection. Vague and misstates the testimony.
BY MR. WILLIAMS:
Q. What do they call themselves?
A. They would probably call themselves Christians. They may say they have same-sex attractions.
Q. And if they have same-sex attraction, what's

the significance of that from a conservative religion point of view?
MR. GANNAN: Objection. Vague.
A. For them, I assume that it would be falling short of the religious ideal. But they are still, obviously, loved by God, you know. But, yes, it would be seen as falling short of the religious ideal for sexual expression, if they -- well, that's another distinction. Right. Whether the person acts on their sexual attractions or not.
BY MR. WILLIAMS:
Q. Falling short? Meaning sinful or something like that?
A. That --
MR. GANNAN: Objection. Vague.
A. I don't know if they would use that language, but they could. And, again, that would be their language.
BY MR. WILLIAMS:
Q. That's a possibility?
A. It is a possibility.
Q. How does that impact the correlation that you are talking about? I'm really trying to understand this, sir.
A. The correlation I'm talking about.

Q. Yeah, the science, the correlative studies and so forth.
MR. GANNAN: Objection. Vague.
A. Again, it's really about their self-identification, because the studies, by and large, are -- are seeking -- part of the exclusion -- or the inclusion criteria is someone who is identified as gay, lesbian, bisexual. Those individuals are not, generally speaking, the ones with same-sex attractions, found in conservative religious environments.
BY MR. WILLIAMS:
Q. What are those people called within that?
A. Christians. They call themselves Christians.
Q. I see.
A. And they have same-sex attraction. At least, that's what -- how they would prioritize their identity. It's a religious identity prioritization --
Q. Got you.
A. -- as opposed to a sexual orientation identity prioritization.
Q. And to some degree, it's a labeling, is it not?
A. It's an identity, self-labeling, yes.
Q. Yeah.
A. But it has --

Q. All right. Forgive me. I'm a lawyer --
A. It's all right.
Q. -- not a psychologist or psychiatrist.
But I do want to make sure I understand one thing. A member of -- it's your opinion, your testimony that a member of a conservative religious population would not label themselves a gay, lesbian, bisexual, or transsexual; is that correct?
MR. GANNAN: Objection. Misstates testimony.
A. Many wouldn't. There are some that do, yes.
BY MR. WILLIAMS:
Q. But most would not, would you say?
A. Probably most on the more conservative side of things.
Q. They would use a different way of describing it?
MR. GANNAN: Objection. Speculation. Asked and answered.
BY MR. WILLIAMS:
Q. Right?
A. They would describe themselves using a religious identity as their primary identity.
Q. Do you know whether that religious population deems homosexuality as sinful?
MR. GANNAN: Objection. Vague. Calls for

speculation.
A. They certainly may.
BY MR. WILLIAMS:
Q. Have you ever heard them say that, any members of that population?
MR. GANNAN: Objection. Vague.
A. I have.
BY MR. WILLIAMS:
Q. How would that impact any therapeutic procedure that you as a clinical psychologist might provide to them, if at all?
MR. GANNAN: Objection. Vague. Calls for speculation.
A. If that is the language the client uses, I would acknowledge it. It's a reflection of their moral view and the life they aspire to live by.
Does that answer your question? I'm sorry.
BY MR. WILLIAMS:
Q. I thought you were going to say something more. If that's your answer, that's your answer.
A. Well -- what was the question?
MR. WILLIAMS: Read the question back, if you would, please.
(The question was read back as follows:
"How would that impact any therapeutic

procedure that you as a clinical psychologist might provide to them, if at all?")
A. Well, I would say that is one reason they may come with a desire to perhaps explore in speech -- in a speech-oriented therapy the fluidity of their sexual attraction and to see if they may be able to shift, experience some shifting towards their desired attraction.
BY MR. WILLIAMS:
Q. What is the desire attraction?
A. Well, it would probably be, for instance, if they were married, they'd probably wish to have more heterosexual responsivity to their wife.
Q. And so you used the term "fluidity" again. You've used that several times. What do you mean by "fluidity" in the context of our discussion here?
A. Just the research seems to suggest that the components of sexual orientation are fluid over time for many individuals, not all, but for many. They change.
Q. They're not static?
A. They're not static, no, not all. There's -- you can't classify one size fits all, but for many individuals they're not static. That's correct.
Q. They may change over time. Is that what you

are talking about?
A. Yes, particularly for youth and for young adults.
Q. Youth being what?
A. Under 18.
Q. What would be the range under 18 that you normally would see that fluidity?
MR. GANNAN: Objection. Vague.
BY MR. WILLIAMS:
Q. Age range, I'm sorry.
A. Well, I mean, the age range where that fluidity would show up?
Q. Yes.
A. Studies were done probably mid -- I'm trying to think.
Q. Sure.
A. Again, this is not --
Q. Take your time.
A. -- 100 percent certain, but studies looking at certainly the mid-teen years to early adulthood.
Q. 14, 15 to --
A. Could be 13, 14, 15, yeah. So a lot of shifting happens during those years.
Q. Was it your opinion, sir, that human sexuality is inherently fluid?

MR. GANNAN: Objection. Vague.
A. My opinion is that it's an extremely complex subject, a lot left to be understood; that reports are that some people experience changes in their sexuality, not in significant number, some people do not.
BY MR. WILLIAMS:
Q. Do you agree with the following statement: "Thus while same-sex attractions may not be experienced as chosen, it is reasonable to hold that they can be subject to conscious choices, such as those that might be facilitated in SOCE, sexual orientation change efforts"?
Do you agree with that statement?
MR. GANNAN: For the record, may I ask where that is being read from?
MR. WILLIAMS: From my work product notes.
MR. GANNAN: Okay.
A. With the caveat that what you're thinking about in terms of SOCE may not be what I'm thinking, I would agree with that statement.
BY MR. WILLIAMS:
Q. Would you also agree with the following statement: "Same-Sex attractions and behaviors are not strictly or primarily determined by biology or genetics and are naturalistically subject to significant change,

particularly in youth and early adulthood"?
MR. GANNAN: Objection. Compound. Vague. Calls for speculation.
A. For many people, yes.
BY MR. WILLIAMS:
Q. What do you mean by "Naturalistically subject to significant change," then? If you agree with that statement, what does that mean?
MR. GANNAN: Objection. Vague. Calls for speculation.
A. My understanding of that is that it means it can change in kind of dynamic interaction with the environment such as affectional, romantic relationships. That's a big one. It may be subject to other influences that would change. I mean, we don't know too much about it other than it does change. For some people, again. I would never overgeneralize this.
Q. Well, does the phrase "naturalistically subject to significant change" apply to heterosexual, opposite-sex attractions?
A. Most natural --
MR. GANNAN: Objection. Vague.
A. The studies suggest most naturalistic change is occurring towards the heterosexual direction, when they do these longitudinal studies. The heterosexual

orientation tends to be the most stable. The next -- I think the next stable are the -- are those who are gay or lesbian who never had any kind of heterosexual or opposite-sex attractions, and then in the bisexual continuum often has a favor of fluidity.

Q. So I'm thinking as you are talking. Does that mean there's more fluidity among people with same-sex attractions than among people that have opposite-sex attractions?

MR. GANNAN: Objection. Vague.

A. That's my reading of what that research is purporting.

BY MR. WILLIAMS:

Q. Well, I'm thinking of it logically. I'm really trying to understand these series of questions. In your experience, are there many people, human beings, who identify as gay or lesbian that are sufficiently fluid -- to use your term -- that they're capable of developing an attraction for a member of the opposite sex?

MR. GANNAN: Objection. Vague. Misstates testimony.

BY MR. WILLIAMS:

Q. By themselves?

A. Are you talking about naturalistic?

Q. Yes.

A. Can you repeat the question? That was a long question.

Q. Okay. I'm learning as we're talking, and these are questions that are being posed to me in my own brain. So let me see if I can repeat -- actually, why don't you read it again, and let me see if I can improve on it if you don't understand it when she reads.

(The question was read back as follow:

"Well, I'm thinking of it logically. I'm really trying to understand these series of questions. In your experience, are there many people, human beings, who identify as gay or lesbian that are sufficiently fluid -- to use your term -- that they're capable of developing an attraction for a member of the opposite sex?")

MR. GANNAN: And I renew my same objection.

A. Well, the reason I'm struggling with it is because generally people who are, you know, identified as gay or lesbian, that's their identity and they really don't have an interest, and that's their perfect right, to pursue that identity. And so I'm not sure that I can quite follow the question.

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BY MR. WILLIAMS:

Q. All right. Let me change the question. I think what you are saying -- correct me if I'm wrong -- that if somebody identifies themselves as gay or lesbian, they're really not all that interested of fluiditing back to where --

A. Exactly.

MR. GANNAN: Objection. Vague. Misstates testimony. Go ahead.

BY MR. WILLIAMS:

Q. So to change the terminology of the labeling here, Doctor, what if somebody doesn't identify themselves using the label "gay" or "lesbian," but rather they -- to use your terminology and this is where I'm trying to understand -- they identify themselves as Christian, albeit, with same-sex attraction and so forth, homosexual.

A. Got it.

Q. Now, do those people have enough fluidity, in your opinion, to be capable of developing an attraction to the opposite sex?

MR. GANNAN: Objection. Vague. You can answer.

A. I think that's very broad. I think there are some. That's part of what professional psychology is,

is we assess this issue. Right. We don't just go in with an agenda. We assess. For instance, what level of fluidity this person may have experienced outside of therapy.

BY MR. WILLIAMS:

Q. Okay. That's a very good question. When you say "level of fluidity," how would you determine that? We're not talking about minors now. We're talking about people over the age of 18. How would you assess the level of fluidity that an adult under the law has? -- to just follow up on the answer you just provided to me.

MR. GANNAN: Objection. Vague. Calls for a legal conclusion.

A. It would be by self-report.

BY MR. WILLIAMS:

Q. What do you mean?

A. I would ask them, for instance, you know, in experience, what percentage would you say, you know, would you experience -- do you experience same-sex attractions versus opposite-sex attractions, and they would give me a figure, and I take that into consideration.

BY MR. WILLIAMS:

Q. That would give you some sense of the level of

fluidity?
A. Exactly.
Q. And if it was -- I'm going to use some hypotheticals here because I want to make sure I understand this. Let's say the individual said, "Well, 80 percent homosexual or same-sex attraction, 20 percent opposite-sex attraction." How would your therapeutic approach be different for that person as opposed to the opposite, 20 percent homosexual, 80 percent heterosexual?
MR. GANNAN: Objection. Vague. Incomplete hypothetical.
BY MR. WILLIAMS:
Q. Those are the two levels of fluidity, if I follow your testimony.
A. What were the percentages again?
Q. One says 80 percent same-sex, 20 percent opposite-sex; and the other is the converse, the obverse, 80 percent heterosexual, 20 percent same-sex.
A. How would that affect?
Q. Your approach to the therapeutic modality that you use.
MR. GANNAN: Objection. Vague.
A. I would think one thing it would do in terms of the informed consent issue, I would probably say if

you've had experience, you know, research may suggest that past experience of fluidity would be your ability to pursue that in therapy, might be more so than someone who had less of that fluidity, so it would affect my assessment, in part, of the likelihood that this experience could experience it.
BY MR. WILLIAMS:
Q. Could experience what?
A. Could experience fluidity, say therapy assisted fluidity.
Q. Okay. Now you're confusing me because I'm looking at my hypothetical if somebody has 80 percent opposite-sex attraction and 20 percent same-sex, what I understood you to say -- correct me if I'm wrong -- is that human being, the level of fluidity is more likely to receive the benefit of SOCE, i.e., change it back to heterosexual, than somebody who is the opposite, 20 percent heterosexual and 80 percent homosexual. Did I get that correctly?
MR. GANNAN: Objection. Vague. Misstates testimony.
A. I think what I said is the more a person has experienced fluidity in the past, whatever that percentage, I think the greater the likelihood that they could experience that in a therapy context.

BY MR. WILLIAMS:
Q. Could experience what in therapy?
A. The fluidity.
Q. Define "fluidity" in the context of that answer.
A. If they wanted to make shifts towards, let's say, opposite-sex attraction --
Q. Yeah.
A. -- or diminishing of the same-sex attraction.
Q. So a person who has 80 percent opposite-sex, 20 percent same-sex versus a person that's 20 percent opposite-sex and 80 percent same-sex, that former person is probably a better candidate to shift back or have fluidity back towards being totally heterosexual. Is that what you are saying?
MR. GANNAN: Objection. Vague. Misstates the testimony.
A. I don't talk about categorical change, which is, you know, the person usually, I think, if they're coming, they want to see if they're attractions are subject to some degree of fluidity. So becoming completely opposite-sex attracted, you know, that's not necessarily the goal. They can experience some fluidity that is satisfying and meaningful for them, then that's a benefit to them.

BY MR. WILLIAMS:
Q. I'm going to confess that I, in listening to your answers, I am gleaning that you are using the word "fluidity" with different nuances depending on the question that I'm asking you.
Because if someone is already 80 percent heterosexual and only 20 percent homosexual, what I have concluded from your answer is that that person is more likely to change over to pure heterosexual than somebody who is 80 percent homosexual and 20 percent, you know, and that would have an impact on the therapeutic modality that you would use?
MR. GANNAN: Objection. Vague. Misstates testimony.
BY MR. WILLIAMS:
Q. Does what I say make sense?
A. There's a lot there. If same-sex attractions are in question, I don't know if it would change -- so in my approach it would change, I think, things I want to tell the client to create realistic expectations and not set the client up for disappointment. Right? And I make no promises about these things.
Q. Sure. So, again, the 80/20, 80 being heterosexual, 20 being homosexual, probably you can have more likely expectation of some success, if that's

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what they want to do, to become totally heterosexual versus the converse. Is that a good way to put it?
MR. GANNAN: Objection. Vague. Misstates testimony.
A. It might be easier for that person to get to 90 percent than the person with 20 to get to 90 percent.
BY MR. WILLIAMS:
Q. Got you. Okay. Or even 100 percent; right?
A. Potentially, but that's fairly rare.
Q. Really. Okay. Have you dealt with what we've been talking about with respect to minors in your practice?
A. I have certainly had parents bring their minors in out of concern, so if that's what you mean, you know, yes.
Q. And when that happens, are you charged with -- you know, the other word for SOCE is conversion therapy -- of trying to convert their child back to heterosexual?
MR. GANNAN: Objection. Vague. Assumes facts not in evidence and misstates testimony.
A. My experience is that parents, these kind of parents, they're not -- I've never had a parent say, "Doc, would you change my child to heterosexual."

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They're concerned with their child. Sometimes just with the behavioral aspects. If the child has been sexually active, they want information. Right. And, of course, now in California I have to -- in my informed consent, I have to say, "I cannot speak to your child in a way that may be construed as encouraging any kind of change." I can educate still. I can talk about the science. I can certainly ask questions of a minor, which I would, but in my experience the vast majority of these cases, what I end up doing is saying the child is just not a candidate for therapy. I have to make that assessment. That's my job to make that assessment.
Q. The child is not a candidate for therapy for what reason?
A. Not a candidate for change.
Q. Not a candidate for change.
A. For therapy. Correct. And that's my job as a professional. Not the state, but that's what I'm trained for. I make that assessment. And when I decide or assess that this child is not a candidate for therapy in that regard, then I would typically meet with the parents and I will educate them and tell them, "You have a precious child. You need to love your child. You need to keep the lines of communication

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open with your child, if at all possible, and -- because you don't know what's going to happen in the future. You don't know, and you don't want to alienate your child, so that they -- so that even if they make choices that you disagree with theologically that you cannot -- they cannot come back to you."
So that is what I would say to the parent of a child who is just not a candidate for, you know, the goal of change of sexual attractions and behaviors.
MR. WILLIAMS: Thank you. Read that answer back. That was a long answer, and I appreciate it, but you are a lot smarter than I am so I'm trying to follow all of this.
(The answer was read back.)
A. Yeah. Not a candidate for any focus on that issue. I can still meet with the adolescent and talk with them.
BY MR. WILLIAMS:
Q. I understand. That would be the same in Tampa, too, wouldn't it, based on the ordinance, or do you know that?
MR. GANNAN: Objection. Calls for a legal conclusion. Vague.
BY MR. WILLIAMS:
Q. If you don't feel qualified to answer the

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question, that's fine, Doctor.
A. I don't know. I don't like the fact that it's -- it's -- even in California, it's not clear what speech constitutes conduct and what speech is subject to normal speech protections.
Q. We'll get to that in this case, I think. Okay.
A. Yeah.
Q. But you made the statement make choices theologically that they don't agree with, the parents don't agree with. Does that mean the population that you are talking about is children from parents who are conservative religious?
A. That would be by and large. I mean, that would be the overwhelming number, yes.
Q. Okay. So you are basically telling the parents that your child is not a real candidate for change if that's what the parent is looking for; is that right?
MR. GANNAN: Objection. Vague. Misstates testimony.
BY MR. WILLIAMS:
Q. Is that right?
A. Not only is it illegal now in California, I would say the same thing prior to the law, that, you

know, therapy, even a minor requires a volitional choice. Right. If it's -- and this is one of the egregious aspects of the way it's portrayed.

Coercive -- any coercive element in a therapy automatically eliminates it in my mind as being a therapy. So coercion is not a part of what I would do.

Q. So there is parental coercion that is antithetical to a legitimate therapeutic medium; is that correct?

MR. GANNAN: Objection. Vague. Misstates testimony.

A. It's not like the parent is taking the child to some kind of conversion therapy. The parent is concerned. They may not be thinking much of anything, other than they're distressed, their child is distressed. So part of my task is to help the parents decrease their distress, as well as, you know, if I'm allowed, understand and give that child some help in terms of reducing his or her distress.

BY MR. WILLIAMS:

Q. What if the child is a candidate, in your opinion? What do you do then?

MR. GANNAN: Objection. Vague.

BY MR. WILLIAMS:

Q. Assume that the law in California doesn't

exist.

A. It would probably be the same thing as I would do with an adult. And, usually, you know, this not going to happen with a 13-year-old. This is more like a 16- or 17-year-old. The first thing I would do, and my training calls for, making a thorough assessment of the client history, one feature which may be their experience of fluidity. But I also really want to understand how they see.

This is what I tell parents, "I want to understand your child through your child's eyes," so I want to do all that empathic understanding of how the child sees their situation.

I want to ask the child, "How do you see your same-sex attraction? What do you think -- what is your understanding of where they come from? How do you feel about them? What do you believe? What are your values around that?" All right.

So I would elicit all this information to get a sense of, is this -- you know, is this child, is this person, you know, freely consenting to this, and are they a candidate? And this -- I want to make sure it's clear -- this is not some exotic therapy.

Q. Okay. Doctor, in 2013, if my homework is correct, you wrote an article in human sexuality

entitled, "Countering a One-Sided Representation of Science: NARTH Provides the 'Rest of the Story' for Legal Efforts to Challenge Antisexual Orientation Change Efforts (SOCE) Legislation."

Is that a true statement?

A. Yes.

(A discussion was held off the record.)

BY MR. WILLIAMS:

Q. Why did you write that article, sir?

A. That, if I'm thinking correctly about this, because I've written quite a few things, it may have been adapted from my earlier declaration in the Pickup trial.

Q. Your earlier declaration?

A. I have to see it to remind myself the context.

Q. See the article?

A. See the article, yes.

MR. WILLIAMS: Let's just take a -- not a break, but a pause.

The date of your declaration in the California case, the Pickup case out there was November 16, 2012. If that helps.

MR. GANNAN: That's Exhibit 1 you are referring to?

MR. WILLIAMS: Yes.

(A discussion was held off the record.)

(Exhibit No. 2 was marked for identification.)

BY MR. WILLIAMS:

Q. I have had marked as Exhibit 2 to your deposition here a copy of the article that I was alluding to earlier.

(A discussion was held off the record.)

BY MR. WILLIAMS:

Q. So it's a copy of the article that I read into the record prior to our pause, just so the record is clear, and the name of the article or the title of the article is "Countering a One-Sided Representation of Science: NARTH Provides the 'Rest of the story' for Legal Efforts to Challenge Antisexual Orientation Change Efforts (SOCE) legislation."

And the date of this article, according to what I'm about to give you is July 26, 2013. So let me hand you this copy. That is Exhibit 2 that I just handed to you. It's a copy of the article that --

MR. GANNAN: And just for the record, I think Exhibit 2 is the entire edition of the Journal of Human Sexuality that contains that article, if I'm not mistaken.

MR. WILLIAMS: Probably so.

MS. ROBBINS: Yes.

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BY MR. WILLIAMS:
Q. My focus is on your article. I want to make sure --
A. I got it.
Q. You said you had to look at it, and I want to make sure that I've done my job to assist you in identifying the article that I asked you about.
A. Oh, it's going this way.
MR. GANNAN: You can unclip it if it's easier.
A. I just needed to look at...
So, yes, this is partially based on my declaration of the California case.
BY MR. WILLIAMS:
Q. Well, the question is, is Exhibit 2, does it contain the full article which you wrote and I identified on the record? Take your time to look through it to make sure you can answer my question accurately.
A. I guess I will agree to that.
Q. I'm sorry?
A. I guess, yes.
Q. You guess yes or --
A. Yes, as far as I can tell, under these circumstances.
Q. Sure. Would you turn to page 143 of your

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article, please. Just let me know when you're there.
A. Okay.
Q. All right. In the bottom part of page 143 there's a roman numeral III. Do you see that down there that's bolded, the subtopic; correct?
A. Uh-huh. Okay.
Q. You have to say "yes" or "no."
A. Yes.
Q. All right. Right above that there is a paragraph, and I'm going to read that into the record, but before I do that, I would like you to take the time, at your pace, to read that paragraph that starts with the word "causatively." And the reason I'm asking this question is I'm going to tell you, is because you used that word or some derivation of it in your last answer, and it triggered my memory of this particular part of your article.
A. Yes.
Q. Have you read it?
A. Yes.
Q. I'm going to read it into the record. Follow me carefully, make sure I don't misspeak.
"Causatively, then, sexual orientation is by no means comparable to a characteristic -- such as race or biological sex -- that is thoroughly immutable.

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Thus, while same-sex attractions may not be experienced as chosen, it is reasonable to hold that they can be subject to conscious choices, such as those that might be facilitated in SOCE. Same-sex attractions and behaviors are not strictly or primarily determined by biology or genetics and are naturalistically subject to significant change, particularly in youth and early adulthood. This should raise serious questions about the legitimacy of SB 1172's and AB 3371's portrayal of same-sex attractions and behaviors as static traits to be embraced only by those minors who might otherwise pursue SOCE."
Did I read that paragraph correctly?
A. Yes.
Q. Let's start at the beginning. You use the term "causatively." Please tell me what you mean by that term in the context of the sentence in which you use it.
A. It has an influence in giving rise to.
Q. Let me go to the last part of that sentence which says, "that is thoroughly immutable." I think I understand what the word "immutable" means, but I want to make sure it's the same as your understanding. Why did you use the word "immutable"?
What do you mean by that in that context?

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A. Not subject to change without exception.
Q. So what you're saying there, if I understand it, is that a person's race is immutable. You're either Caucasian or not Caucasian; you're either Asian, or you're not Asian. Am I correct? It's an objective characteristic?
A. Repeat that, please.
Q. By using the term "thoroughly immutable" after the reference to race or biological sex -- I'll use biological sense -- you are either a male, or you're not a male biologically; is that correct?
A. I believe so, yes.
Q. And that's what you mean there?
A. Yes.
Q. All right. And you are saying that causatively sexual orientation is by no means comparable to that, i.e., an immutable characteristic of someone's being. Am I correct?
A. In the sense that it is subject to some degree of change and fluidity, yes.
Q. "It" being what?
A. The components of sexual orientation.
Q. Whereas my biological sex is not really subject to change, sexual orientation is. Is that what you are saying?

MR. GANNAN: Objection. Vague. Misstates testimony.
A. I either have X and Y chromosome or XX chromosome or I don't. In that sense, biological sex is immutable.
BY MR. WILLIAMS:
Q. Yes. But sexual orientation is not. Is that what you're saying?
MR. GANNAN: Objection. Vague.
BY MR. WILLIAMS:
Q. In that sentence?
A. The components of sexual orientation are -- can be subject to change. That's people's experience.
Q. Okay. Isn't that the objective of SOCE?
MR. GANNAN: Objection. Vague.
BY MR. WILLIAMS:
Q. To cause change?
A. I think a better way of putting it, at least in terms of how I would describe it, is by using mainstream techniques we will see -- and based on the client's own understanding of their sexual attractions and their history, it would be to see whether a change emerges in the process of therapy.
Q. But change is an integral part of SOCE, is it not?

MR. GANNAN: Objection. Vague.
A. Again, in professional counseling, looking at exploring fluidity with a client is only going to happen, and it's only through talk, and it's only going to happen if that is what the client requests.
BY MR. WILLIAMS:
Q. That's a practical answer. My question is really the acronym SOCE, sexual orientation change efforts, the word "change" is there for a reason, because the efforts are to effectuate change, if you are providing SOCE to the client at the client's request?
MR. GANNAN: Objection. Vague. Asked and answered.
BY MR. WILLIAMS:
Q. Is that a correct statement, sir?
A. Not exact, no. I do not use the term "SOCE" in my practice.
Q. Well, you used it in your article.
A. I know because that's the standard language that I have to use --
Q. Why?
A. -- in these circles. For instance, I write an article, if I don't use SOCE and I try to submit it to APA journal, if I use what the Alliance would prefer to

use "sexual attraction fluidity exploration" in therapy, if I use that term, my manuscript would be kicked out in a nanosecond.
So it's the -- there's a hegemony with regards to the language, and so if I'm going to have anything published, it's going to have to work with that language, but I personally have a distaste -- and understand that this language was developed by people who aren't sympathetic to these goals.
Q. Aren't sympathetic to what goals?
A. The goals of a client who wished to pursue the fluidity in their same-sex attractions.
Q. Fluidity in their same-sex attractions being changing their same-sex attraction; right?
MR. GANNAN: Objection. Vague. Misstates testimony.
A. See, this is where language is so poor.
BY MR. WILLIAMS:
Q. It's critical, sir.
A. But I would say experiencing shifts, experiencing movement, experiencing change. If you want to define that as change, that's fine. SOCE, in my mind, implies orientation change, and that's not something I promise. And that's not something that happens frequently. We're talking about change on a

continuum of change.
Q. Well, SOCE stands for sexual orientation change efforts. The "E" is for "efforts," is it not?
A. That's what it stands for.
Q. Yeah. Effort doesn't necessarily mean you are going to succeed in changing back to being heterosexual. It just means you are going to make that effort. Am I right?
A. Whose effort are we talking about?
Q. Pardon?
A. I'm sorry. Whose -- what's your understanding -- whose effort is this?
Q. Whoever is utilizing SOCE in therapy?
A. Okay. So it's the client's effort, right. Okay. So I would help facilitate that if it's the client's effort. And facilitate, again, seeing if it will emerge by working on -- working with sorts of against standard therapeutic practices.
Q. Well, I think what you told me was that you wouldn't even engage in it unless the client wanted to pursue that effort?
A. Absolutely. Freely chosen.
Q. And obviously in any clinical or therapeutic situation, the client/patient has to contribute to the overall objective, do they not?

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A. Has to be completely client centered.
Q. Sure. I mean, that's --
A. That's psychotherapy 101.
Q. It's life 101, sir.
And that's where the "E" comes in. The client has to embrace the effort part of the SOCE, does she not?
MR. GANNAN: Objection. Vague. And objection. Calls for a legal conclusion.
A. That would have to be a freely chosen, self-determined goal of the client.
BY MR. WILLIAMS:
Q. Now, let me go to the next sentence. You say, "Thus, while same-sex attractions may not be experienced as chosen" -- take that first clause. What does that mean? Elaborate on that, "experienced as chosen"?
A. For the most part, a strong majority of individuals experiencing the same-sex attractions, they sort of discover it rather than make a choice, say, "Okay. I'm going to be a gay adolescent today." They may label that later, but it's a discovery.
Q. Okay.
A. That's how they would describe it.
Q. Thank you. I think I understand that.

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And you say, "Such as those that might be facilitated" -- excuse me. Let me read the whole thing.
"Thus, while same-sex attractions may not be experienced as chosen," -- you just clarified that clause -- "it is reasonable to hold that they can be subject to conscious choices, such as those that might be facilitated in SOCE."
Okay. All right let's take that second clause, "subject to conscious choices." What do you mean by that?
A. I'm just thinking for a second.
Q. Please take your time.
A. I think it suggests that there are choices a client can make that may indirectly impact their experience of same-sex attraction but are not directly related -- they're not choices, like to chose their experience of having same-sex attraction, but choices they might make.
I mean, I guess one example would be a woman may choose to, because of romantic attraction or romantic interest on emotional attraction to a male, they may choose to be in a relationship and have a relation with that male, and through that, they may experience shifts in their attractions, so that they

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actually are attracted to that male in an erotic fashion, or at least that potential would develop. So they would be making choices not directly to change, but in the context of making choices to partner with a man that they may experience that kind of fluidity.
Q. A young woman may discover that she has same-sex attractions, and then at some other time may think to herself, "Well, Charlie over there, I like him," and she may make a conscious choice to experience that kind of sexual --
A. Not exactly like --
MR. GANNAN: Objection. Vague.
A. Not exactly like that, no. She may choose, if she wishes to be with him, for other reasons, and in the course of emotional intimacy, over time, that she may find her attraction for him sexually emerge out of that. She's not making the change like that.
BY MR. WILLIAMS:
Q. And her sexual attractions for other women would then be diminished. Is that --
A. That's -- I assume that is theoretically possible, but at that point, it would not be relevant for her. And it's...
Q. And then you go on to say, "such as those that might be facilitated," which I take to mean a fancy

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word for making easier, smoother or so forth, "by SOCE."
Did I read that correctly?
A. Yes.
Q. And SOCE, I recognize that you are forced to use that term?
A. Exactly.
Q. But it does mean sexual orientation change efforts. To somebody like me, who is not a member of the APA, that's the way I read it, and the "change efforts" would result in conscious choices, would they not?
MR. GANNAN: Objection. Vague.
BY MR. WILLIAMS:
Q. If they're successful. That would be the goal, at least, would it not?
MR. GANNAN: Objection. Vague.
A. I'm not sure I follow your question.
BY MR. WILLIAMS:
Q. All right. Let me see if I can rephrase it. Let me read the whole sentence, and then we'll break it down just a bit.
"Thus, while same-sex attractions may not be experienced as chosen" -- we went through that, not chosen, discovered -- "it is reasonable to hold that

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they can be subject to conscious change" -- in other words, I make a decision to change, just like I might make a decision to stop smoking or start smoking. That's a conscious choice -- "such as those that might be facilitated in SOCE."

So I'm reading that to mean that a sexual orientation change effort as part of a therapeutic venue would make it easier for that person to make a conscious choice to be more heterosexual than less heterosexual?

MR. GANNAN: Objection. Vague. Misstates testimony.

BY MR. WILLIAMS:

Q. Did I -- is that --

A. No, you are incorrect.

Q. Tell me how I'm incorrect.

A. Back to this "conscious choice" piece, the woman who chooses that she wants to have a relationship with a man after -- you know, maybe she's had same-sex attractions and may be in a relationship with a woman, she's choosing at that point to follow -- maybe she likes the companionship, she has an emotional intimacy with him that she hasn't experienced with a man before, and so she chooses to relate to him, to grow in that relationship depth emotionally.

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She's not choosing not to have same-sex attractions at that point, but what she will choose is her relationship with him. And over the course of time -- and this would be an example of naturalistic change -- over the course of time, she may find that her sexual responsivity to him grows, but it's not like she's choosing, "Okay. I'm going to respond now."

Q. I get that. I understand what you just said.

A. That's what I mean. It's not like choosing.

Q. The naturalistic part I certainly understand. I'm glad you said it, because I don't read the last clause of that sentence, "such as those that might be facilitated in SOCE" as being naturalistic. I read that to mean that, if this person goes through SOCE, that process will facilitate, make easier, her ability to choose, a conscious choice, to become more heterosexual rather than naturalistically head in that direction. That's the way I read the sentence. You can convince me that I'm wrong, because I can't read it any other way, Doctor.

MR. GANNAN: Objection. Vague. Misstates testimony. And asked and answered.

A. It's hard to answer without -- I can give you an example, but I don't know if that's called for here. Again, it's -- the approach is to work on -- first work

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on the distress of the client. And if the client, for instance, feels, let's say, that they believe that trauma, childhood trauma influenced their sexual attractions, then using speech and only speech we would address the trauma, and if they believe that the trauma might be connected to the -- have some influence on the development of same-sex attraction, so we would work on the trauma, and they may find, if they do, no guarantees, that in addressing the trauma, their fluidity increases.

So in that sense they're working on related issues, but not necessarily straight head on the attractions, but they may find that the attractions do shift in relationship to the work of, like, trauma work.

Q. Fluidity and shifting being second cousins, so to speak; right?

A. Okay.

Q. Is that a good way to put it?

MR. GANNAN: Objection. Vague.

BY MR. WILLIAMS:

Q. Strict language. Can't shift without some fluidity, can you?

A. I'll just leave it at fluidity. I mean --

Q. Well, let me ask you this question, then. I

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don't want to interrupt. Did you finish?

A. Go ahead.

Q. If SOCE is irrelevant, why didn't you just say "such as those that might result from a naturalistic change"?

MR. GANNAN: Objection. Vague.

BY MR. WILLIAMS:

Q. In that sense as opposed to invoking facilitation by SOCE?

A. Again -- and this gets down to my view of it -- the difference is the client has come and has a goal of therapy. They have self-determined a goal. I would like to see what level of fluidity or -- you know, change my sexual attractions may have, you know.

So that, in my definition, is the distinctive part about what SOCE is, is that I'm following the client's goal.

If I understand these laws correctly, I have to say to that client, if the law is placed, "I cannot help you with this. I cannot serve this goal of yours through speech." I can't do that.

Q. You can talk about it under the California law, can't you?

A. I can't -- not in a way -- that's the danger. I can't talk about it in a way that can be construed as

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change, whatever that means.
Q. As facilitating a conscious choice in one direction. Is that what you're saying?
MR. GANNAN: Objection. Vague. Calls for a legal conclusion.
A. It is vague. I don't know what constitutes speech that becomes conduct and is -- could be considered the attempt to change by virtue of things I'm saying.
BY MR. WILLIAMS:
Q. Change efforts require the client to embrace the notion that, if change is going to take place, she or he is going to have to --
A. I'm sorry.
MR. MIHET: Let him finish his question, please.
A. Sorry.
BY MR. WILLIAMS:
Q. And --
MR. MIHET: Rob, are you asking or testifying?
MR. WILLIAMS: I'm thinking right now. I'm asking a leading question. I can do that because he's your expert. But it's more of an inquiry.
Read back the first part of my question.
(The question was read back as follows: "Change

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efforts require the client to embrace the notion that, if change is going to take place, she or he is going to have to --")
BY MR. WILLIAMS:
Q. The rest of that question, she or he is going to have to be cognizant of his or her own self-determination in that sense. If you don't exert efforts, Mr. and Mrs. Client, then no change is going to take place. Is that a fair way of saying that?
MR. GANNAN: Objection. Vague. Asked and answered. Compound. Misstates testimony.
A. The client has to be involved in the process for it to be therapy.
BY MR. WILLIAMS:
Q. The client has to be involved in making an effort to make any change that the client is looking for, does he or she not, also; right? If they're looking for change, they have to be a part of that change process. That is where the word "effort" comes from; right?
MR. GANNAN: Objection. Vague. Asked and answered.
A. Effort in that context may be the effort to address the trauma and to see whether it affects any fluidity experience on the part of the client. That

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would be the effort, for example.
BY MR. WILLIAMS:
Q. So I go back to my question: Why did you put the phrase "such as those that might be facilitated in SOCE"? Why didn't you just say "such as those that might be facilitated by the natural evolution of getting in touch with your feelings" or something like that?
MR. GANNAN: Objection. Asked and answered. And I'm getting the sense you are just asking the same question over and over.
MR. WILLIAMS: This is the last time I'm going to ask it, so...
A. I apologize that the language I'm forced to use is not very helpful in this. But, again, my distinction is so the issue is the client has a self-determined goal to pursue their fluidity as part of the therapeutic experience in order to see what may be possible and what may come about, what may emerge through the use of standard psychotherapeutic techniques.
BY MR. WILLIAMS:
Q. Well, the reason I've kind of focused on this, Doctor, is --
A. I see.

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Q. -- is raised by the next sentence, which says -- and I'm going to read it word for word. "Same-sex attractions and behaviors are not strictly or primarily determined by biology or genetics and are naturalistically subject to significant change, particularly in youth and early adulthood."
So I go back to the last clause of your earlier sentence, "such as might be facilitated in SOCE." Well, given what you said in the next sentence, that are "naturalistically subject to significant change," why does SOCE have anything to do with it?
Why wouldn't you put "naturalistically such as those are facilitated by naturalistic efforts which can lead to significant change." Why wouldn't you say it that way?
MR. GANNAN: Objection. Vague.
A. I'm sure that naturalistic efforts are happening frequently outside of therapists' office. However, these are individuals who are coming to their therapist because apparently those naturalistic elements have not sufficiently, anyway, addressed their goals; otherwise, they wouldn't come to therapy.
BY MR. WILLIAMS:
Q. You finally couple the first part of that paragraph that we've gone over with the sentence, "This

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should raise serious questions about the legitimacy" of, I guess, the two pending statutes in California. Is that what they were called?
A. Well, the one was AB 3371 was the New Jersey.
Q. Oh, okay. So SB was California, and AB was New Jersey?
A. That's correct. And they were very similar.
Q. And AB New Jersey is the King case, is it not?
A. Correct.
Q. Were you an expert in that case?
A. No.
Q. How are you familiar with that, sir?
A. I was asked to, I guess -- again, I said this earlier, and I'm not sure the terminology -- but I submitted some kind of declaration on behalf of the plaintiffs in the case.
Q. So --
A. But I did not come and do a deposition or anything like that.
Q. No, I understand that.
A. Okay.
Q. But you did prepare and file a declaration on behalf of the plaintiffs in the New Jersey case?
A. That's correct.
MR. MIHET: Objection.

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BY MR. WILLIAMS:
Q. At whose request?
A. I'm sure it would've been Liberty Counsel.
Q. Mr. Gannam or Mr. Mihet?
A. No. No.
Q. The other guy, Schmidt?
A. I don't know for sure who was handling that case.
Q. Just a lawyer with Liberty Counsel?
A. Yes.
Q. Do you know where that lawyer was located geographically?
A. No. I'm sorry.
Q. It wasn't Mr. Schmidt; correct?
A. I don't know for sure.
Q. You can't remember. Okay.
A. I just really don't know.
Q. All right. So your declaration in the California case and your declaration in the New Jersey case were both result of requests by lawyers from Liberty Counsel; correct?
A. I believe so.
Q. And the same is true in this case; right?
A. Yes.
MR. WILLIAMS: All right. Why don't we break for lunch.
(A brief recess was taken.)
BY MR. WILLIAMS:
Q. Dr. Rosik, do you have your declaration handy? If not, I can give you a copy.
A. I do not have mine. I just have what you gave me here.
Q. All right. I'm going to mark --
A. Maybe it is. This is --
Q. That's different. I'll have this marked as Exhibit 3, which is a copy of your declaration in this case.
MR. WILLIAMS: I will give you a copy.
(Exhibit No. 3 was marked for identification.)
BY MR. WILLIAMS:
Q. All right. Let the record reflect that the court reporter has marked as Exhibit 3 the declaration of Christopher Rosik, Ph.D., dated May 6th, 2019. Would you turn to page 25 of Exhibit 3, Doctor, and just confirm that is your signature.
A. Yes.
Q. And would you peruse your declaration and just confirm for the record that it appears to be what I have represented it to be, and that is an authentic copy of your declaration?

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A. It appears to be.
Q. Turn to page 23. Actually -- well, we can start at 23. Actually, start at 24, please. I direct your attention to paragraph 77 on page 24 of your declaration.
A. 77?
Q. Paragraph 77 on page 24 of your declaration.
MR. MIHET: That's not 24.
MR. WILLIAMS: It is in mine.
MR. MIHET: It only goes to 75 in the copy you gave me.
MR. WILLIAMS: You are absolutely right. My apologies, Doctor. I'll have marked as Exhibit 4 your rebuttal.
(Exhibit No. 4 was marked for identification.)
BY MR. WILLIAMS:
Q. And would you turn to page 27 of your rebuttal declaration and confirm that that is your signature there as well?
A. Yes.
Q. Dated July 17th, correct, of 2019?
A. Yes.
Q. Now, turn to page 24 of your rebuttal declaration, and you should see paragraph 77. Do you see that, sir?

A. Uh-huh, yes.
Q. Read the first sentence of paragraph 77 to yourself, if you would, please.
A. Okay.
Q. In the first sentence of paragraph 77 on page 24 of your rebuttal declaration, you use the phrase "ideologically left-of-center dominance of professional mental health association leadership and the community of academic psychology."
Did I read that correctly?
A. Yes.
Q. First, what do mean by "ideologically left-of-center dominance"?
A. It has multiple layers of meaning.
Q. I'd like all of them.
A. One would be political.
Q. Political in what sense?
A. I guess, party affiliation, which is somewhat of a proxy for other things, values.
Q. What do you mean "party affiliation"?
A. Republican, democrat, independent, libertarian.
Q. Okay. Let's go one by one. Of the ones that you -- of the party affiliations that you just identified, which are the ones that are left of center?

A. Obviously, there's variation, but overall, I would say the democrat party is left of center, leans left of center.
Q. And the republicans are?
A. They would probably lean right of center.
Q. What is center?
A. With variation.
Q. What is center?
A. Well, in terms of policy, I mean, it's things like the role of government. And, of course, when you are talking about APA comes in, it would be more on social policy matters.
Q. So is your belief that -- let me correlate it back...
To turn back to page 19. Take a look at the last sentence of paragraph 56, which is at the top of page 19. Do you see that, sir?
A. Yes.
Q. And turn to the prior page, 18, paragraph 55 where the last -- next to the last sentence uses the term "essentially politically and ideologically homogenous, left-of-center groups."
Do you see that?
A. Yes.
Q. And then at the bottom of paragraph 56, you

use the term "conservative prospectus," do you not?
A. Which paragraph? I'm sorry.
Q. 56, at the top of 19.
A. Yes, although that is the language of authors, but I would tend to concur.
Q. All right. And then we've already gone through the "ideologically left-of-center dominance."
A. I should add that that -- yeah, that's self-identified conservatives and -- liberal, progressive -- yeah, so it would be self-identification, yes.
Q. A person who identifies as a conservative person politically. Is that what you are referring to?
A. I think that would be included in there, yes.
Q. What does "conservative" mean in today's medium? Do you know?
A. I will give you my understanding of it. I have for a long time had very much of an interest in the moral dimension. And the authors here, particularly the one Jonathan Haidt, H-A-I-D-T, is a psychologist, social psychologist now at New York University.
He has done a lot of work in what he calls moral foundations theory. I don't know if I talk about it here, but basically a lot of interesting research

that suggests that those who -- he's identified through evolutionary and a cross-cultural analysis what he describes as six different moral foundations, which are -- foundations are like taste buds is the example he gives.
So people have these six pretty universal moral foundation. And left-of-center folks would -- self-identified, I should say, have a different profile on these moral foundations than those who would be conservative. Essentially --
Q. Right of center?
A. Right. Right of center, right.
Q. So you identify conservative with the right of center, and left of center, you consider them liberal?
A. Left center would probably be liberal progressive, as you go further out. Again, I like -- I'm not so much interested in the political aspect. I'm interest in the moral aspect, which is really fascinating stuff.
And that is that of these six moral foundations, self-identified liberals tend to really emphasize what he calls the harm-care foundation. And that is essentially -- what he says is the sacred values of those left of center is caring for those who they perceive to be oppressed and that is at the heart

of the care-harm foundation.

And so there's also a fairness and reciprocity --

Q. Reciprocity.

A. -- reciprocity foundation. I messed that one up.

And that's just about playing on a fair field and basic ideas of fairness.

And then is a liberty-oppression foundation, which has to do with those deemed to oppress or otherwise restrict the freedoms of individuals, and so self-described liberals tend to score very high on the harm-care foundation and the -- somewhat less so on the liberty-oppression foundation.

Now, conservatives, self-identified conservatives, there are three other foundations. One is disrespect for authority, order. They like order in society, and there is an in-group loyalty, which would be like a certain nationalism or loyalty or church or family, and then there is the purity foundation, which is a lot of the sense of sacred and avoiding contamination, bodily, spiritually.

And conservatives tend to score much higher on those three foundations than self-identified liberals do. So you have a mismatch that liberals --

self-identified liberals tend to form the moral sense around harm-care, whereas conservatives tend to have more equal distribution across all six foundations.

And so what happens is -- and this is interesting research on this -- that because of their emphasis on harm-care, liberals, they -- left of center, will -- they don't really recognize morality based on purity, based on in-group loyalty and respect for authority, especially when it comes into conflict with care-harm/harm-care considerations. Right.

So their value is caring for oppressed peoples; whereas the conservative, self-identified, tend to be more concerned with just preserving the integrity of the institutions of society. So they're concerned with groups and establishment of groups.

Another way of putting it is that for the liberal, things like the institutions and the groups in society are servants of the individual. They're there to help the individual, to serve the individual; whereas for conservatives, these groups, individuals in a sense have an obligation to the institutions. That's a big difference.

And I think it shows up in -- one of the reasons why some of these cultural debates go on is because I think we're arguing from, essentially,

different moral frameworks, although for the -- and this is one of his articles, for the left-of-center individual whose morality is based primarily on harm-care considerations. They don't recognize it as moral. It doesn't compute as a moral consideration.

Like, let's say, purity, sanctity. Example might be what you were giving earlier, like scripture. That doesn't seem you can base a moral argument on scripture. Just makes no sense in terms of harm-care, at least in places.

And so my view is underpinning a lot of this conflict, which I am very -- I grieve about. A lot of this conflict is these very discordant moral visions. What is good? What is the good life? What is -- how does one achieve fulfillment? How does one achieve what makes for a thriving life?

This is all undergirding it. And you can tell by the language people use, the moral people language use.

So that would be an answer to your question. That's how -- one of the ways I define the idealogical difference. One that I'm most familiar with and appreciate, as providing understanding in these debates, is the moral issue, moral ideology, moral beliefs. Where does morality stem from? What makes

for a moral argument? Those kinds of things.

DR. HUDSON: That's a great answer.

MR. WILLIAMS: It's an answer.

BY MR. WILLIAMS:

Q. Do you know who Graham Nash is?

A. Is that Crosby, Stills, Nash & Young?

Q. Yeah.

A. That's about all I know of him.

Q. Returning to paragraph 77 where you state -- and I'm going to read this into the record -- "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 community" -- "and the community of academic psychology?"

I read that correctly, did I not?

A. Yes.

Q. Amplify the word "ideologically" as it is connected to "left of center." I heard your answer, and listened very carefully to it. I don't remember you saying the word "ideologue" or "ideologically" or "ideology" in your --

A. Perhaps I should've said -- with regards to in this case I could've said "moral ideology, morally

ideologically left of center." That would be included in there. I suppose it could be more, but that's primary sense that I have, and I've thought about these issues that way.

Q. A moral ideology that is left of center or right of center, as the case may be?

A. Yes.

Q. And that moral ideology would -- essentially, I can understand it by the lengthy answer you gave me a little while ago; right?

A. Yes.

Q. So if I go back and read the transcript, I should have a pretty good grasp of it?

A. I hope so. Probably there's much more to it than what I tried to explain.

Q. These are all very interesting questions. What is the source of your information that the professional mental health association leadership is dominated by morally ideologically left of center?

A. Well, I've been a member of the APA since 1984, I believe. So I'm pretty familiar with the workings of the organization. I'm not involved in them, but I certainly read what they put. You can be pretty sure, for instance, the resolutions, when they touch on social issues, you're pretty much guaranteed

they're going to sympathize with a more socially liberal or progressive perspective.

Q. A left-of-center perspective?

A. Yeah. Yeah.

Q. And why are you assured of that fact? How would one know that?

A. Oh, you can go look at the resolutions on the website, APA website. They have a list -- source of all the resolutions that they've provided, and you can -- if you want to read them all, they will -- you'll kind of see where they come down on these.

Q. So if I -- I'm just a lawyer. I'm not a psychologist or a psychiatrist.

A. Yeah. Yeah.

Q. But if I were to go to those resolutions and read through them -- and hopefully I'm a politically and socially astute, reasonably well-read citizen of the United States of America, which I think I am --

A. Uh-huh.

Q. -- I would read all those and come to the conclusion, in your opinion, that those resolutions have a left-of-center bent in them?

A. The ones that touch on --

MR. GANNAN: I just want to object. It assumes facts not in evidence.

A. The ones that touch on -- you know, sort of contentious social issues, yes.

BY MR. WILLIAMS:

Q. And SOCE is a contentious social issue?

A. I would say that it has become that.

Q. So what you are really saying -- and I think you've said it in your declaration -- is that the leadership of the APA is liberal, not conservative; right?

A. Broadly speaking, yes.

Q. Is that a negative thing or a positive thing, or it doesn't matter?

MR. GANNAN: Objection. Vague.

A. You know, there is a good analogy that Nicholas Cummings, the former APA president said, you know, for science to thrive and for most anything to thrive, for the plane to land -- to take off, it needs a left wing and a right wing. If it only has one wing, it doesn't function very well. And if the organization leadership has one wing, it's not going to function at its optimal because it's missing, it's missing input, it's missing perspective, it's missing like viewpoint diversity.

BY MR. WILLIAMS:

Q. And is it your belief that the APA, for

example, which is the one you've been referring to, ignores the viewpoint of the right-of-center members of the organization?

A. It does not represent them. That is why many have left over the years. But they don't feel represented.

Q. Okay.

A. That does not mean -- I mean, for the record, like I said, I've been a member, I think APA does a lot of good things. I don't have animus toward it as an organization. It's just when they touch on these sort of social issues that it's difficult for me to feel represented by them.

Q. I understand what you're saying. And has a counter-organization been formed by those who have left the APA because they don't think they're represented, to come up with their own organization to reflect the values and thoughts and prospectus and viewpoints of more conservative psychologists? Right of center, I guess you call it.

A. That's -- that one is a little harder to say. I think the younger generation, they're not affiliating with organizations, not nearly as much. I don't know if that is the way it is with the legal associations, but younger professionals are not affiliating as much

as the older ones did. But I certainly know of individuals who have departed or disagreed seriously with the APA on some of these sort of, like I said, social policy resolutions.

I don't really see them starting their own organizations in the mass. I think they may -- some of them have religious backgrounds may affiliate with some of the smaller faith-based mental health organizations. Some have gotten tired with all the politics and joined -- there's another American Psychological Society, APS I think it's called. It doesn't weigh in on a lot of policy stuff. They simply want to promote science. They're not -- they don't, I think, present themselves as political.

(Exhibit No. 5 was marked for identification.)

BY MR. WILLIAMS:

Q. All right. Doctor, I have marked as Exhibit 5 to your deposition a copy of Ordinance No. 2017-47, which is the ordinance that is the subject matter of this litigation that we're here today on.

It's the ordinance that was enacted by the City of Tampa City Council back in March of '17 and -- actually, April of '17 and approved by the mayor, then Mayor Bob Buckhorn on April 10th, 2017. The court has taken judicial notice of this ordinance, and I don't

think there is any issue as to its authenticity and accuracy.

MR. GANNAN: I will stipulate the court has taken judicial notice of the ordinance, that it is the ordinance.

BY MR. WILLIAMS:

Q. Sure. Could you review it and tell me if this is the ordinance that you looked at prior to today that you alluded to earlier this morning?

A. I believe so. It's been a while.

Q. All right. We've been talking about the left-to-center/right-to-center dichotomy amongst the leadership of the American Psychological Association, among other things.

A. Sure.

Q. Are you familiar with the report --

MR. WILLIAMS: So I'm going to have marked as Exhibit 6 a copy of what I'm about to talk to you about.

(Exhibit No. 6 was marked for identification.)

BY MR. WILLIAMS:

Q. Just as an intermediary topic of discussion, Exhibit 6 is a report by the American Psychological Association and specifically a Task Force on Appropriate Therapeutic Responses to Sexual

Orientation.

Are you familiar with that?

A. Yes.

Q. How do you define "sexual orientation," sir?

A. Well, I have a definition that I use, but it's challenging because there is lots of discussion about how to define it. But I guess you can say that sort of the bones of it might be the direction which, to a greater or lesser extent, the person's sexual attractions and behavior and identity is oriented.

MR. WILLIAMS: Read that back to me, please.

(The answer was read back.)

BY MR. WILLIAMS:

Q. "Sexual identity" I think is a word that you haven't used before. Is that the same as gender identity?

A. I don't believe so.

Q. How would you distinguish between the two?

A. Gender would be --

Q. Gender identity.

A. Yeah. The degree of which I identify as a male or female or something in between, I guess. Sexual identity would be more my sexual attractions, be they exclusively oriented to same sex or to the opposite sex or -- and behaviors, I would say. How I

identify myself, my sexual affections and behaviors.

Q. Okay. So that's the distinction between gender identity and sexual identity, what you just articulated as far as you are concerned?

A. I mean, I'd need to probably think about it to give you the best answer more, but --

Q. We'll come back to it then.

A. But, yeah, I mean, there's --

Q. Let me move on.

A. -- there's gay, lesbian, bisexual, sexual orientation. There is transgender.

Q. Back to the ordinance, Exhibit 5.

(A discussion was held off the record.)

BY MR. WILLIAMS:

Q. You are familiar with the APA report with the Task Force on Appropriate Therapeutic Responses to Sexual Orientation, Exhibit 6, are you not?

A. Yes.

Q. And I'm going to assume that you've read that task force report thoroughly prior to today. Is that a correct statement?

A. Yes.

Q. And you've mentioned that you had also reviewed the ordinance, Exhibit 5, but it's been a while; correct?

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A. Yes.
Q. All right. When you read the ordinance, whenever you read it for the first time, did you note that the task force report, Exhibit 6, was identified in the ordinance itself?
A. Yes, that's part of the boilerplate.
Q. What -- you call boilerplate. You mean it's --
A. It's in every -- every proposed legal document, proposed legislation. It's -- you are going to see that.
Q. Is that good or bad or is it indifferent, in your opinion?
A. I don't know. I know why it's there.
Q. Why is it there?
A. The appeal to authority. As I mentioned in my declaration.
Q. What do you mean by that?
A. I think the American Psychological Association is seen -- I mean, is an appeal to the broader reader, to the politician and otherwise as an authoritative organization, so they appeal that way.
Q. Do you see the American Psychological Association as an authoritative organization?
A. Depends on the domain. I think in domains

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where they have no significant advocacy interest they are very authoritative. In areas where they have clear advocacy interests, which they make no bones about, I would say that's where you get your issues with confirmation bias and incomplete science.
Q. Okay. Referring to the last "whereas" clause, on page 1 of the ordinance, Exhibit 5, there is a reference to the task force report that is Exhibit 6 to your deposition, is there not?
A. Yes.
Q. It reads "Whereas, the American Psychological Association's Task Force on Appropriate Therapeutic Responses to Sexual Orientation ('APA Task Force') conducted a systematic review of peer-reviewed journal of literature on Sexual Orientation Changes, SOCE," and then it goes on to talk about that. I'm not going to read the whole thing.
What do you know about the task force that it refers to right there?
A. I know I guess -- you know, I don't know personally the individuals on the task force, but --
Q. You don't know any of the individuals that made up the task force itself; is that true?
A. Not on a personal level. I know a few of them, I mean, in terms of some of the writings and

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things like that.
Q. Have you ever talked, literally conversed with any member of the task force that came up with Exhibit 6 about the subject matter of the task force report?
A. The subject matter of the task force report?
Q. Yes, appropriate therapeutic responses to sexual orientation, that's what I would call the subject matter. That's what they --
A. I'm just trying to think if we talked specifically about that, but I have spoken with one member of the task force.
Q. Who would that be?
A. Dr. Beckstead.
Q. And Dr. Beckstead, what is his full name?
A. A. Lee Beckstead.
Q. Is Dr. Beckstead still alive?
A. Yes.
Q. Where does he reside, if you know?
A. I believe he is in private practice in Utah.
Q. Salt Lake City?
A. I believe so.
Q. When did you talk to Dr. Beckstead about this report?
MR. GANNAN: Objection. Assumes facts not in

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evidence.
BY MR. WILLIAMS:
Q. Well, you said you talked to him, did you not?
A. Yes. I don't remember if we talked specifically about the report, though.
Q. I'm sorry. I misunderstood you.
Do you recall that you talked about the report when you talked to Dr. Beckstead?
A. I recall that he presented at an Alliance conference a couple of years back, when it was in Utah, and he spoke -- you know, referenced the report.
Q. Do you remember what he said? If you don't, that's fine too.
A. I think he said that there were aspects that he would do differently if he were doing that committee again.
Q. Well, he was a member of the task force that came up with the report, was he not?
A. Yes.
Q. Is Dr. Beckstead -- how would you characterize him, left of center or right of center?
A. In terms of his approach to these issues, we would have some differences that I would put him up to left of center. I don't know politically if that's the case. We didn't have those kind of conversations. But

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I would say we have civil disagreements about certain aspects of this subject matter.
Q. SOCE?
A. SOCE and -- yeah.
Q. So as it relates to the subject matter of the report, you would consider Dr. Beckstead to be left of center; is that correct?
A. As it relates to his perspective on SOCE, I would say that would be more in keeping with someone who has sympathies in that direction. I don't know. I don't know of other things regarding his affiliation.
Q. I could care less about his political stuff.
A. Okay.
Q. I'm talking about this. If somebody can tell me what a real conservative is today --
A. But, again, I am speculating. We haven't really talked specifically about this. I just heard him talk about it.
Q. I'm just asking your opinion --
A. Yes.
Q. -- as to whether or not you deem Dr. Beckstead to be left of center, right of center, or smack dab on the center?
MR. GANNAN: Objection. Asked and answered.
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BY MR. WILLIAMS:
Q. You are saying that, as far as you are concerned on this subject, the subject report, he's left to center. Is that a correct statement?
A. I would say -- I mean, if he agreed with everything in the report, then we would have some differences about how to understand that. My sense would be those differences would be reflected in my earlier assessment about my -- his sort of moral prospective on things and my perhaps moral perspective on it. That's, again, how I would want to understand those issues.
Q. That's a little difficult for me to comprehend. So from a moral perspective as it relates to appropriate therapeutic response to sexual orientation, is he left of center, in your opinion?
A. It would be a general -- close to a complete guess, but if I had to completely guess, pull it out of a hat, I would say he is probably left of center, at least in comparison to me.
Q. Are you right of center, sir?
A. I would say I'm probably right of center. Part of our -- part of our obligation as professionals is to understand our biases, that's why I'm so interested in the moral -- the moral framework of

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things.
Q. Yes. All right. And so Dr. Beckstead, if I recall your testimony correctly, is the only member of this task force that you have actually spoken to; is that correct? Based on your memory?
A. That would be correct.
Q. And the other members of the task force, if you have any knowledge of them, it would be derivative? And what I mean by "derivative," it would based on reading materials that they have prepared or things of that nature?
A. Well, that would not be correct.
Q. Correct me then, please.
A. I have gone to probably half a dozen APA conferences over the years. I know for a fact, at least once, I listened to Dr. Glassgold speak on the panel. I'm trying to think of the other members. It's possible I've heard other members in the context of workshops or seminars, you know, symposiums at the APA conferences.
Q. And so whatever you know about Dr. Judith Glassgold, who is an expert in this case, as you well know, because you've rebutted her declaration --
A. Yeah.
Q. -- you would know from comments she made at

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these conferences, the APA conferences and perhaps also from what you've read of hers. Is that a true statement?
A. I believe so.
Q. All right. That's Dr. Glassgold. Any other member of the task force that you have heard or read that you've garnered some knowledge about their thinking?
A. Well, as I understand, the members of the task force, at least five of them were LGB identified, and so when you're looking at just the -- where the LGBT-identified individuals tend to affiliate or affiliate with a party, it would be a democrat party. That doesn't mean all of them do. I'm not being excessive, or I'm not trying to say there aren't exceptions. I'm just saying I believe it's pretty clear that most, many, the majority certainly would identify with a democrat party affiliation.
Q. When you say five of the members of the task force were LBG identified, you mean that they themselves are either lesbian or gay or something like that? Is that what you mean?
A. I believe that was the number, yeah.
Q. How do you know that? How do you know whether somebody is a lesbian or a gay man?

A. Well, what I recall is that Dr. Nicolosi had a piece that he did some work and looked at their writings and looked at their -- how they identified, and that was his conclusion. He put it out there. I mean, it's on -- I think it's probably still on the Internet. And it seemed pretty -- I haven't read it for a while, but it seemed pretty supportive of that conclusion.

Q. Okay. Let's drill down a bit down, if I may. Dr. Nicolosi was not a member of the task force, was he?

A. No.

Q. Dr. Nicolosi is someone that I think you would identify as right of center, would you not?

A. I think that's --

MR. MIHET: He was.

BY MR. WILLIAMS:

Q. Was. Thank you.

A. Correct. Yes.

Q. Dr. Nicolosi lives on in spirit. Okay.

MR. MIHET: Though, perhaps not with the party affiliation.

THE WITNESS: Yeah.

MR. WILLIAMS: Who knows. Who knows.

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BY MR. WILLIAMS:

Q. And so Dr. Nicolosi, right of center when he was alive and perhaps still, who knows, did some research or reading and as a result of whatever he did, he put out something in writing that at least to you informed you that five of the members of the task force were gay or lesbian or --

A. Identified.

Q. -- identified, yeah.

MR. GANNAN: I just object to -- misstates the testimony.

A. I would have to review that article to -- I mean, I haven't read it in a while, so I am trying to recall to the best of my ability. I think that's what it said. Again, it was based on their own self-descriptions and affiliations and those kinds of things, as I recall.

BY MR. WILLIAMS:

Q. According to Dr. Nicolosi; right?

A. Well, I mean, I believe he pulled them from sources.

Q. I got it. But your source of information is something that Dr. Nicolosi gleaned from their writings or whatever they did, these five people; right? Isn't that correct?

A. I don't know if I gleaned it all. It was kind of confirming. I mean, it doesn't take much to do a Google search on somebody and find out sort of what their affiliations are.

Q. Have you done an individual Google search on those five?

A. No.

Q. In any event, to the extent that you believe that five of the members of the task force were -- let's just call them homosexual in one form or another, that's based on Dr. Nicolosi's writing that he obtained by looking at a bunch of other stuff; is that correct, sir?

MR. GANNAN: Objection. Misstates the testimony. Dr. Rosik testified that he believed they identified as LGBT, not that he concluded they were.

BY MR. WILLIAMS:

Q. Did they identify to you, sir, these five people?

A. Dr. Beckstead has identified as a bisexual.

Q. Say that again.

A. I said Dr. Beckstead has identified as a bisexual.

Q. Okay. So Dr. Beckstead is -- he said, "I'm

bisexual." Okay. You used the word identify, but I just talk straight language. I'm either bisexual, or I'm not bisexual. So -- and I'm not, by the way. But Dr. Beckstead has publicly stated he is bisexual; correct?

MR. GANNAN: Objection. Asked and answered.

BY MR. WILLIAMS:

Q. Correct?

A. I believe he made comments to that effect when he was at the conference, the Alliance conference. He's also talked about it in other communications, so he's identified himself that way.

Q. Well, that's fine with me. I'm just trying to find out the source of your information. Was he one of the five of the task force that you are talking about?

A. Yes.

Q. Have the other four ever identified to you, to use your term, "identified," I'm either bisexual or homosexual? Do you have any firsthand knowledge of that?

A. Not directly to me.

Q. So I go back to where I started. Any knowledge you have as to the sexual identity of the other four members of the task force that you claim to be -- believe to be LGB is based on what Dr. Nicolosi

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wrote in his paper; is that correct?
A. No, it's not exclusively that.
Q. Well, what else is there? Tell me what else there is.
A. I think I make certain deductions from a person's involvement in say Division 44 of the APA, which is the division for sexual orientation and gender diversity. There was a Division 44 charge that provided people to develop the document, the report. I mean, the APA, it was the ultimate charge, but I believe many of those individuals are affiliated with Division 44.
Q. Many of what individuals?
A. On the task force.
Q. Members of the task force?
A. Yes, I believe so. I'm not -- I don't want to be -- I could have -- I may be accurate, but I think most, if not all of them, are.
Q. Dr. Rosik, if a psychologist is a member of the APA and also a member of Division 44, is it your opinion that they are -- either are gay or probably gay?
A. I think there's a strong possibility.
Q. What does that mean?
A. I mean, I'm not wanting to say it's universal.

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There are probably non-GLBT-identified individuals with the division.
Q. But the fact that they're members of Division 44 is a deduction on your part, is it not?
A. Just as if I'm a member of Division 36, which is the division of the psychology for religion and spirituality, that probably I have an interest in that, if I'm a member. I may have some active involvement in faith-based matters if I'm a member of that division.
Q. Certainly, I agree. That doesn't necessarily mean you are religious person, does it? Devout Christian, that doesn't mean that, does it? It doesn't actually lead to the conclusion that you, sir, are a devout Christian, does it?
MR. GANNAN: Objection. Compound.
A. I wouldn't use the word universally. I would use the word "probabilistically."
BY MR. WILLIAMS:
Q. More probable than not? How does that sound?
MR. GANNAN: Objection. Vague.
A. I guess I would agree with that.
BY MR. WILLIAMS:
Q. How many members of the task force were there? Do you know?
A. I believe there were six members and one,

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sometimes he is counted a sixth or seventh, but the executive director or something. I don't have -- I mean, it's right here. Yes, six members and the staff liaison.
Q. And who is that?
A. Mr. Anderson, probably Dr. Anderson.
Q. So I think what you are saying is that out of the six members of the task force, it is far more probable than not that five of them were either homosexual or bisexual?
MR. GANNAN: Objection. Misstates the testimony.
BY MR. WILLIAMS:
Q. Well, tell me if it misstates it. I want to be correct.
A. I think that's possible. I am not wanting to conclusively say that that is the case, but based on, again, my sense of Division 44, and how divisions work, that there's a -- there's a reasonable probability that five or so have that identification.
Q. As homosexual or bisexual?
A. They don't -- no, as gay or lesbian, bisexual.
Q. What is the difference between a gay and lesbian?
A. They detest the word homosexual unless it's

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used in a medical sense.
Q. All right. Let's use gay and lesbian.
A. Yeah.
Q. Five of the six, because they're part of Division 44, are either gay or lesbian or bisexual. We know that Beckstead has said he is bisexual, so knock him off. The other four you believe were either gay or lesbian because they are member of the Division 44; is that correct?
MR. GANNAN: Objection. Vague. Compound. Misstates the testimony.
BY MR. WILLIAMS:
Q. Correct me if I'm wrong. I don't want to misstate your testimony. I'm trying to understand it.
MR. MIHET: He has already corrected you a number of times.
MR. WILLIAMS: Good. He can correct me another time.
A. They -- there is a -- again, this is to my knowledge of it. They're a probabilistic possibility that that many other -- not all, but some of the others are, in fact, LGBT identified, LBG identified. Certainly, they are, you know -- they certainly share a moral and philosophical perspective, I guess, or that would be my -- my sense of it based on the document.

Q. All right. Which document, the report itself?
A. Yes.
Q. All right. So other than Dr. Beckstead, we can agree you have no direct knowledge of the other members of the task force because you haven't talked to them; they've never said to you, "I'm gay, I'm lesbian," have they? Isn't that correct, sir?
A. I'm trying to remember what I heard Dr. Glassgold talk about. She talked about I think her mother being -- kind of lapsing from her Jewish faith when she was -- I don't know if it was growing up or later in her life and how she, I guess, into more of a feminist, ardent feminist perspective, and I think that was influential for her.
Q. All right. That's your answer?
MR. MIHET: Let him finish. He's still thinking.
BY MR. WILLIAMS:
Q. If you are still thinking, think away and answer away.
A. I do recall that she said during her talk -- and this is in San Francisco last year, that -- I'm trying to get this right -- that "love overcomes even religious law." Pretty sure that's what the quote -- "love overcomes even religious law." Which isn't

something you would hear a conservative say. They would have a different understanding of it, I think.
What I do recall from these -- and I've been to a number of these symposiums from the APA, probably three over the years that they -- the subject matter is the conflict between religious values and same-sex attractions, and they present cases, case material from their practices of individuals who have this conflict between their religious values and their same-sex sexual behavior, and what I'm pretty confident about is, as they go through these cases, every single case is resolved in the direction of prioritizing sexual identity and essentially revising religious belief.
What struck me as -- and given the fact that I work with individuals for whom their religious identity tends to remain primary, even though they may experience same-sex attractions. And so it struck me as not in keeping with a broad client experience.
Q. Does that conclude your answer?
A. I'll stop, yes.
Q. Given your answers to the last half dozen questions I've posed to you, sir, is it your belief that the -- withdraw that question.
Do you know how the task force was selected by at APA?

A. I'm not confident in this. But I think they -- yeah, I'm not confident in it. There's a couple of ways you can do it. One is you can select directly: They can ask people to serve. Otherwise, they can have nominations of people, and then they go to those people and see if they're willing to serve.
So I don't know if it was a direct process of selection or if it was people needing to be nominated and then they select from those who are nominated. But it was probably something like that.
Q. Well, my question is do you know, and I think your answer is you don't know; is that correct?
A. Not more specifically than that.
Q. Well, that tells me you don't know. That's the way I understood your answer. You are speculating to the possibilities. You have no personal knowledge, do you, sir, actual direct knowledge as to how the task force was actually selected, do you?
MR. GANNAN: Objection. Asked and answered.
A. Only from my understanding of how the task force in general have -- operate within the APA.
BY MR. WILLIAMS:
Q. I'm not talking about task force in general. I'm talking about this task force.
A. I don't know why this task force would deviate

from that, but if that's the case, then I don't know within those specifics I've listed which was done.
Q. If you were to find out, how would you -- what inquiries would you make -- let me rephrase it.
If you wanted to know how the task force was constituted by the APA, what inquiries would you make and of whom?
A. I'm not sure. Is it in the document? It often is, but I don't know. I don't remember.
Q. Let me ask a follow-up question: Have you ever inquired of the APA as to how they constituted this particular task force?
A. I have not inquired.
Q. Why not?
A. In the broadest sense, the document, I mean, stands on its own, in terms of I don't need to know the backgrounds, the process of selection or the identities of the task force specifically to -- as I read the document, to understand that they're approaching this from a -- certain aspects of it anyway -- I think their interpretation of things would reflect as sort of a left-of-center perspective.
Q. So you can glean that left-of-center perspective for certain aspects of Exhibit 6 just by reading the substance --

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A. Well --
Q. Let me finish.
A. I'm sorry.
Q. -- substance of those sections that you just alluded to; correct?
MR. GANNAM: Objection. Vague. Misstates testimony.
A. Let me give you an example.
BY MR. WILLIAMS:
Q. Well, answer my question if you would, please.
Read the question back, please. And see if you can answer the question and then you can talk about it all you want, Doctor. I just want to make sure the record is clean here.
(The question was read back.)
A. I think I can make an educated guess.
BY MR. WILLIAMS:
Q. Is that the same as gleaning it?
A. All right. I guess, yes.
Q. Okay. Now, with that in mind, what you just confirmed in your last answer that you were able to glean from certain sections of reading the report by the task force that the task force had a left-of-center -- I used the word "bend" a lot.
A. Grid.

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Q. -- grid on those topics, those sections; is that correct?
A. Aspects of the report, yes.
Q. Yes. And in that sense, do you believe the report was rigged to begin with because of the constituted members of the task force?
MR. GANNAN: Objection. Vague.
A. "Rigged," I wouldn't use the language. I would probably say --
BY MR. WILLIAMS:
Q. It just seems to be in the national news so much.
A. I would say that there was risk of confirmation bias.
Q. Okay. And that risk of confirmation bias was itself confirmed when you read certain aspects of the report, because there it was. Is that what you are saying?
A. Yes.
Q. Thank you.
A. I will give you an example of this.
Q. Please. No, go ahead. Please give me example.
A. As part of preparation for this, I -- in 2008, the APA had a report on abortion and mental health. I think I alluded to this. And what's fascinating about that report is that the methodological critique that was used to conclude that SOCE is ineffective, that same methodological critique, in many respects, was used to show that there was no harm from abortion, at least first trimester abortions for women who don't have subsequent abortions.
So, again, the methodological criteria were applied very differently depending on the nature of the issue, and that gets back to the idealogical and moral perspective. So that with abortion, these studies that may have suggested there were harms, were ruled or basically ruled out or dismissed because these studies did not meet the methodological criteria that were efficient. Whereas, with the APA task force, there appear -- versus sexual orientation, they use many of those same methodological criteria to dismiss the efficacy, but they didn't use it -- they did not use those same criteria to talk about harms.
So with abortion, they use the criteria to talk about harms. With SOCE, they don't use it to talk about harms. They use it to talk about efficacy. That is a huge distinct -- I mean, that's the kind of thing that makes one suspect that there is a different standard being applied.

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Q. You would agree with me that the American Psychological Association is a generally well-respected professional association in the United States, wouldn't you?
MR. GANNAN: Objection. Vague. Facts not in evidence.
A. The research is suggesting that they're becoming less respected, especially by -- you know, the country, unfortunately, is polarizing, but they're becoming less respected by half the country who would consider themselves not in support of these -- some of these kinds of resolutions that they're putting out.
BY MR. WILLIAMS:
Q. Half the country, meaning the population -- there is about 340 million of us.
A. Oh, okay. I mean the red part of the country, conservative part. They're distrustful.
Q. I'm not talking about those people. I'm talking about psychologists.
A. Uh-huh.
Q. Is it generally a well-respected professional association in the United States of America by your colleagues, the psychologist in the country?
A. It depends again. I mean, psychologists are largely left of center. It's a caring profession. So

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one would understand that you would likely have more individuals in that profession that really stress the harm-care moral foundation. But there are certainly conservative psychologists who they just don't affiliate with the APA, but they --

Q. You said that earlier.

A. -- they don't -- they would not agree with the APA on these kinds of resolutions and policy statements and that sort of thing. I think I said there in my declaration, too, I mean, APA represents probably a 40 percent of psychologists in the country, which is a lot, but it's not the majority of psychologists. We don't know where they lean. I would suspect many of them probably are --

Q. Is the American --

MR. MIHET: Were you finished?

THE WITNESS: I'm done.

BY MR. WILLIAMS:

Q. I thought you were.

A. That's okay.

Q. If I interrupt you because I glean from your testimony that you're finished and you are not finished, you just to stop me and say, "I'm not finished, Mr. Williams. Let me finish."

A. Fair enough.

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Q. And I will be happy to do that, because I do not intend ever to interrupt your answer.

A. I'm sorry for interrupting you.

Q. I just want to make sure that you and I clear.

A. Right.

Q. You're the witness. You have a right to say anything you want.

Doctor, is the American Psychological Association the most visible psychological association in the United States?

A. I would say that's accurate.

Q. Is it the most prominent?

MR. GANNAM: Objection. Vague.

A. I guess if I had to lean, it would be yes.

BY MR. WILLIAMS:

Q. Now, you've spent quite a bit of time answering my questions, and I want to thank you for being as thorough as you've been, because I'm not a psychologist. I'm just a simple lawyer. I'm married to one, so I have some osmotic understanding of what you are talking about. I hardly believe that I'm an expert at all.

So if I'm a layperson, which I am when it comes to psychology, and I read Exhibit 6, this report, how would I know all about the biases and so forth that

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you have gleaned from reading it because I don't have the expertise that you do?

MR. GANNAN: Objection. Vague. Calls for speculation.

A. The sad fact is you probably wouldn't.

BY MR. WILLIAMS:

Q. Would not; right?

A. You would not be -- you know, you would have to be able to dig into the science to understand it, to understand what it says, what it can't say. You have to have knowledge of the APA, how it operates, their resolutions in these areas to kind of look at the whole -- a broader swath and say, you know, this is does not seem even handed.

Q. So as a layperson -- and as a layperson, I will confess, I would be also ignorant of this, just like I think you would probably be a layperson who is ignorant of a lot of legal stuff; right?

A. Yes.

Q. As a layperson ignorant of the science and profession of psychology, if I read this and said, "It makes sense to me," there's no real way to slice and dice it the way you have and to determine, as you've said, flawed, is there?

MR. GANNAN: Objection. Vague. Calls for

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speculation.

A. Not unless you were, I suppose, to talk with someone like myself, or I suppose there are some -- I mean, there are critiques of the APA. There are critiques of mental health organizations.

BY MR. WILLIAMS:

Q. Sure. Sure.

A. Along some of these lines that are on the Internet.

Q. There is no reason why, as a layperson, I can read the king's English and I'm pretty good at it, that I could read it and say it sounds okay to me, right, because the American Psychological Association is --

A. That's the appeal to authority.

Q. That's what you call the appeal to authority. I agree. I agree with you that's what you call it. Okay.

So if I wanted to learn about this stuff and read this and say, "Okay. American Psychological Association, this report is, gosh, over 100 pages long, all kinds of citations, the task force seems to be a pretty impressive group of people, well presented, no reason for me not to just accept it at face value," is there?

MR. GANNAN: Objection. Vague. Calls for

speculation.
A. I mean, can you rephrase the question? It's a little -- I'm not quite sure I get it.
BY MR. WILLIAMS:
Q. What I'm trying to convey to you, sir, is that -- I think you've already answered it, but I, as a layperson, could read a report like this, just like you could read an ABA report and not have any real reason to say, "This sounds okay to me"; right?
MR. GANNAN: Objection. Calls for speculation. And I think it's also getting beyond the scope of Dr. Rosik's assignment.
MR. WILLIAMS: Answer that question. And then if -- I don't want to spend a lot of time on it either.
A. I mean, I think that happens all the time.
BY MR. WILLIAMS:
Q. What happens all the time?
A. People who are ignorant by and large of the issues that go into play here, the inner workings of how scientific organizations are and the APA in particular, they would simply accept it on the authority of the APA, even if it is, like I say, flawed, although that is becoming -- like I said, that's becoming less. People are --

Q. But as a layperson -- but as a layperson, that's a reasonable thing for me to do, would you agree?
A. I think -- no, here's --
MR. GANNAN: Objection. Vague. Asked and answered.
A. I think a better of way of saying it really, if you are so inclined that way morally, you probably would agree. If you are not, I think you would have more skepticism. Right. So really -- and this is how anybody approaches science, because, you know, research even is subject to different interpretations. Certain questions shape how the data shows up. So if there was something that -- about it, a conclusion whatever, that didn't meet with my sense of morality, I would have a problem with it.
Example would be, you know, if -- and it didn't call for this, but if I as a conservative have a strong emphasis on respect for authority, like parental authority, I will just instinctively react to bans that take away that parental authority --
BY MR. WILLIAMS:
Q. Okay.
A. -- when it's just a matter of speech.
Q. Well, let me go back to the ordinance, if I

may.
(A brief recess was taken.)
MR. WILLIAMS: We're back on the record.
BY MR. WILLIAMS:
Q. Doctor, I refer you to the second "whereas" clause in the ordinance on page 1. That refers to the American Academy of Pediatrics. Do you see that, sir?
A. Yes.
Q. Are you familiar with the American Academy of Pediatrics?
A. I know of them. I -- you know, in some of the research, you know, obviously, from my declaration, I looked at it a little bit, but I'm not nearly as familiar with them as I am with the APA. I'm not a pediatrician.
Q. Correct. You are a psychologist?
A. Correct.
Q. Do you have any reason to believe that the American Academy of Pediatrics isn't a well-regarded professional organization?
MR. GANNAN: Objection. Calls for speculation. Beyond the scope of Dr. Rosik's opinions.
A. I really have no idea how they're -- how they're viewed within the public. I mean, it's just --

if I had to guess, I guess I would say they probably carry some esteem.
BY MR. WILLIAMS:
Q. Let me hand to you exhibit what I will have marked as Exhibit 7.
(Exhibit No. 7 was marked for identification.)
BY MR. WILLIAMS:
Q. Exhibit 7 is an article from Pediatrics -- or American Academy of Pediatrics publication in 1993. It's entitled "Homosexuality and Adolescence," and apparently it was written by the Committee on Adolescents, a committee of the American Pediatric Association.
I will represent to you that the document that we've marked as Exhibit 7 is the document that is referred in the second "whereas" clause on page 1 of the ordinance. Are you with me so far, sir?
A. Okay. Page 1?
Q. Of the ordinance.
A. Yes.
Q. The second "whereas" clause in the ordinance says, "Whereas the American Academy of Pediatrics in 1993 published an article in its Journal stating," okay, and then it says, it quotes, it has a quote in the whereas clause, does it not?

A. Yes.
Q. All right. Now, look page 633 of Exhibit 7, the "Homosexuality and Adolescence." And I'm going to read from page 633 under the subtopic "Concept of Therapy." If you go down about six or seven lines, you will see the following sentence: "Therapy directed specifically at changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation."
Did I read that correctly?
A. Yes.
Q. Now, if you look at the second "whereas" clause on page 1 of the ordinance, Exhibit 5 to your deposition, that is the same sentence that's quoted in the "whereas" clause in the ordinance, is it not?
A. Appears to be, yes.
Q. Okay. Look at the third "whereas" clause on page 1 of the ordinance, which -- and I will read it out loud -- states as follows: "Whereas, the American Psychiatric Association in December of 1998 published its opposition to any psychiatric treatment, including reparative or conversion therapy, which therapy regime is based on the assumption that homosexuality is a mental disorder per se and that a patient should change

his or her homosexual orientation."
Did I read that correctly?
A. Yes.
MR. MIHET: For the record, I think you said "and that" where it says "or that," but the document speaks for itself.
MR. WILLIAMS: Yes, it does. And if I said that, I mean "or."
BY MR. WILLIAMS:
Q. My first question to you is, is the American Psychiatric Association a well-regarded professional association?
MR. WILLIAMS: Objection. Vague. Calls for speculation.
BY MR. WILLIAMS:
Q. To your knowledge, sir.
A. I would say, you know, given the limitations I expressed before, I think within a certain segment of individuals it's esteemed. With others, they probably, when it comes to these kinds of proclamations, is probably suspect, at the public level.
Q. The public level meaning what?
A. People in general and --
Q. Non-psychiatrists?
A. Yes, but also psychiatrists that perhaps don't

share that perspective.
Q. But aside from that -- there is always a minority opinion -- is it a well-regarded professional association, to your knowledge, sir?
MR. GANNAN: Object. Asked and answered.
A. Within those circles, I would assume it is, yes.
BY MR. WILLIAMS:
Q. All right. And before I get into the quote and everything or the document itself that is referenced, it says, "which therapy regime is based on the assumption that homosexuality is a mental disorder."
Do you see that part?
A. Uh-huh.
Q. Do you agree that homosexuality is a mental disorder or mental illness?
A. I would not use that language, no.
Q. You disagree with that?
A. I don't think it's -- I don't think inherently it has to be. Okay.
Q. I don't know what you mean by that. Please expand on that.
A. And, again, I mean, I've done some assessments with individuals with same-sex attractions that are,

you know, quite good, I mean quite healthy, so clearly in and of itself, that's not language I would use.
Q. Okay. It's not the language you would use. Do you agree or disagree that homosexuality is a mental disorder?
A. I think I would --
Q. Yes or no, please, and then you can expand.
MR. MIHET: I'm sorry. You have to let the witness answer.
BY MR. WILLIAMS:
Q. I want a yes-or-no answer. You either agree or don't agree, sir.
MR. MIHET: It may or may or not be answerable with a yes or no.
MR. WILLIAMS: Sure, it is.
MR. MIHET: You can't dictate the answer. You get to ask the question. The witness gets to --
BY MR. WILLIAMS:
Q. I don't dictate the answer, but the question is answerable, yes or no. You either agree, or you don't agree. If you don't agree, expand on it.
MR. MIHET: You need to let the witness answer the way he wants to answer, not the way you want him to answer.
MR. WILLIAMS: I'm entitled to a straight

answer. You know that.
MR. MIHET: You are entitled to his answer, not yours.
BY MR. WILLIAMS:
Q. Can you answer the question, Doctor?
A. I would disagree that it is a mental disorder.
Q. In short, you don't consider homosexuality a mental disorder; is that correct?
MR. GANNAN: Objection. Asked and answered.
BY MR. WILLIAMS:
Q. Is that correct?
A. Not in terms of meaning that there is inherent mental pathology, emotional psychological pathology.
Q. If I changed the phrase "mental disorder" to "mental illness," would you agree that homosexuality is a mental illness?
A. I don't see the difference.
Q. Okay. You know that DSM-III and ultimately IV dropped homosexuality as a mental illness, do you not?
A. Yes.
Q. And it hasn't been indicated as a mental illness in DSM for a couple of decades or more; correct?
A. Yes.
Q. Do you agree with that?

A. Do you agree that the decision to remove homosexuality as a mental illness in DSM-IV and 5 is a correct decision.
MR. GANNAN: Objection. Vague. Asked and answered.
A. I understand it, and I can agree with it.
BY MR. WILLIAMS:
Q. Let me hand to you Exhibit 8.
(Exhibit No. 8 was marked for identification.)
BY MR. WILLIAMS:
Q. Exhibit 8 is referenced on the footnote to the third "whereas" clause, No. 2, I believe, and it is a hard copy, printed copy of the position statement that is alluded to in the third "whereas" clause, and it's entitled at the top, "APA Official Actions." APA in this case meaning the American Psychiatric Association, and that's different than the American Psychological Association, is it not, sir?
A. Yes.
Q. And the position statement, the title is "Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative Or Conversion Therapies)."
Did I read that correctly?
A. I'm sorry. What paragraph?

Q. That's the title.
A. Oh, the title. Okay. Yes.
Q. And then it says, before the substance of the article, or the position statement, "Approved by the Board of Trustees, March 2000, Approved By the Assembly, May 2000."
Did I read that correct?
A. Yes.
Q. Then it says, in quotes, "Policy documents," and I assume this is what this or else they wouldn't say it -- "are approved by the APA Assembly and Board of Trustees. These are position statements that define APA official policy and specific subjects." And then it quotes the APA Operations Manual.
Did I read that correct?
A. Yes.
Q. All right. Let me read into the record, and you tell me if I read it correctly.
In the preamble, it says, "In December of 1998, the Board of Trustees issued a position statement (see attached) that the American Psychiatric Association opposes any psychiatric treatment, such as 'reparative' or conversion therapy, which is based on the assumption that homosexuality is per se a mental disorder or based upon on a priori assumption that the

patient should change his or her sexual homosexual orientation."
Did I read that correctly?
A. Yes.
Q. Do you agree with that?
A. Yes.
Q. Then it says, "In doing so, the APA" -- again, in this context, it's the American Psychiatric Association -- "joined many other professional organizations that either oppose or are critical of 'reparative' therapies, including the American Academy of Pediatrics, the American Medical Association, the American Psychological Association, the American Counseling Association, and the National Association of Social Workers."
Did I read that correctly?
A. Yes.
Q. Go down to page 3, go to the fourth "whereas" clause down.
MR. MIHET: You're back on the ordinance now?
MR. WILLIAMS: Yes. I'm sorry. I apologize. Thank you.
BY MR. WILLIAMS:
Q. Page 3 of the ordinance, fourth "whereas" clause down, which reads as follows, Doctor: "Whereas,

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In 2016, the American Medical Association issued policy statement H-160.991, which expressly opposed the issue of 'reparative' or 'conversion' therapy for sexual orientation or gender identity."

Did I read that correctly?

A. Yes.

Q. Is the American Medical Association a well-regarded professional association?

MR. GANNAN: Objection. Vague. Calls for speculation.

A. Again, within -- when it comes to these kinds of pronouncements, I think it is respected within certain circles and not within others.

BY MR. WILLIAMS:

Q. And, apparently, Dr. Hudson represents the others.

A. Well, it's important to remember that AMA represents, at most, 20 percent of the doctors in the country. Many have left the AMA over things like Obama. The Affordable Care Act was opposed by a large portion of the membership, and so it can't be said to speak for probably 80 percent of the -- for sure 80 percent of physicians in the country.

Q. All right. The ordinance, you will agree with me has a number of "whereas" clauses referring to a

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number of associations, organizations which according to the "whereas" clauses take the position that is very similar to that of the American Psychological Association as relates to conversion therapy; is that correct?

MR. GANNAN: Objection. Vague. Assumes facts not in evidence calls for speculation.

A. Can you repeat the question.

(The question was read back.)

A. I guess I would agree with that, yes.

BY MR. WILLIAMS:

Q. Are you familiar with the term "SAMHSA"?

A. I'm familiar with it.

Q. What does it stand for, if you know?

A. Substance abuse and something, so I'm not as familiar with that document.

(Exhibit No. 9 was marked for identification.)

BY MR. WILLIAMS:

Q. I have handed to you Exhibit 9. Exhibit 9 is a lengthy document dated October 2015, and it is entitled Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth."

Do you see that on the cover?

A. Yes.

Q. And SAMHSA stands for, according to the front

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page, Substance Abuse and Mental Health Services Administration.

Do you see that?

A. Yes.

Q. And over to the left, it talks about the Department of Health & Human Services; correct?

A. Correct.

Q. Which is a federal agency, is it not?

A. Yes.

Q. Are you familiar with this SAMHSA document?

A. I've read it, but I wouldn't say that I've been able to dig into it to the same extent.

Q. You have read it, did you say?

A. I have read it.

Q. When did you read it, sir?

A. Within the last month. I think I read it once before that, a few years aback.

Q. Why did you read it in the last month? In connection with this litigation, for example?

A. Yes.

Q. Why did you read it in connection with this litigation?

A. Because it was referenced in Dr. Glassgold's declaration and I thought it would be important to at least have some cursory knowledge of it.

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Q. And when you read the SAMHSA report, Exhibit 9, did you obtain at least a cursory knowledge of its contents and substance?

A. Very cursory.

Q. It's a lengthy document. It's over, gosh, 65 pages or so, cites a lot of -- a lot of papers, like all you guys do.

A. Right.

Q. Everybody cites a lot of papers.

A. Right.

Q. Did you understand the contents of Exhibit 9, the SAMHSA report, sir?

A. As much as a cursory reading might allow, but there may be things that I don't fully understand because I couldn't dig into them.

Q. You couldn't dig into them. Is that what you just said?

A. Yeah, well, I mean, right, reflect on them.

Q. Why couldn't you?

A. The time I had to prepare was limited.

Q. The time you had to prepare for what? I'm sorry.

A. Prepare my rebuttal declaration.

Q. I see. So you read the SAMHSA report, Exhibit 9, in connection with preparing your rebuttal

declaration; is that correct?
A. Yes.
Q. And because you had a limited amount of time, you weren't able to perform more than a cursory review of Exhibit 9. Is that your testimony?
A. Yes.
Q. All right. And therefore had obtained a cursory understanding of what its contents are. Is that a correct statement?
A. Yes.
Q. Turn to page 11 of Exhibit 9. About a third of the way down you'll see a -- I have the advantage of a color version, so yours is not like mine, but it's a rectangular block that says "Professional Consensus on Conversion Therapy with Minors."
Did you see that?
A. Uh-huh.
Q. The ordinance that you have been reviewing with me from time to time today bans SOCE or conversion therapy as relates to minors only, does it not?
A. Yes.
Q. All right. Let me read into the record paragraph 1 under the heading, I suppose, the best way to put it, heading of "Professional Consensus on Conversion Therapy with Minors."

Now, first, when it says "Professional Consensus," what does that mean to you?
A. That looking just at the paragraph on top of it there, that these organizations, at least, I won't to say members of the organization, but the leadership and those who formulate these statements are in consensus.
Q. Okay.
A. Subject to the same sort of issues I'm concerned about with regards to restricted moral and political diversity.
Q. Right. You have said more than once today that you have some questions, issues, you take issue with the -- what you perceive to be a left-of-center bent I call that. You used another term. What did you use? I'll just say "way of thinking." Okay?
A. Viewpoint.
Q. That permeates the leadership of some of these organizations, particularly the American Psychological Association. Am I correct?
A. Certainly in these arenas.
Q. Yes. And the professional associations that are apparently included here, at least from what I read, is the American Psychiatric Association and the

American Psychological Association, the National Association of Social Workers. Those are the three that are identified at least right above the phrase --
A. Right.
Q. -- "Professional Consensus Conversion Therapy with Minors." And then the statements of professional consensus at the top speaks for itself, and I won't take the time to go over that.
So let me direct your attention, if I may, to paragraph 1 under "Professional Consensus of Conversion Therapy with Minors," and I will read it into the record out loud.
"Same-gender sexual orientation (including identity, behavior, and/or attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder."
Do you agree with that statement?
A. Can you clarify what is meant by "normal" in this context?
Q. I gave it its plain and simple meaning, because I don't know of any other meaning that you would ascribe to that word in the context of this.
A. Well, you can prescribe normal as being free of psychopathology, which may be the case. I think I

mentioned in the declaration there are other definitions. Statistically what normal would be, and then there is the definition, which probably many people that I work with would be working under, which would be a sort of a natural law definition.
Q. Are you finished?
A. Well, in other words, normal is framed by the physical realities of the body, and so normal might be defined as that which functions according to design, and so many people -- and that isn't necessarily implicitly implying any kind of pathology, but it is a different moral evaluation of the -- of behavior, so -- and I would say many people from a conservative religious context would read that and disagree with it based on a different definition than probably what's implied here. I'm assuming implied here is it's not pathological -- you know, maybe it occurs naturally, which is also not -- can't speak to the issue of the moral evaluation of the behavior.
Q. Well, let me rephrase my question and say this. From your answer that you just articulated into the record, I am concluding that you are not sure what the phrase "normal spectrum of human diversity" means in the context of the sentence numbered 1 in the document.

MR. GANNAN: Objection.
BY MR. WILLIAMS:
Q. Is that correct?
MR. GANNAN: Asked and answered. Assumes facts not in evidence.
A. I'm just saying there are different understandings of these words, probably from what these committees that have put these statements together and what they intend and what consumers or individuals that may come to therapists with conservative religious values, how they would read something like that.
BY MR. WILLIAMS:
Q. And I go back to my question. Just reading it as it is in plain simple English language, "normal spectrum of human diversity" -- "spectrum" you know what that means, don't you, Doctor?
A. Yes. But that's too simplistic. I mean, it's not --
Q. Hold on. Let me finish if I may.
A. I'm sorry.
Q. You know what "spectrum," means; right?
A. Uh-huh.
Q. You know what "human" means, don't you?
A. Yes.
Q. And "diversity," do you know what that means?

A. Yes.
Q. So the word that you are having some question about is the word "normal" modifying "spectrum of human diversity"; is that correct?
A. Well, we can argue some about whether spectrum -- you know, spectrum implies, generally speaking, a fairly equal distribution across a continuum, but in the case of sexual orientation, for instance, you have 90 percent heterosexual oriented and then much smaller percentages across the spectrum all the way to a -- maybe a -- yeah, it's not even a big number percentage.
Q. Okay.
A. So it's really more of a skewed distribution.
Q. All right. So you do understand what "human" means, that word?
A. Yes. Yes.
Q. You understand what the word "diversity" means?
A. Yes.
Q. You give it the plain and simple meaning that --
A. Human beings.
Q. Yes. But the word "normal" as used in that phrase and the word "spectrum," I think you are telling

me that you are not sure exactly how those words -- the intended meaning of those words in that sentence. Is that what you are saying?
A. I'm saying, I guess. I mean, I'm thinking here that these are words that are embedded, just embedded with values that come outside of psychology. Psychology can't determine values. Psychology can comment on human behavior and study it and see what consequences are related to two different behaviors and psychological experiences, but a value of what is normal is going to probably come -- it's going to come from outside psychology per se. You are going to pick your definition of what that means. I'm sure that -- my hunch is, anyway, the committee would mean this is normal, it has no moral evaluation of significance; therefore, it's good, it's a good.
Q. Well, I'm not asking for your hunch.
A. Okay.
Q. Okay. What I'm asking is whether you can tell me what the word "normal" means in the context of that phrase, and I think your answer is it could be a lot of things, so you are not sure; right?
MR. GANNAN: Objection. Asked and answered. Calls for speculation.
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BY MR. WILLIAMS:
Q. Correct?
A. I would be -- you know, I guess I would say I would be guessing. The words --
Q. All right. There you go. All right. Thank you.
Now, this phrase -- excuse me -- this sentence uses the term "gender identity." I think I've seen that in some of your stuff as well.
What is gender identity?
A. Again, the sense that a person has of being masculine or feminine or something in between.
Q. If a human being has a gender identity as you just described it, but differs from their birth sex, do you know what causes that?
A. The thing I would say with some confidence is that there are multiple factors involved that probably differ for different people. I myself have worked with trauma victims, severe trauma victims who have dissociative identity disorder, which is a very interesting disorder.
And these individuals sometimes -- it's not unusual -- sometimes have gender -- gendered states, mental identity states that are opposite of their biological sex. So there might be a male identity

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state inside a female-bodied person.
And this would be, for instance, because extreme sexual trauma, they would in a sense mentally create a part of their mind that is relatively subjectively experiences autonomous that notices that the sexual abuse isn't happening to boys, but it is happening with girls so I will be a girl. And that state -- I'm sorry, I will be a boy.
And so that state then identifies in a gendered sense itself as a boy. It can actually look in a mirror and see itself -- this is extreme disassociation, but it can see itself as a -- as a male, and it will talk it -- it will be absolutely convinced that it is male.
I'm not saying this is the majority of gender dysphoric situations, although it is something that WPATH guidelines say you need to assess for because I think it does happen in some situations, but from my experience, that would be one -- that would be one potential way that this would show up in a counselor's office, not the only way, but it could happen; that a highly traumatized individual who has multiple identity states that are disassociated from one another would have one of those states that would be opposite gendered in reference to its biological sex.

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Q. So if there is a causal relationship between -- that results in a gender identity different from one's birth sex, that causal relationship could be a lot of things. Is that what you are saying?
A. For any person, you have to, yeah, probably take a good history.
Q. Yeah. One size doesn't fit all; correct?
A. Oh, yes.
Q. All right. So tell me what your understanding of "transgender" is.
MR. GANNAN: Objection. Vague. Calls for speculation.
BY MR. WILLIAMS:
Q. Well, that's a good question. Do you know what "transgender" is?
A. In a -- it's not my field of deep study, but obviously these issues touch upon one another. I believe it would be someone who would identify in some form or other in the gendered -- a sense of gender that is different from their biological sex.
Q. In that sense, do you think there's a -- how would I put it, a developmentally normal pathway that would lead to someone being transgender?
A. I do not know the answer to that question. It's conceivably possible; however, the cases that I've

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worked with where that's an issue, like extreme trauma cases, that is definitely not the case.
Q. Have you dealt with minors who identify as transgender in your practice?
A. On a few occasions.
Q. Did you reach any conclusions in dealing with those minors that identify as transgender that they were -- they identified that way because of any other unresolved mental health issues?
MR. GANNAN: Objection. Vague.
A. I'm just trying to think back. It's been a while.
BY MR. WILLIAMS:
Q. Sure.
A. I don't believe the therapy lent itself, my contact really lent itself to a thorough examination of those issues. Usually, I'm working with -- again, I'm working with the parents, helping them to love and care for their child and, you know, keep the connection and understand that things can change over time, not a promise of that, but they do, so you need to love and care for your child even the transgender child, of course.
Q. I hope you would agree with me that a parent shouldn't need a psychologist to tell them that, do

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they?
A. Sometimes parents think that what is loving is actually doing damage to their attachment to their child.
Q. Help me out on that. I would like to understand that.
A. Severe kinds of discipline. If the parent has problems with emotional regulation themself, by that I mean they blow up their emotions, they can't control their emotions.
Q. The parent?
A. Yes, the parent. That that is not helpful for connection to their child. Those would be the examples. Issues of discipline, issues of connection, emotional regulation.
Q. You keep affirming Graham Nash through this entire deposition. Thank you.
Earlier we talked about normal spectrum of human diversity, and I want to go there again, because I'm going to ask you a simple question. Do you believe that transgender identity is a natural part of that spectrum of human diversity?
MR. GANNAN: Objection. Vague.
A. I wouldn't see it as a spectrum, again, because it's very -- it's not distributed even close to

evenly across any --
BY MR. WILLIAMS:
Q. Then I will rephrase the question to a natural part of human diversity. Forget the spectrum part.
MR. GANNAN: Objection. Vague.
A. I do not know every instance of transgender experience. I do know that what I see with traumatized individuals lends me to believe that there is a subpopulation of transgenders that quite conceivably -- that trauma history is a major factor in the development of their sense of opposite-sexed gender.
BY MR. WILLIAMS:
Q. Do you think there's ever a situation where going through a gender transition is ever appropriate as a treatment modality for a minor?
MR. GANNAN: Objection. Vague. Assumes facts not in evidence.
A. I can't really give a professional opinion on that. As a parent, I would have a hard time letting my daughters -- I have two daughters -- I would have a hard time letting them at 13 or 14 or 15 or 12 -- you know, obtain puberty-blocking drugs cross-sex hormones, hormones that have serious -- can have serious repercussions with regards to fertility, among other things. That would be a real hard sell for me as a

parent to do.
Q. But you can't give me a professional opinion because it's not in the ambit of your expertise; is that right? I get the parent part. I'm a parent too.
A. Yeah. If I was presented with that situation, I mean, I would have to use my common sense as a parent.
Q. Yeah, I agree.
A. And, again, the parents coming -- they would probably -- given their backgrounds, would probably have -- support that kind of maybe watchful waiting kind of thing.
Q. Well, then let's switch to the same question, is it ever an appropriate treatment for somebody over the age of 18?
MR. GANNAN: Objection.
BY MR. WILLIAMS:
Q. An adult in the eyes of the law?
MR. GANNAN: Beyond the scope of Dr. Rosik's assignment as an expert.
A. I guess theoretically it's feasible that it could be. However, I would say the state of science regarding this is not nearly as definitive as I would want it to be. In other words, the long-term studies. I would like to see some 10-, 20-year studies of those

that have transitioned, particularly surgically.
There aren't many out there, there are a few, the one I'm familiar with in particular, would suggest that these individuals, they feel a great deal of relief related to their gender identity, but over time their comorbidity conditions or their, I say, co-occurring conditions do not remit, suicide, depression, those sorts of things. So one would have to -- you'd have to kind of balance those things.
Q. Do you know what the term "gender dysphoria" means?
A. If I had to hazard a definition, I would say an individual who is dissatisfied in some way with their biological sex, does not feel like it's consistent with their gender experience, feelings.
Q. My research in preparation for this deposition led me to, I believe, uncover the simple fact that the American Psychiatric Association, which decided to change the diagnosis of gender identity disorder to gender dysphoria.
A. Right.
Q. Are you familiar with that?
A. Yes.
Q. Do you agree with that, that change?
MR. GANNAN: Objection. Vague. Calls for

speculation. Beyond the scope.
A. I don't know if I can say directly. I think I understand either perspective. I understand it as a disorder. I understand it as a dysphoria. My understanding is that it was -- a reason why it was labeled "gender dysphoria" as opposed to just removed from the DSM, like homosexuality, is because transgender individuals who wish to have these medical treatments need insurance coverage, and so to remove it altogether, they would not be able to have insurance coverage, and so it kind of put the profession in a bit of a bind. How do we depathologize transgenderism and yet allow there still to access medical benefits because insurances don't pay for -- often for nondiagnostic conditions, and so gender dysphoria was kind of a way, at least partially a way around that concern.
Q. A way around --
A. The concern of --
Q. -- no insurance coverage?
A. -- if we declassify this, if it's not longer in the DSM, we cannot get surgery, we cannot get medical treatment, at least for the insurance to cover them.
Q. So does changing it to "dysphoria" solve that

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problem?
A. Yeah, it's not a disorder. That was the point. And I understand that was the point.
Q. That was the motivation for the American Psychiatric Association to change --
A. No, that --
Q. -- the diagnosis of gender identity?
A. No, no, no.
MR. GANNAN: Objection. Vague. Calls for speculation. Misstates testimony.
A. It was the reason why it wasn't eliminated altogether. They could've easily, just like homosexuality, struck it from a diagnostic category, but they needed to preserve -- they need to preserve something to enable transgender individuals who wish to change their biological sex to have insurance, access to insurance coverage for these very expensive procedures.
BY MR. WILLIAMS:
Q. I'm sure it is. And by changing it to gender dysphoria, they solved that problem. Is that what you are saying?
A. Yes, exactly.
Q. Turn to page 12 of the SAMHSA report, sir. Paragraph 3, under the heading "Professional Consensus

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on Sexual Orientation and Youth," do you see that, sir?
A. In the top, the top portion?
Q. Yes.
A. Okay. Yes.
Q. Page 12.
A. Right.
Q. And I'm going to direct your attention to paragraph 3 under that heading, and I'm going to read that paragraph 3 into the record out loud. "There is a lack of published research on efforts to change sexual orientation among children and adolescents; no existing research supports that mental health and behavioral intervention of children and adolescents alter sexual orientation. Given the research on secondary outcomes of such efforts, the potential for risk of harm suggests the need for other models of behavioral health treatment."
Did I read that correctly?
A. Yes.
Q. Do you agree with that statement?
A. Let me read it again.
Q. Please.
MR. GANNAN: I'm going to make an objection. Beyond the scope of Dr. Rosik's opinions.
A. Let's say there's a lack of research that

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meets the extremely rigorous methodological standard of, say, the APA task force. If those are the standards you are dealing with, yes, there is a lack, but I think those are artificially high.
My understanding is that there is -- I think the APA report talked about, you know, research done on adolescents and children. But one has to understand, again, there's a context here with the declassification of homosexuality. Research has stopped -- not stopped, but it drastically changed. There is no money going to support researchers who wish to -- who might wish to investigate these issues. No grant funder now is going to fund a study that might be sympathetic to change, the possibility of change.
Q. Why is that?
A. I would add researchers as well to that, and I think that's because they are likely to be punished.
Q. By whom?
A. In the public domain.
Q. By whom?
A. I would look at the same individuals that -- what happened to Mark Regnerus, look what happened to Spitzer, they're colleagues. With Regnerus, I mean, he had colleagues that came down on him. Basically, you are risking your -- you know, it's kind of a career

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suicide move even if your research would be solid because it's just -- again, it's the ideological --
Q. Left of center?
A. -- lack of diversity. The lack of diversity, yes.
Q. Well, I said left of center. The left-of-center bent -- I used that term because it fit for me -- results in ostracization of people who do not comport to that left-of-center ideology. Is that what you are saying?
MR. GANNAN: Objection. Vague. Asked and answered.
A. If you look up what happened to Mark Regnerus.
BY MR. WILLIAMS:
Q. Mark who?
A. He is a researcher out of the University of Texas or something, but anyway, and what happened to Spitzer after this study. I mean, it's distressing.
Q. What happened to those two gentlemen?
A. Well, Regnerus was brought up for review, as I understand. He was criticized extremely in the scholarly and in the popular press, because the study did not -- it had limitations, like all studies, but it was the fact that he found and suggested some interpretation of the data that did not comport with

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the narrative that I think the mental health associations and others would want to -- would agree with. And, again, it probably worked against the narratives that they wished to support. And I think I cite one article in my declaration by Woods that talks about a lot of this if you're interested in it.

Q. I'm interested in everything, Doctor.

Would you look at page 1 of your original declaration, which is dated May 6, 2019.

A. Page 1. Okay. That's the table of contents.

Q. Yes, sir. Under the heading number roman numeral III, "Analysis and Opinion," you say, A, "The Objectivity of the 2009 APA Task Force Report on SOCE is demonstratively suspect; Therefore the Report's Representation of the Relevant Literature Concerning Efficacy of and Harm from SOCE is Neither Complete nor Definitive."

Did I read that --

A. Yes.

Q. Is the way of or methodology for determining efficacy the same as it is for harm?

A. I believe there are differences.

Q. What are those differences?

A. Something that is not effective is not necessarily a -- I think it would -- less urgency as

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opposed to something that was shown to be definitively speech that harmed people.

MR. WILLIAMS: Read that back. I'm not sure I understood it. Late in the day.

(The answer was read back.)

BY MR. WILLIAMS:

Q. You are going to have to amplify that, Doctor. I sorry. I didn't really understand what you just said. Could you repeat it and perhaps elaborate on it? The question is --

A. Yes.

Q. -- you determine -- I used the word "methodology," and maybe that's not the right word, but you talk about the "Literature Concerning Efficacy of and Harm from." So does that literature use a methodology to determine the efficacy of SOCE, and is that same methodology or approach used to determine the harm of SOCE?

A. Something that is not efficacious and not harmful would not be considered in the same way something that was not efficacious and harmful would be.

Q. Are you saying if something is not efficacious, that doesn't ipso mean it's harmful?

A. Efficacy on its own would not necessarily have

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anything to say about -- again, this is a complex issue. I would say if you are holding out as -- you had given out guarantees of sexual orientation change, that kind of thing, that could be harmful when the client does not experience that.

Q. So in that context, efforts to be effective could, in fact, lead to harm because of the expectation level that was represented at the beginning and did not eventuate or actually take place. Is that what you are saying?

MR. GANNAN: Objection. Vague. Misstates testimony.

A. Potentially, if that was promised by a therapist; however, I know of no therapist that promises this. I'm talking about a licensed therapist.

BY MR. WILLIAMS:

Q. Sure. So going back to my original question. I want to make sure I intellectually comprehend the difference between, I guess, evaluating, measuring efficacy versus determining harm. They're not necessarily synonymous but they're not necessarily totally unrelated. Is that what you are saying?

MR. GANNAN: Objection. Vague. Asked and answered.

Are you asking him how those subjects were

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treated in the APA report, or are you asking in general?

MR. WILLIAMS: In general.

A. Well, there are different criteria that you have to weigh. Something --

BY MR. WILLIAMS:

Q. For each?

A. What's that?

Q. For each? Different criteria for efficacy than for harm?

A. Well, let's put it -- I'm sorry -- in a medical sense. You may have a drug that gives you a chance of ameliorating your cancer at some percentage of efficacy, but it may have a high percent of doing harm. So you have to weigh, you know, what is the -- looking at this, given my condition do I want to take this sort of risk. So you are weighing efficacy. A client would be weighing that in their decision to pursue that treatment.

Q. You know, we're inundated with drug ads, legal drug ads, I should say, on TV all the time that always have smiling people saying how wonderful the drug is, and then some guy in a subliminal boasts, and by the way, it could cause a heart attack, cancer, this -- you know what I'm talking about.

Is that what you are referring to? Each treatment modality may be effective, but it also may have adverse impacts?
A. You know, I guess I'm referring to like a medical doctor talking about the risks, potential risks and benefits of a treatment.
Q. Sure.
A. That's just appropriate practice.
Q. Is it the ethics of the psychological profession that the client is informed of potential harms before you possibly proceed forward with the particular treatment modality that the professional believes is efficacious?
MR. GANNAN: Objection. Vague. Calls for speculation.
A. I would assume that that would be a part of ethical practice.
BY MR. WILLIAMS:
Q. You assume. Do you know? You are a clinical psychologist.
A. That's what I do.
Q. That's what you do.
And would you expect all your colleagues to do the same?
MR. GANNAN: Objection. Calls for

speculation.
BY MR. WILLIAMS:
Q. Is that standard of care? Let me put it that way.
A. All the colleagues that I know, we have compared consent forms and all that, so they all have various consent forms that have certain disclosures that are necessary, understanding that this is a potentially -- you know, it's a controversial area of practice, so you better be prepared and better show that there is clear consent of risks and harms, potential harms, you know.
Q. And you are referring to SOCE when you talk about --
A. I'm referring, again, just because I don't -- the word is constraining -- that acronym is constraining, but I'm referring to clients who would come with a self-determined goal of pursuing their degree of sexual fluidity through speech, talk-oriented psychotherapy, to determine to what extent that might be possible for them. It's hard to say that. It's much easier to say SOCE, but --
Q. Well, I heard you say that earlier, and I respect the fact that you don't like the word -- the term "SOCE," but since I'm not educated like you are,

I'm not so smart as you are, I'm just going to use SOCE as a lay synonym for what you just described. Is that fair?
A. Unfortunately, with the way the word is thrown around, what it's often come to mean, I think I understand what you are saying, but it has the -- carries the risk of, you know, creating prejudice with regards to what I do. That's why I don't like to use the word.
Q. Well, you used it in your paper, though?
A. I did, and I --
Q. Because you had to get it published?
A. With that proviso, right.
Q. Yeah, I get that. When you used the term "SOCE" in your paper, you were really referring to the more elaborate description that you just gave me?
A. That's correct.
Q. Doctor, I have heard the term "aversive therapy" as it relates to conversion therapy or SOCE or whatever you want to call it. Are you familiar with what I'm talking about?
A. Yes.
Q. What am I talking about? What does that refer to, that term?
A. These are generally behavioral techniques that

were applied to sexual orientation back in the '60s and the '70s. They would include -- I mean, this was with -- they were applied not just to sexual orientation. This was at the time in psychology when these types of techniques were being utilized with a number of different conditions.
Q. Not just sexual orienting?
A. Correct. But they might include electric -- or some mild shocking paired with images of whatever -- images of spiders or exposure kind of to things. It was kind of a conditioning paradigm, trying to decondition your association of the same-sex attraction by setting some aversive stimuli to pair it with that attraction and then pairing some more positive stimuli with the heterosexual or the opposite-sexed image.
That's just an example. But, honestly, these were determined to not be effective and to be potentially harmful when it -- when it comes to sexual orientation, and so they were discarded back in the '80s. Haven't been used by -- haven't been used professionals, even professionals in the Alliance and people who are in this would be -- are open to working with clients to explore their fluidity, hasn't been used by those individuals, professional therapists I'm speaking about, probably in decades, and that's what,

as I note in my declaration, Clifford Rosky in Utah had mentioned, these have not been used by a licensed therapist, since all we do is talk, and which makes it personally upsetting that these kind of portrayals are continually brought before governing boards like the Tampa Council, like the California State Legislature, describing, directly or by allusion, these kinds of practices that are alleged to be currently used by therapists such as myself, and there's not a stick of truth in it.

Q. Well, I have some familiarity with that personally, because I used to represent a long-term psychiatric hospital here in the Tampa Bay area, and you are right, they used it even to the early '80s, not for that, but for other --

A. Yeah.

Q. -- other issues. But my experience, sir, and I will just say it, is that that stopped a long, long time ago, decades. I agree with you.

And so can you state on the record that you believe affirmatively that these aversive techniques are no longer used and have not been used in connection with conversion therapy, SOCE, whatever you want to use, in the United States of America?

MR. GANNAN: Objection. Vague.

BY MR. WILLIAMS:

Q. To your knowledge, sir.

A. I cannot think of an exception with regards to any of my colleagues that I know through the Alliance or just professional circles that these are techniques that are in use.

Q. Today?

A. Yes, today and probably for decades.

Q. Okay.

(A discussion was held off the record.)

MR. WILLIAMS: After consultation with my colleague, Ms. Robbins, I have no further questions. Doctor, thank you very much for your efforts today. It's been a long day, and I appreciate you willing to talk to me.

THE WITNESS: Thank you.

MR. GANNAN: Dr. Rosik will read and sign.

STIPULATION

It was stated by counsel that the exercise of reading and signing the transcript would not be waived.

(WHEREUPON, the taking of the deposition was concluded at 3:45 p.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF HILLSBOROUGH)

****

I, ELSA HERNANDEZ, FPR, Notary Public, State of Florida, certify that the witness CHRISTOPHER ROSIK, Ph.D., who produced a driver's license for identification, personally appeared before me and was duly sworn.

WITNESS my hand and official seal this date: 29th day of July, 2019.

ELSA HERNANDEZ, FPR
Notary Public, State of Florida
Commission No. FF897203
Expires 9/30/2019

CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF HILLSBOROUGH)

I, ELSA HERNANDEZ, FPR, Court Reporter, and Notary Public, do hereby certify that I was authorized to and did stenographically report the deposition of CHRISTOPHER ROSIK, Ph.D.; that a review of the transcript was requested; and that the foregoing transcript, pages 1 through 209, is a true record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, or attorney, or counsel of any of the parties' attorneys or counsel connected with the action, nor am I financially interested in the action.

DATED this 12th day of August, 2019.

ELSA HERNANDEZ, FPR
Notary Public

ERRATA SHEET

IN RE: ROBERT L. VAZZO v. CITY OF TAMPA
CASE NO: 8:17-cv-02896-WFJ-AAS
DATE TAKEN: July 29, 2019
DEPOSITION OF: CHRISTOPHER ROSIK, Ph.D.

DO NOT WRITE ON THE TRANSCRIPT - ENTER CHANGES HERE

Please sign, date, and return this sheet to our office.
If additional lines are required for corrections, attach additional sheets.

At the time of the reading and signing of the deposition, the following changes were noted:

PAGE	LINE	CHANGE	REASON

Under penalties of perjury, I declare that I have read my deposition and that it is true and correct subject to any changes in form or substance entered here.

SIGNATURE OF DEPONENT: _____

DATE: _____

August 12, 2019

ROGER K. GANNAM, ESQUIRE
HORATIO G. MIHET, ESQUIRE
Liberty Counsel
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In Re: Vazzo v City of Tampa

Dear Mr. Gannam:

Enclosed please find the original errata page with your copy of the transcript so Dr. Rosik may read and sign. Please have him make whatever changes are necessary on the errata page and sign it. Please make a copy of the errata page and place it in your copy of the transcript. Please then forward the original errata page back to our office at 101 South Franklin Street, Suite 101, Tampa, Florida 33602.

If the errata page is not signed by the witness within 30 days after this letter has been furnished, we will then process the transcript without a signed errata page. If your client wishes to waive their right to read and sign, please have her sign on the signature line at the bottom of this letter and send it back to our office.

Your prompt attention to this matter is appreciated.

Sincerely,
Elsa Hernandez, FPR
Anthem Reporting

I do hereby waive my signature

_____
CHRISTOPHER ROSIK, Ph.D.

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA
SACRAMENTO DIVISION

DAVID PICKUP, CHRISTOPHER H. ROSIK, PH.D., JOSEPH NICOLOSI, PH.D, ROBERT VAZZO, NATIONAL ASSOCIATION FOR RESEARCH AND THERAPY OF HOMOSEXUALITY (NARTH), AMERICAN ASSOCIATION OF CHRISTIAN COUNSELORS (AACC), JOHN DOE 1, by and through JACK AND JANE DOE 1, JACK DOE 1, individually, and JANE DOE 1, individually, JOHN DOE 2, by and through JACK AND JANE DOE 2, JACK DOE 2, individually, and JANE DOE 2, individually

Case No.:2:12-cv-04297-KJM-EFB

Plaintiffs

v.

EDMUND G. BROWN, Jr., Governor of the State of California, *in his official capacity*, ANNA M. CABALLERO, Secretary of the California State and Consumer Services Agency, *in her official capacity*, KIM MADSEN, Executive Officer of the California Board of Behavioral Sciences, *in her official capacity*, MICHAEL ERICKSON, PH.D, President of the California Board of Psychology, *in his official capacity*; SHARON LEVINE, President of the Medical Board of California, *in her official capacity*.

Defendants.

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

1. I am over the age of eighteen years and am one of the Plaintiffs in this action. The statements in this Declaration are true and correct and if called upon to testify to them I would and could do so competently.

2. I am submitting this Declaration in rebuttal to the Declarations submitted by the State of California when filing their Memorandum in opposition to Plaintiffs Motion for a Preliminary Injunction.

3. I am a Phi Beta Kappa graduate of the University of Oregon's honors college and graduated with a Bachelor of Arts in Psychology in 1980. I also studied one semester at the University of Copenhagen, Denmark while completing my undergraduate work. I received my Master of Arts degree in Theological Studies from the Fuller Graduate School of Psychology, Fuller Theological Seminary in 1984. I received a Doctor of Philosophy degree in Clinical Psychology from the Fuller Graduate School of Psychology, Fuller Theological Seminary in 1986. I am a clinical psychologist licensed by the State of California and have been so licensed since 1988. (A copy of my curriculum vitae is attached as Exhibit A).

4. My practice is located at the Link Care Center, which is a religious non-profit foundation in Fresno, California. Link Care Center employs a staff of twelve clinicians, which include psychologists, marriage and family therapists, a social worker, and an intern, and it employs two pastoral counselors. The majority of Link Care Center's clients come to the facility because of its Christian identity and their trust that their Christian values and beliefs will be represented in treatment. I served as the Clinical Director for Link Care Center Counseling Center from 1996-1999.

5. Since 2001, I have also been on the clinical faculty of Fresno Pacific University, and I teach psychology research practicum every year. I have published over 40 articles and book chapters in peer reviewed journals, many of them on the subject of homosexuality. I am a member of the American Psychological Association and have been a member in good standing since 1984; a member of the International Society for the Study of Trauma and Dissociation and have been a member in good standing since 1992; and member and former-president and board member of the Christian Association of Psychological Studies, Western Region; and am the current President of the National Association for Research and Therapy of Homosexuality.

The Objectivity of the APA Task Force Report on SOCE is Demonstrably Suspect; Therefore the Task Force's Representation of the Relevant Literature Concerning the Efficacy of and Harm from SOCE is neither Complete nor Definitive

6. Although many qualified psychologists were nominated to serve on the Task Force, they were rejected because they did not align with the one-sided view of the Task Force. This fact was noted in a book co-edited by a past-president of the American Pyschological Association (APA) (Yarhouse, 2009) (A copy of a bibliography of all cited studies is attached as Exhibit B). The director of the APA's Lesbian, Gay and Bisexual Concerns Office, Clinton Anderson, offered the following defense: "We cannot take into account what are fundamentally negative religious perceptions of homosexuality—they don't fit into our world view." (Carey, 2007). It appears that the APA operated with a litmus test when considering Task Force membership—the only views of homosexuality that were tolerated are those that uniformly endorsed same-sex behavior as a moral good. Thus from the outset of the Task Force, it was predetermined that religious or other viewpoints would only be acceptable when they fit within their pre-existing worldview. One example of this is the Task Force's failure to recommend any religious resources that adopt a traditional or conservative approach to addressing conflicts

between religious beliefs and sexual orientation. This bias can hardly be said to respect religious diversity and had predictable consequences for how the Task Force addressed its work.

7. This bias was particularly evident in the Task Force's highly uneven implementation of standards of scientific rigor in the utilization and evaluation of published findings pertaining to SOCE (Jones, et al., 2010). Of particular note is the contrast between the exceptionally rigorous methodological standards applied to SOCE outcomes and the considerably less rigorous and uneven standards applied to the question of harm. With regard to SOCE outcomes, the Task Force dismisses most of the relevant research because of methodological limitations, which are outlined in great detail (Task Force, 2009, pp. 26-34). Studies pertaining to SOCE outcomes that fall short of the Task Force's rigorous standards are deemed unworthy of examination and dismissed as containing no evidence of value to the questions at hand. Meanwhile, the Task Force appears to adopt very different evidentiary standards for making statements about harms attributed to SOCE. The standard as regards efficacy is to rule out substandard studies as irrelevant; however, no such standards are employed in considering studies purporting to document harm. In addition, the Task Force uses the absence of evidence to argue that SOCE is unlikely to produce change and thus strongly questions the validity of SOCE, but shows no parallel reticence to endorse affirmative therapy despite acknowledging that, "...it has not been evaluated for safety and efficacy" (Task Force, 2009, p. 91).

8. The six studies deemed by the Task Force to be sufficiently methodologically sound to merit the focus of the Task Force targeted samples that would bear little resemblance to those seeking SOCE today and used long outdated methods that no current practitioner of SOCE employs. This brings into question the Task Force's willingness to move beyond scientific

agnosticism (i.e., that we do not know the prevalence of success or failure in SOCE) to argue affirmatively that sexual orientation change is uncommon or unlikely. The Task Force seems to affirm two incompatible assertions: (a) we do not have credible evidence on which to judge the likelihood of sexual orientation change and (b) we know with scientific certainty that sexual orientation change is unlikely. However, the absence of conclusive evidence of effectiveness is not logically equivalent to positive evidence of ineffectiveness (Altman & Bland, 1995).

9. There are places where the Task Force does seem to acknowledge that, given their methodological standards, we really cannot know anything scientifically definitive about the efficacy of or harms attributable to SOCE. For example, the Task Force states, "Thus, we cannot conclude how likely it is that harm will occur from SOCE." (Task Force, 2009, p. 42). Similarly the Task Force observes, "Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective" (Task Force, p. 43). The Task Force argues at length that only the most rigorous methodological designs can clearly establish a causal relationship between SOCE methods and subsequent change, but the Task Force does not hesitate to make such causal attributions consistently regarding harm while repudiating any such claims for efficacy. From this highly uneven application of literature review methodology, the Task Force goes on to assert confidently that success of SOCE is unlikely and that SOCE has the potential to be harmful. It is also telling that in subsequent references to the Task Force the potential for harm has morphed into "the potential to cause harm to *many* clients" (APA, 2012, p. 14) (emphasis added) and a "*substantial* risk of harm" (Beckstead Decl, p. 10) (emphasis added). The harms from SOCE appear to grow greater the farther away one gets from the original Task Force's conclusions.

10. That the Task Force utilized a far lower methodological standard in assessing harm and other aspects of the science than it did in assessing SOCE outcomes can be demonstrated by a few examples. Echoing the Task Force, Herek (Herek Decl., pp. 12-13) references the many varieties of methodological problems deemed sufficient to render useless most of the SOCE research. Yet the Task Force and scholars such as Herek seem ready to overlook such limitations when the literature addresses preferred conclusions. Consider the work of Hooker (1957), which is routinely touted as groundbreaking in the field and affirmed by the Task Force and other APA publications as evidence indicating no differences in the mental health of heterosexual and gay men. However, this research contains such serious methodological flaws that it is inconceivable an even-handed methodological evaluation by the Task Force would have not have mentioned these problems. Among the many methodological problems noted by Schumm (2012), the control group was told the purpose of the study in advance, clinical experts were not blind to the objectives of the study, imperfect matching of participants, low scale reliability, the use of a small and recruited control group rather than existent national standardized norms, the post hoc removal of tests that actually displayed differences, and the screening out of men from the study if they appeared to have pre-existing psychological troubles. As she wrote many years later (Hooker, 1993), "I knew the men for whom the ratings were made, and I was certain as a clinician that they were relatively free of psychopathology." Despite these serious methodological problems, which would never be tolerated by the Task Force were this SOCE research, Herek described this Hooker's study as part of the "overwhelming empirical evidence" that there is no association of sexual orientation with psychopathology (Herek, 1991, p. 143; see also Herek, 2010). The point here is not to argue for such an association, but to underscore that a consistent application of the Task Force

standards Herek affirms should have led to the dismissal of the Hooker study as supportive of the no differences hypothesis.

11. Perhaps the most egregious example of the Task Force's methodological double standard is evidenced in their heavy reliance on the Shildo and Schroeder (2002) and Schroeder and Shidlo (2003) research in conclusions about harm from SOCE. Several methodological problems cited to dismiss the SOCE outcome literature complicate these studies. These studies were conducted in association with the National Gay and Lesbian Task Force, with the explicit mandate to find clients who had been harmed and document ethical violations by practitioners. This was abundantly clear in the study's original title: "Homophobic therapies: Documenting the damage" (See Exhibit C). In addition, over 50% of the 202 sample participants were recruited through the GLB media, hardly a random or generalizable sampling procedure. Only 20 participants in this study were women, creating significant skew toward gay male accounts. These subjects reported their experiences came from a mix of licensed therapists, nonlicensed peer counselors, and religious counselors, leaving open the reasonable suspicion that negative therapeutic experiences might differ significantly by level of training. The study results are thus based on a non-representative sample likely to be heavily biased in the direction of retrospectively reporting negative therapy experiences, some of which occurred decades ago. The Task Force appears to have ignored the warnings from the study's authors: "*The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy*" (Shildo & Schroeder, 2002, p. 250, emphases original). It is difficult to understand how this research can be cited without qualification or context as demonstrating likely harm from SOCE conducted by licensed professionals. Again, what we can say with confidence is that some SOCE clients report harm

and others report benefit, and we do not know from the literature how often either outcome occurs.

12. A third example of the Task Force's uneven application of methodological standards concerns their conclusion that, "Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation" (Task Force, 2009, p. 23). Of the ten studies cited in support of this conclusion, three were not readily accessible on databases and one was a review article, which is an interpretation and not an empirical study. An examination of the remaining six studies (Bell, Weinberg, & Hammersmith, 1981; Freund & Blanchard, 1983; McCord, McCord, & Thurber, 1962; Peters & Cantrell, 1991; Siegelman, 1981; Townes, Ferguson, & Gillem, 1976) revealed many of the same methodological flaws cited in the Task Force critique of SOCE (Rosik, 2012). For example, Beckstead (Decl., p. 3) cites the Freud & Blanchard (1983) study as evidence against any role of family dynamics or trauma in the origin of same-sex attractions but fails to mention this study's methodological problems, including unclear scale reliability, participants being known to the researchers as patients, the use of a convenience sample, and a narrow and therefore non-generalizable sample composition of psychiatric patients. All these problems were considered to be fatal flaws in the Task Force's appraisal of the SOCE outcome literature.

13. Given that many of the methodological limitations used by the Task Force to assail the SOCE research existing in the etiological literature, questions have to be raised as to why they chose to definitively dismiss this literature as "failing to support" developmental theories. It appears, based on the same criteria they used to dismiss SOCE, that their own conclusions have little basis in the literature. A fairer rendering of the etiological literature they reference would appear to be that this research is so methodologically flawed that we cannot

make any conclusive statements concerning the applicability of developmental factors in the origin of homosexuality. Thus by the Task Force's own methodological standards, the literature they cite fails to support *or rule out* a role for these potential developmental influences in the genesis of sexual orientation. If such ambiguity exists in the SOCE literature on methodological grounds, then by the Task Force's own criteria, this ambiguity also is present in the referenced etiological research. It appears that the Task Force has been inconsistent in the application of their methodological critique to the broader literature on homosexuality and they have been willing to offer more definitive conclusions about theories they wish to dismiss than is warranted by their own standards. In a word, there is again the appearance of substantial bias.

14. Contra to the repeated claims of Beckstead and the Task Force that it is an established "scientific fact" that "no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma" (Task Force, 2009, p. 86), there currently exists recent, high quality, and large-scale studies that provide empirical evidence consistent with potential familial or traumatic contributions to sexual orientation (Bearman & Bruckner, 2002; Francis, 2008, Frisch & Hviid, 2006; Wilson & Widom, 2009). Despite their significant relevance for scientific discussions on the etiology of same-sex attractions, these studies were ignored by the Task Force.

15. A fourth example of uneven methodological implementation of standards is the Report's treatment of the "grey literature," which is dismissed in favor of only peer-reviewed scientific journal articles in the assessment of SOCE. No developed rationale is offered for this choice. Consequently, a highly scholarly study on SOCE supportive of change for some individuals is dismissed in a footnote (Jones & Yarhouse, 20007; the footnote is found on page 90 of the Report). Yet the Task Forces appears to have no compunction in citing the grey

literature on other subjects, such as demographics relating to sexual orientation (Laumann, Gagnon, Michael, & Michaels, 1994) or the issue of psychological and familial factors in the development of sexual orientation (Bell, et al., 1981), even though the latter book utilizes a sample of questionable representativeness.

16. A fifth example of differential application of methodological critique highlights the systemic nature of this problem within the broader literature pertaining to homosexuality. A recent analysis of the 59 research studies cited in the APA's brief supporting same-sex parenting (Marks, 2012) in essence applied methodological standards of similar rigor to those the Task Force applied to the SOCE literature. The study concluded that,

> "...some same-sex parenting researchers seem to have contended for an 'exceptionally clear' verdict of 'no difference' between same-sex and heterosexual parents since 1992. However, a closer examination leads to the conclusion that strong, generalized assertions, including those made by the APA Brief, were not empirically warranted. As noted by Shiller (2007) in American Psychologist, 'the line between science and advocacy appears blurred'" (p. 748).

While Marks' analysis does not focus on SOCE, it is relevant in that it underscores that APA's worldview regarding homosexuality appears to result in public policy conclusions and development (whether right or wrong) that go beyond what the data can reasonably support. This is appears to be precisely what is occurring in the linking of the Task Force with the banning of professional SOCE as represented in SB 1172.

17. A final example of this problem of differential rigor in methodological critique can in fact be found in SB 1172 itself. The bill cites a study by Ryan, Huebner, Diaz, and Sanchez (2009) in the respected journal *Pediatrics*, presumably as its best support for claims that SOCE with minors results in serious harms. It is evident that this study also contains many of the methodological limitations cited by the Task Force to invalidate the SOCE literature, including participants not being blind to the study purposes, likely biases in the participant recruitment

process, and the reliance on self-report measures that had participants recalling experiences from the distant past. Generalization difficulties are also created by the sample composition of Ryan, et al. (2009). The sample is limited to young adult non-Latino and Latino LGB persons. The Task Force (2009) noted that research on SOCE has "...limited applicability to non-Whites, youth, or women" (p. 33) and, "No investigations are of children and adolescents exclusively, although adolescents are included in a very few samples" (p. 33). This means that even had Ryan and colleagues assessed for SOCE backgrounds among participants, it would be inappropriate to generalize their findings in a manner that would cast aspersions on all SOCE experiences of minors, which again is precisely what AB 1172 is determined to do. In addition, Ryan, et al. (2009) acknowledge that "...given the cross-sectional nature of this study, we caution against making cause-effect interpretations from these findings" (p. 351). Presumably, this caution alone should have been enough to prevent the authors of SB 1172 from employing the Ryan study. Even had the study findings been generalizable, they would have not been able to indicate whether SOCE caused the negative health outcomes or if youth with negative health markers disproportionately sought SOCE. Based on this analysis, there appears to be no scientific grounds for referencing the Ryan study as justification for a ban on SOCE to minors. The study's findings, while likely reflecting some underlying connection between family rejection and mental health outcomes, are not reliable and have no scientific justification for being generalized to minors who engage in SOCE with licensed therapists. It is troubling that SB 1172 would utilize Ryan, et al.'s work when the internal and external validity limitations of the study make such claims profoundly misguided, as underscored by the Task Force.

18. The Task Force's concludes that, "None of the recent research (1999-2007) meets methodological standards that permit conclusions regarding efficacy or safety" (Task Force,

2009, p. 2). Taking this statement at face value, which is arguable as noted above, nevertheless only serves to underscore the enduring validity of comments from Zucker (2003), long-time editor of the *Archives of Sexual Behavior*, who observes:

> From a scientific standpoint, however, the empirical database remains rather primitive and any decisive claim about benefits or harms really must be taken with a grain of salt and without such data it is difficult to understand how professional societies can issue any clear statement that is not contaminated by rhetorical fervor. Sexual science should encourage the establishment of a methodologically sound database from which more reasoned and nuanced conclusions might be drawn (p. 400).

A scientific response as opposed to a response based largely on advocacy would pursue research that will allow for more nuanced conclusions about SOCE, not create new law that sets the precedent of placing a blanket prohibition on an entire form of psychological care.

Spitzer's Reassessment of His 2003 Study on SOCE

19. Herek understandably pointed out that Robert Spitzer, M.D., author of one of the primary studies conducted on SOCE (Spitzer, 2003), has recently changed his assessment of the study and believes that it does not provide clear evidence of sexual orientation change (Spitzer, 2012; Herek Declaration, p. 14).). 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 his 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, an assertion made by others at the time of the study. Instead, he now asserts that participant's accounts of change were "self-deception or outright lying" (Spitzer, 2012).

20. It is curious that Spitzer's (2012) apology seems to imply that he earlier claimed his researched 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 SOCE 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?

21. Since nothing has changed regarding scientific merit of the 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. 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.

22. In fact, the reasonableness of this position has been bolstered recently 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, in press). 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 seem 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.

How Enduring is Sexual Orientation?

23. Herek contends that sexual orientation is an enduring trait (Herek Decl., pp. 5-6), and by implication that it cannot be changed, which would indicate the futility of change attempts, including among minors. However, there is solid data to suggest this understanding is by no means universally accurate. The definitive study by Laumann, et al. (1994), cited by both the Task Force and Herek, involved hundreds of thousands of American adults between the ages of 18 and 60. This report contains the most careful and extensive database ever obtained on the childhood experiences of matched homosexual and heterosexual populations.

24. One of the major findings of the Lauman, et al. study, which even surprised the authors, was that homosexuality as a fixed trait scarcely even seemed to exist (Laumann, Michael, and Gagnon, 1994). Sexual identity is not the least fixed at adolescence but continues to change over the course of life. For example, the authors report

> ...this implies that almost 4 percent of the men have sex with another male before turning eighteen but not after. These men, who report same-gender sex only before they turned eighteen, not afterward, constitute 42 percent of the total number of men who report ever having a same-gender experience. (Laumann, Gagnon, et al., p. 296)

They also note that their findings comport well with other large-scale studies.

> [O]verall we find our results remarkably similar to those from other surveys of sexual behavior that have been conducted on national populations using probability sample methods. In particular two very large-scale surveys...one in France [20,055 adults] and one in Britian [18,876 persons]. (p. 297)

25. This data seem to suggest that heterosexuality is normative even for those who at one point in the past reported minority sexual orientation. Heterosexuality appears to exert a constant, normative pull throughout the life cycle upon everyone. While admittedly Laumann attributes this reality to American society, the same findings have been found in other societies where it has been studied. A simpler explanation might look to human physiology, including the physiology of the nervous system, which is overwhelmingly sexually dimorphic, i.e, heterosexual. Therefore it is not surprising that the brain would self-organize behavior in large measure in harmony with its own physiological ecology, even if not in a completely deterministic fashion. Whether measures by action, feeling, or identity, Laumann, Gagnon, et al.'s (1994) data concerning the prevalence of homosexuality before age 18 and after age 18 reveal that its instability over the course of life was unidirectional and reflected significant decline. This evidence of spontaneous change with the progression of time among both males and females is hardly a picture of sexual orientation stasis in adolescence that SB 1172 assumes. To be fair, we cannot tell from this data how many, if any, of those reporting change pursued SOCE. However, the data do provide a developmental context for the plausibility that SOCE could aide some individuals (including minors) in modifying same-sex attractions and behavior. It appears that the most common natural course for a young person who develops a homosexual identity is for it to spontaneously disappear unless that process is discouraged or interfered with by extraneous factors. Conceivably, therapies unlike SOCE that obstruct this process could be interfering with normal sexual development.

26. A New Zealand study by Dickson, Paul, and Herbison (2003) further brings into question the claim that change might affect same-sex *behavior* but not same-sex *attraction*. This study found large and dramatic drops in homosexual attraction that occurred spontaneously for both sexes. Interestingly, the results also indicated a slight but statistically significant net movement toward homosexuality and away from heterosexuality between the ages of 21 and 26, which suggests the influence of environment on sexual orientation, particularly for women. Specifically, it appears likely that the content of higher education in a politically liberal environment contributed to the upswing in homosexuality in this educated sample of twenty-somethings. This notion is further supported by the fact that this increase in homosexuality follows a much larger decrease that would have had to taken place in the years prior to 21 in order to account for the above findings. Furthermore, once the educational effect wears off, the expected decline in homosexual identification resumed. The authors conclude that their findings are consistent with a significant (but by no means exclusive) role for the social environment in the development and expression of sexual orientation.

27. A large longitudinal study by Savin-Williams and Ream (2007) is also noteworthy as it focuses on the stability of sexual orientation components for adolescents and young adults. Three waves of assessment began when participants were on average just under 16 years of age and concluded when participants were nearly 22 years old. The authors observed a similar decline in homosexuality over the time of the study: "All attraction categories other than opposite-sex were associated with a lower likelihood of stability over time" (p. 389). For example, 16 year olds who reported exclusive same-sex attractions or a bisexual pattern of attractions are approximately 25 times more likely to change toward heterosexuality at the age of 17 than those with exclusively opposite sex attractions are likely to move towards bisexual or

exclusively same-sex (Whitehead & Whitehead, 2010). Ninety-eight percent of 16 to 17 year olds moved from homosexuality or bisexuality towards heterosexuality over the course of the study. To be fair, such changes were more pronounced among bisexuals and women. But keep in mind that SB 1172 does not discriminate in its prohibition between SOCE provided for exclusively same-sex attracted minors and those whose unwanted same-sex attractions are part of a bisexual attraction pattern. Nor does SB 1172's ban distinguish between boys and girls. Savin-Williams and Ream observed that, "The instability of same-sex attraction and behavior (plus sexual identity in previous investigations) presents a dilemma for sex researchers who portray nonheterosexuality as a stable trait of individuals" (p. 393). They acknowledge that developmental processes are involved even as they focus mostly on problems with measurement. The reality of such spontaneous changes in sexual orientation among teenagers is not in accord with SB 1172 whose defenders contend sexual orientation is a universally enduring trait. In fact, these data suggest it is irresponsible to legally prevent access to SOCE and only allow affirmation of same-sex feelings in adolescence on the grounds that the feelings are intrinsic, unchangeable, and therefore the individual can only be homosexual.

28. Finally in this regard, it is instructive to observe what Herek did not tell us about his 2005 survey findings (Herek et al., 2006; Herek Decl., p. 6). He reported that "only" 7% of gay men reported experiencing a small amount of choice about their sexual orientation and slightly more than 5% reported having a fair amount or great deal of choice. Lesbian woman reported rates of choice at 15% and 16%, respectively. It is worth noting that these statistics, which are not inconsequentially small, do suggest that sexual orientation is not immutable for all people and again suggest the plausibility that modification of same-sex attractions and behaviors could occur in SOCE for some individuals. Even more important, however, is what Herek failed

to disclose: 22% of male bisexuals and 15% of female bisexuals report having a small amount of choice about their sexual orientation and 40% of bisexual males and 44% of bisexual females reported having a fair amount or great deal of choice. These numbers create a significantly different impression about the enduring nature sexual orientation than the picture painted by Herek. If such a large minority of individuals (albeit mostly bisexuals) experience a self-determinative choice as being involved in the development of their sexual orientation, why would it not be conceivable that SOCE might augment this process for some individuals with unwanted same-sex attractions and behaviors?

Stigma, Discrimination, and SOCE

29. Defenders of SB 1172 frame a significant degree of their arguments concerning harm and SOCE on the negative consequences of stigma and discrimination. While these factors certainly can have deleterious consequences for those with minority sexual orientation, this possibility must be balanced by additional considerations. First, stigma and discrimination alone do not appear to be the complete explanation for greater psychiatric and health risks. Several examples can illustrate this point. Mays and Cochran (2001) reported that discrimination experiences attenuated but did not eliminate associations between psychiatric morbidity and sexual orientation. 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). 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).

30. Second, some health risks, such as HIV transmission among gay men, may be influenced by stigma but are ultimately grounded in biological reality. A recent comprehensive review suggested just this conclusion, finding 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). Recent CDC statistics indicate the rate of new HIV diagnoses in the United States among men who have sex with men is more than 44 times that of other men (CDC, 2011). 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.

31. Third, and perhaps most importantly, 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. 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 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. SB 1172 would eliminate this potential means of reducing the effects of stigma and consequently 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).

32. 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 SOCE for many clients, though this is no doubt hard for those not sharing the religious values of SOCE consumers to comprehend. There is no longitudinal research involving consumers of SOCE 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 unfavorable manner in which SOCE is portrayed by the mental health associations. SOCE practitioners and consumers are associated with poor practices as a matter of courses (Jones, et al, 2010; APA, 2009), despite that fact that they have developed their own set of practice guidelines that, when followed, can be expected to reduce the risk of harm to SOCE consumers (NARTH, 2010).

Concluding Statements

33. There should be no doubt that licensed mental health professionals who practice some form SOCE care deeply about the well-being of sexual minority youth and see SOCE as a valid option for psychological care, while simultaneously affirming as well the client's right to pursue gay affirmative forms of psychotherapy. While it is not possible here to respond to all the accusations that have been made regarding SOCE, the information in the present declaration should be sufficient to question the scientific (not to mention constitutional) merits of SB 1172.

34. As outlined above, there is evidence to reasonably suggest that professional associations such as the APA do not approach the SOCE literature in an objective manner but

rather with an eye to their advocacy interests. This is seen in the purposeful exclusion of conservative and SOCE sympathetic psychologists from the APA Task Force as well as the clearly uneven application of methodological standards in assessing evidence of SOCE efficacy and harm. As the Task Force noted, the prevalence of success and harm from SOCE cannot be determined at present. Anecdotal accounts of harm, which are a focal point of attention by supporters of SB 1172, cannot serve as a basis for the blanket prohibition of an entire form of psychological care, however meaningful they may be on a personal level. Furthermore, such accounts cannot tell us if the prevalence of reported harm from SOCE is any greater than that from psychotherapy in general, where research demonstrates 5-10% of clients report deterioration while up to 50% experience no reliable change during treatment (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004).

35. The normative occurrence of spontaneous change in sexual orientation among youth, the nontrivial degree of choice reported by some in the development of sexual orientation, and the questionable blanket application of the literature on stigma and discrimination to SOCE further bring into question the appropriateness of SB 1172. Sexual orientation is not a stable and enduring trait among youth, and this lends plausibility to the potential for professionally conducted SOCE to assist in change in unwanted same-sex attraction and behaviors with some minors. Granted, research is needed to confirm this suspicion. However, it should be mentioned in this regard that SB 1172 would make further research on SOCE with minors impossible in California, despite the APA Task Force's clear mandate that such research be conducted (Task Force, 2009).

36. Any genuine harm that results from SOCE practice with minors can most appropriately be remedied by the application of ethical principles of practice, including informed

consent, and addressed through the existing oversight functions of state regulatory boards and state mental health associations. One has to wonder: if the tangible, prosecutable harms from SOCE are as widespread as SB 1172 sponsors claim, why have we heretofore not seen SOCE practitioners losing their licenses and mental health association memberships? SB 1172 is a legislative overreach (*LA Times*, 2012) that takes an overly broad and absolute approach to SOCE harm and success despite evidence suggesting age, gender, and sexual minority orientation differences in the experience and degree of change in sexual orientation. In particular, it is fair to ask whether bisexual youth are well served by SB 1172, a distinction the bill does not make.

37. The religiously conservative faith community will not be well served if SOCE among minors is judged *never* to be an appropriate modality for psychological care, especially when the affirmative interventions include the "correction of the client's false assumptions." (Beckstead Decl., p. 6). Should the court agree with this line of argument, then the court is unconstitutionally taking a stand on the validity of certain forms of religious belief. By implying that there is always a better method than any form of SOCE, backers of SB 1172 presume to know what form of psychological care for unwanted same-sex attractions and behaviors is best for the religiously motivated minor clients and their parents. Neither the courts nor the APA should be substituting their judgment for that of a 17-year old who is calculating a cost-benefit analysis in deciding whether to undergo SOCE despite the risks. The APA is quite clear that it supports the competence of a 17-year old girl to give consent to an abortion. Why does the 17-year old lose competence when it comes to SOCE? Similarly, the APA is on record as supporting the availability of sexual reassignment surgery for adolescents (APA, 2008). Should one 17-year old be allowed to surgically remove genitalia while another with unwanted same-sex attractions

and behavior not be allowed to seek change in the dimensions of sexual orientation? This question is especially relevant in light of recent high quality longitudinal research that suggests such surgery does not remedy high rates of morbidity and mortality among these individuals (Dhejne, et al., 2011).

38. The Task Force Report (Task Force, 2009), and the mental health associations that subsequently relied on it for their resolutions on SOCE, provide one viewpoint into research and reasoning that may some merit but must be considered incomplete and therefore not definitive enough to justify a complete ban on SOCE with minors. Currently, there is a lack of sociopolitical diversity within mental health associations (Redding, 2001), which has an inhibitory influence on the production of scholarship in controversial areas such as SOCE that might run counter to preferred worldviews and advocacy interests. An authentically scientific approach to a contentious subject must proceed in a different direction in order to give confidence that the relevant database is a sufficiently complete one on which to base public policy:

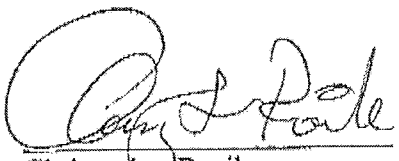
> Fostering hypothesis competition and a heterogeneity of views and methods can simultaneously serve the search for the truth and the search for the good. But there is a pressing need to better articulate the boundary between adversarialism and what might be called heterogeneous inquisitorialism—a partnership of rigorous methodological standards, a willingness to tolerate uncertainty, a relentless honesty, and the encouragement of a diversity of hypotheses and perspectives" (MacCoun, 1998, pp.281-282)

A truly scientific response to the concerns of the sponsors of SB 1172 would be to encourage bipartisan research into SOCE with minors that could provide sound data to answer questions of harm and efficacy that currently are only primitively understood. SOCE practitioners would assuredly embrace such an opportunity (Jones, et al., 2010). Unfortunately, the approach taken by SB 1172 sponsors represented only one (political and legislative) perspective on how to best

address the challenges that come with the psychological care of unwanted same-sex attractions and behaviors. It is therefore a scientifically premature curtailment of the rights of SOCE consumers, their parents, and their therapists and should not be allowed to stand.

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

Executed this 16th day of November, 2012



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Rosik, C.H. (1989). The impact of religious orientation on conjugal bereavement among older adults. International Journal of Aging and Human Development, 28, 251-260.

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For more information, please contact Dr. Michael Schroeder and Dr. Ariel Shidlo telephone (212) 353-2558, email gayconvert@aol.com

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Journal of Human Sexuality

The *Journal of Human Sexuality* is an academic, peer-reviewed journal, an official publication of the National Association for Research and Therapy of Homosexuality (NARTH).

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Contents

Editor's Comments

The National Association for Research and Therapy of Homosexuality (NARTH) is a professional and scientific organization founded in 1992. NARTH's mission is to promote and ensure a fair reading and the responsible conduct and reporting of scientific and clinical research about the factors that contribute to and/or co-occur with homosexuality (same-sex attraction and behavior, or SSA) and that allow psychological care to be effective for those with unwanted SSA. NARTH upholds the rights of individuals with unwanted SSA to receive competent professional medical and mental health care and the rights of professionals to offer that care.

In 2009, NARTH launched the *Journal of Human Sexuality* (*JHS*) in service of this mission and as a way of presenting, encouraging, and producing quality clinical and scientific scholarship on these topics. After its inaugural issue, *JHS* also has included articles on other sexual minority issues and on human sexuality in general.

Same-Sex Attraction is a *Bio-Psycho-Social* Phenomenon

In 2008, the American Psychological Association (APA) published a brochure titled *Answers to Your Questions for a Better Understanding of Sexual Orientation & Homosexuality.*

In this brochure, APA addressed the question of what causes a person to have a particular sexual orientation with this statement:

> There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles. (p. 4)

Reflecting on this statement, which was a significant change from a decade-old APA statement that emphasized the genetic and biological bases of homosexuality, Byrd (2008) noted that APA finally had concluded that "a bio-psycho-social model best fits the data."

Unfortunately, the general public has failed to hear—or at least to understand—that the APA does *not* espouse the belief that persons with SSA are "born that way"! The first volume of the *Journal of Human Sexuality* concluded after a review of public opinion polls that "over the past few decades there has been a clear trend toward the belief that homosexuals are born that way—a belief that is increasing among the general public, as well as in the homosexual community" (NARTH, 2009, p. 44). And a recent Gallup poll reported:

> Currently, 47% of Americans view being gay or lesbian as a sexual orientation individuals are born with, while 33% instead believe it is due to external factors such as upbringing or environment. That 14-percentage-point gap in favor of "nature" over "nurture" is the largest Gallup has measured to date. (May 16, 2013)

Clearly, much education is needed if the public is to come to understand with the APA that "nature and nurture both play complex roles" in the development of SSA. With that goal in mind, volume 5 of the *JHS* offers several articles and a book review. Readers unaware of the range of opinions, theories, and studies about how SSA develops are encouraged to begin with the review and summary of Neil Whitehead and Briar Whitehead's book, *My Genes made Me Do It!* This review/summary tries to simplify what is already an excellent, comprehensive review by the Whiteheads of the scientific and clinical evidence about the bio-psycho-social causes of SSA.

The articles by Lester G. Pretlow ("The Impact of Neurophysiologic Development on the Regulation and the Management of Homosexual Impulses") and by Neil E. Whitehead ("Is First Same-Sex Attraction a Developmental Milestone?")

provide an in-depth examination of questions about how biological factors in particular may influence the development of SSA. Finally, the article by Carolyn Pela—"Narrative Therapy and Women with Same-Sex Attraction (SSA): Claiming Lost Stories"—describes how clinicians may better serve some women but also focuses on how the human need for understanding and drawing meaning from the experiences of our lives may contribute to developing or maintaining SSA.

In Defense of Client and Therapist Rights

Volume 5 of the *JHS* also contains a number of documents in a section entitled "In Defense of Client and Therapist Rights." These documents express NARTH's commitment to the responsible conduct, dissemination, and use of science by professionals and public policymakers, legislators, and other nonmental health professionals involved in promoting personal and public medical and mental health. In particular, these documents express NARTH's unabashed *advocacy* in support of the rights of licensed mental health professionals and their clients to give and receive competent care.

When volume 4 of *JHS* was published a year ago, the governor of the state of California had just signed SB 1172, which seeks to prevent licensed mental health providers from helping *minors* either to change their behaviors or expressions of gender, or to eliminate or reduce sexual or romantic attractions or feelings toward persons of their own gender. Nine months after the California bill was passed, the governor of the state of New Jersey passed a similar bill preventing licensed medical and mental health professionals from serving minors in this way.

This section includes a number of documents with which NARTH and/or NARTH clinical partners have attempted to clarify what clinical and scientific research does and does not reveal about the alleged harmfulness of "sexual orientation change efforts" (SOCE). Unfortunately, as these laws were written and revised, the APA and

other national associations of mental health professionals were negligent in clarifying the nature of the actual research on the potential harmfulness of SOCE—and *all* approaches—to professional care. While the APA and others have persistently warned of the potential harmfulness of SOCE for clients, these associations have failed to inform the general public that *every* approach to medical and mental health care has the potential for harmful—or at least unwanted—side effects.

Lambert (2013) reports that reviews "of the large body of psychotherapy research," particularly the research "literature on negative effects" of psychotherapy, offer "substantial … evidence that psychotherapy can and does harm a portion of those it is intended to help." These include "the relatively consistent portion of adults (5% to 10%) and a shockingly high proportion of children (14% to 24%) who deteriorate while participating in treatment" (p. 192). This general finding is found for all approaches to psychotherapy for all manner of presenting problems.

Can anything but ideological bias allow the APA and others to warn against the *potential* harmfulness of SOCE while failing to warn about the documented harmfulness of *all* approaches? We think that anyone who gives the documents in this section of *JHS* a fair reading will realize that nonscientific and nonprofessional standards—under the guise of science—are being used to prevent medical and mental health professionals from offering care to which minors and their parents freely consent. We think that readers may agree with the NARTH president's response to the news that California governor Jerry Brown has signed SB 1172 into law: "Anecdotal stories of harm are no basis from which to ban an entire form of psychological care. If they were, the psychological professions would be completely out of business" (Rosik, October 1, 2012).

A Note for Potential Authors

Authors of articles, reviews, and official statements of *JHS* are held to the same criteria; namely, what is written needs to be based on a fair reading and the responsible reporting of scientific data and demonstrable professional experience. Readers of *JHS* are invited to review this, as well as past and future volumes, and to decide for themselves and even critique how well—or poorly—we have achieved this goal. Authors interested in submitting papers for future volumes should contact the editor at 1-888-364-4744 or via e-mail at info@narth.com

Philip M. Sutton, PhD

Editor, *Journal of Human Sexuality*

National Association for Research and Therapy of Homosexuality (NARTH)

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Narrative Therapy and Women with Same-Sex Attraction (SSA): Claiming Lost Stories

Carolyn Pela[1]

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Abstract

A metaphor of the construction of a Roman arch has been used to describe the process of narrative therapy. This metaphor is applied to the process of conducting narrative therapy with women presenting with same-sex attraction (SSA). The dominant cultural narrative about SSA is that it is part of the client's identity and is intransient. The foundational philosophy of narrative therapy is suspicious of any claim of permanence. Narrative therapy for SSA helps individuals deconstruct stories that have limited options about sexuality and then facilitates construction of stories that support self-determination. This report offers an alternative to the purely biological, developmental, and psychodynamic approaches to interacting with same-sex attraction.

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Marriage and family therapist Bill O'Hanlon (1994) has used the metaphor of the careful construction of a Roman arch to explain the process of narrative therapy. The classical Roman arch is built with wedge-shaped stones that are held together with the pressure of gravity (Lusted, 2009). The builders carefully and patiently shape each stone to fit with the adjoining stones. When the final stone, the keystone, is put in place, the arch becomes a solid structure—but until the keystone is positioned, the arch needs external support (Lusted, 2009). It may be helpful to imagine the builders laying the stones one at a time, first on the right, then on the left, continuing to alternate sides. Finally, the builders solidify the new construction with the keystone at the center top of the arch. While the stones of the arch are representative of the steps of narrative therapy, the supporting structure is the metaphor for the therapist and other collaborators who are involved in the reconstruction of the client's narrative.

Laying the Foundation

A solid arch needs a solid foundation; in this case, a solid foundation is built with a clear understanding of the philosophy of narrative therapy. The founders of narrative therapy, Michael White and David Epston (Nichols, 2010; O'Hanlon, 1994), approached their work with individuals and families influenced by Bateson's communications theory and Michel Foucault's views on the power of words (White & Epston, 1990). In brief, narrative therapy is concerned with identifying troublesome stories, deconstructing these stories, and constructing (or reclaiming lost) helpful stories. Yarhouse (2008) has written a comprehensive yet accessible review of Foucault's influence on the development of narrative therapy. In summary, Foucault, White, and Epston claim that individuals' realities are constructed within society and through the use of language (White & Epston, 1990). This cocreation of reality is synergistic as we rehearse, elaborate, and together create the discourse.

"Life is about telling and retelling" (M. White, personal communication, October 11, 1996), and because of our tendency to rehearse these stories and to see only what we already believe to be reality, our personal discourses become fixed, shaping our identity. An example is the current Western cultural story about homosexuality as a fixed component of an individual's identity. The dominant narrative continues with the supposition that dissatisfaction with the influence of homosexuality on oneself is actually internalized homophobia. When these dominant discourses are clearly troubling to the individual, the narrative therapist's task is to collaboratively deconstruct the story and build (or discover, reclaim, etc.) a more helpful story.

Underlying this task is the narrative supposition that the problem—not the client—is the problem. This view necessarily impacts the language used in the deconstruction of the old story and ultimately creates freedom from the dominant discourse that the problem is within the individual. This brings into play the core technique of externalization of the problem. Externalizing language begins with the first interview as the therapist asks the client about the problem using language that places the problem outside of the client. Typically, the story that the client brings to therapy is the dominant cultural story that contends that the problem is who she is—whereas the narrative therapist insists, through the consistent use of externalizing language, that the identity of the client is separate from the problem.

Narrative theory is philosophically opposed to practicing psychotherapy from the dominant tradition, which privileges the therapist with knowledge about the client that the client herself is not privy to (White & Epston, 1990). A power differential between the counselor and therapist was troubling to Michael White (M. White, personal communication, October 11, 1996), and the limitations that come with these fixed narratives are problematic in the quest to discover a more helpful story. For example, the dominant paradigm concerning women with same-sex attraction (SSA) may be that they tend to *be* "borderline" or *have* "poor ego functioning." Since therapy is a collaborative

process between the client and the therapist in which stories are cocreated, the concern of the narrative philosophy is that these stories about the woman, owned by the therapist, will permeate the conversation and quite possibly lead to the continued power of SSA over the woman. Challenging the dominant psychotherapeutic approaches, narrative therapy seeks to privilege the client's understanding of the development and meaning of the problem in order to locate the stories that have been lost under the dominant cultural narratives (including the stories from the mainstream mental health culture) and the client's unhelpful, personal narratives.

With this foundational understanding of reality, the narrative approach to SSA will inherently question the current cultural discourse about same-sex attraction (along with related stories about homosexuality, sexual orientation, and gender identity), and will defer to the meaning the client has developed. Toward that end, the therapist will want to ask questions that reveal the client's perceptions. For example, is she bothered, distressed, limited, coerced, or oppressed by the SSA discourse? What is her understanding of the discourse? What does SSA say that she can and cannot do or be? Is she satisfied with these limits or are they distressing? As discussed earlier, one does not need to look far to find the dominant cultural discourse of SSA; this narrative views SSA as permanent and intransient. Conversely, the viewing of problems from a narrative perspective automatically brings those problems claiming intransience under suspicion ("stability is an illusion"—M. White, personal communication, October 11, 1996). A natural response to SSA from a narrative perspective is to doubt the claim that women should accept and embrace unwanted SSA as an identity.

Alice Morgan (2006) has published a comprehensive, user-friendly review of narrative therapy. For those interested in pursuing a clearer understanding and possibly desiring to incorporate narrative theory into their work, Morgan's *What Is Narrative Therapy?* is highly recommended.

Building the Arch

Stone #1: Identifying the Problem

Beginning with laying this first stone—identification of the problem—it is important to start privileging the client's account of her relationship to the problem and her agenda for therapy. This therapeutic predisposition will influence the language the therapist chooses and will set the stage for laying the subsequent stones.

The process of problem-labeling often results in the emergence of subtexts that become the agreed-upon label for the problem. For a woman initially presenting with a global problem of SSA, these subtexts may involve the impact of sexual abuse, the emptiness that she may feel, or a troubling relationship with her father. She may have concluded that men are unsafe or that she cannot have "normal" relationships with them. She may believe that she cannot have nonsexual relationships with women. Through the conversation around the presenting problem of SSA, the collaborators (therapist and client) may finally label the initial problem as one or more of these subtexts.

Whether the collaboration results in the global problem-label of SSA or a subtext of the SSA narrative (mother-hunger, fear of femininity, wounds from father, etc.), it is important to make this label clear before moving on. If the label does not resonate with the client or if she is using a label that the therapist does not yet understand, the therapist and client cannot set an agenda. A mutual understanding of the label is also a confirmation of the therapist's awareness of the client's perspective. Further, a clear and salient label is essential for continuing the use of externalizing language and for successfully personifying the problem. .

When working with a woman experiencing SSA, another task in laying this first stone is discovering if the client has adopted cultural stories around SSA. For example, she may have adopted the "born that way" paradigm. She may also see SSA as an integral piece of her identity, with the internalized conclusion, "I am a lesbian." According

to narrative philosophy, we are prone to rewrite our own history so that it becomes congruent with our current reality. She may have done this, and the resulting theme of her story may read, "I have always been sexually attracted to women." Additionally, she may have created an identity deeply informed by her relationship with the gay community. A narrative therapist will keep in mind that the deconstruction of the problematic personal narrative may involve the deconstruction of the dominant cultural narrative.

Stone #2: Discovering the Client's Agenda

Discovering the agenda of the client should naturally progress from laying the first stone. The agenda often begins to take shape during the first step, but it needs further honing and should be firmly set in place during this phase. When laying this second stone, it is important to continue to use externalizing language, insisting that the problem is the problem. During this phase, the therapist discovers more about the client's relationship with the problem.

White (1991) provided a categorization of two types of questions that may be used for the process of clarifying the client's agenda: landscape-of-action questions and landscape-of-consciousness questions. Landscape-of-action questions direct the individual toward revealing preferred events in her life. They ask, "What does she want to be doing differently?" Landscape-of-consciousness questions focus on preferred beliefs and values that are lived out through the woman's actions. They may ask, "What does she want to be feeling or believing?" Examination of the relationship between preferred actions and preferred beliefs may further reveal the source of distress that the client is experiencing. Establishing congruence between actions and values may be the sole agenda of a woman experiencing SSA.

Some examples of the final agendas for women that I have worked with are diminishing SSA, resolving the incongruence between her values and her actions or desires (often resulting in a heterosexual orientation and identity), a wish to pursue

celibacy, or even acceptance of SSA. It is possible that a more nuanced agenda will emerge from the conversation with the client. Perhaps the agenda is specifically about dealing with sexual abuse or a problematic relationship. The client may have complex goals, but the goals need to be simplified into a workable agenda.

Laying stone #2 may be an iterative process with establishing stone #1. As the agenda becomes clear, the problem definition may shift. During the construction of the agenda, the problem may be further deconstructed, revealing a different view of the problem. In this process it is important to keep the problem label externalized, and the agenda feasible. The collaborators are only ready for the next stone when the client's agenda is clear and necessary adjustments have been made to the first stone.

Stone #3: Personification

Personification is a hallmark of narrative therapy (Durrant & Kowalski, 1990; O'Hanlon, 1994; White & Epston, 1990). The process of personification of the problem began earlier in the arch construction with the use of externalizing language, and it continues in this stage with the primary focus on extricating the client from a shallow, limiting, or unhelpful story. The label of the problem established in the laying of the first stone will often be the metaphor used in personification. For example, if the complaint is SSA, the discussion will involve talking about SSA as if it holds a personality and a mind of its own. Personification of the problem reinforces the perception of the problem—not the client—as the problem.

A key to using metaphors in the process of personification is to avoid language that implies causation. The problem does not cause clients to think, feel, or behave—it only influences, coerces, convinces, tricks, and so on. Personal agency in relationship to SSA, gender identity, and sexual orientation is further enforced through the avoidance of deterministic language and a preference for language that allows hope and autonomy. Personification is a transitional step between stone #2, determining the agenda, and stone

#4, discovering the influence of the problem. Clear personification and externalization of the problem reduces the risk that the client will fear that she is losing a piece of herself rather than an unwanted visitor.

Stone #4: Discovering the Impact of the Problem

In the discovery of the impact of the problem, the therapist uses the label identified in the first step to ask questions about how the problem has influenced, coerced, haunted, tricked, or otherwise impacted the client. Landscape-of-action and landscape-of-consciousness questions (White, 1991) should be used in this phase as in the earlier process of discovering the agenda. For the same-sex-attracted woman, perhaps the problem has been labeled as ambivalence in regard to SSA. In that case, the therapist will want to ask questions like, "How long has Ambivalence been in your life?" "How has Ambivalence kept you from living fully, isolated you from others, maybe even isolated you from God?" "What are the lies that Ambivalence tells you?" "What does Ambivalence tell you about your relationship with God?" "How has Ambivalence wedged its way between you and your family?" "How has Ambivalence limited your choices?" The goal is for the client to continue to externalize the problem, recognize the *problem* as the problem, and further deconstruct the limiting narrative.

Laying stone #4 fosters a view of the problem as external to the client, sees the problem as having ill intent, and should ultimately incite a renewed desire to battle the problem. This desire to battle against the personified problem will allow the conversation to move to laying the next stone. Without the motivation that comes out of seeing the oppressive intentions of the problem—the limitations on the choices and identity of the client—the next stone will not fit with the previous ones. Waiting for evidence that the client sees the problem as separate from her identity and an indication that she is ready to do battle with the problem will facilitate a smooth fit with the next stone.

Stone #5: Exception-Seeking: Discovering Unique Outcomes

Laying stone #5 is the pivotal point in the therapeutic process as it moves from deconstructing the old story to constructing a new story (Durrant & Kowalski, 1994). Prior to laying this stone, the problem has been identified, externalized, and personified. The negative influences of the problem have been documented, and now the therapist and client are ready to find exceptions to the problem. Reclaiming the lost story—wherein the preferred identity lives—is the goal of exception-seeking.

It may be important to pause here to clarify different ways of conceptualizing the "new" story. Since exception-seeking is about finding a history of exceptions to the problem, it presupposes that the new story isn't really new at all, just lost. The alternative, parallel story has been hidden, and "events in the shadows should be reverenced" (White, personal communication, October 11, 1996). The very idea that there are exceptions to the dominant story reveals a core supposition of the narrative theory, that "stability is an illusion" (M. White, personal communication, October 11, 1996). The only thing that we can count on is change (S. de Shazer, personal communication, October 11, 1996).

This process of exception-seeking can be challenging. It is natural for individuals to notice the tyranny of the presenting problem. It gets their attention as it blocks them from experiencing a life of freedom and from experiencing themselves and others deeply. On the other hand, it is very difficult to pay attention to the exceptions to the problem. The insistence of a collaborator becomes crucial during this process. Questions should be crafted to point the client toward times when the problem was not a problem. For example, the therapist might ask, "Tell me about a time when you expected _____ to get in your way, but it didn't." "Tell me about a time when things were going a little better. What was different then?" "Has _____ever taken a vacation? When have you felt free from its tyranny for even a brief period of time?" "What's the longest time that you've stood up to _____?" In his discussion about narrative therapy (specifically applied to problems of sexual identity), Yarhouse (2008) offers this question:

"In what ways are you understanding your sexual identity differently than when you first thought of yourself?" (p. 206) The process of discovery of unique outcomes allows the reclaimed parallel story to emerge.

Since stories are created in community, it may be helpful to ask the client what others may have observed as she seemed to stand up to the problem. The client may choose to ask this question of significant others in her life in order to invite them as co-authors of this reclaimed story. During this time, the collaborators want to underscore, in particular, the times that the client's agenda is supported. Yarhouse (2008) identifies these moments as "identity-congruent actions and attributions" (p. 207). The next stone, stone #6, can be fitted recursively with stone #5 as the exceptions are identified. Highlighting personal agency in the reclaimed story reinforces the reclaimed identity.

Stone #6: Finding Personal Agency in the Exceptions

Since the client has now identified the exceptions, it is critical in this next phase to seek evidence of her personal agency in producing these exceptions (Durrant & Kowalski, 1990). This process will function to further diminish the influence of the old, dominant story in which the client is powerless. The therapist might ask, "How did you manage to maintain this part of your identity in spite of the Ambivalence?" "What made you decide to pursue your interests in spite of Fear?" "How did you stand up to Lesbianism's stereotypes about you?" The therapist wants to know how the client did it and what this tells her about herself (Durrant & Kowalski, 1990). Questions are constructed to take the experiences out of the category of random events so the client can see them as choices she has made from the position of this recovered identity.

Epston's therapeutic letters (White & Epston, 1990) may be introduced here, although they could be used throughout the therapeutic process to document the new story. In short, therapeutic letters are the therapist's reflections and observations of the conversations with the client, written in a letter form, to the client. These letters serve to

punctuate this important part of the client's story now that she has identified a series of exceptions to the problem. These letters seek to highlight the personal agency of the client and capitalize on the personification of the problem. The use of direct quotes or summaries of what the client has communicated is often part of the letter. Inclusion of client-constructed metaphors is especially powerful. My experience has been that the client's own words serve as particularly effective agents of healing as they are reflected in the letters.

The therapeutic letter will often set the agenda for the next session, and it may be sent to the client with that in mind. Letters may also be read at the beginning of the next session as a way of connecting the conversation from one session to the next. On a practical note, the letter may also serve as a progress note for the client file. A rich resource of examples of therapeutic letters can be found in White and Epston's *Narrative Means to Therapeutic Ends* (1990), and a quickly accessible source of examples is found on Epston's website: *http://www.narrativeapproaches.com/antianorexia%20folder/anti_anorexia_index.htm* (n.d.).

Stone #7 The Keystone: Celebrating a New Story/Identity

The seventh stone in the arch is the keystone, which is the apex of the arch. The keystone of an arch is often embellished—and it is fitting for the final metaphorical stone of this process to look special, because it *is* special. Stone #7 functions as the support for the six stones that were previously laid. Once the keystone is set in place, the supporting structure can be removed, and the arch becomes self-supporting (Lusted, 2009). During this phase the therapist asks questions that solidify the identity that has been pulled out of the clutches of the problem. These questions move the client into recovering a complex, rich history of her identity. The therapist encourages the client to reach back and find historical evidence of this new view of herself and to invite others to testify to her recovered story. It is important to be aware that the witnesses to the client's life have often been just as duped as the client in believing the limiting story. The selection of friends and family who will support the reclaimed story is essential.

Another task of this phase is looking to the future and considering how it may be different in light of the recovered story. A question might be, "In light of your ability to stand up to Fear of Femininity, what might be different about your future?" A question for her family might be, "What do you think your daughter's life will be like now that Fear of Femininity is not pushing her around?" Just as the cocreation of the old problematic narrative influenced her story, the cocreation of the reconstructed narrative gives it power. It is not enough for the client and the therapist to have knowledge of this new story; the client must also have an audience. My typical experience has been that this audience has emerged over the course of the therapy and has been celebrating and enjoying the emerging story of the client all along. Nevertheless, this is an important element of keeping the arch together for the long haul. The client's audience may be invited to a session for a celebration, or the client may want to plan a party at home to celebrate with her family and friends.

This is a good place to include another of Epston's contributions to the narrative approach. Near the end of therapy, the client may be invited to co-construct a certificate that celebrates and acknowledges her accomplishments. In addition to serving as a celebratory tool, this process further emphasizes the personal agency in claiming the recovered story. These certificates will typically use the metaphor that was established during the laying of the first stone, emphasizing the client's victory. As an example, the certificate might read, "This is to certify that Jasmine has been victorious over Fear of Femininity (FOF) and all the lies and shame that FOF contains. This will serve as a reminder to Jasmine, and all those who love her, that her identity is no longer controlled by FOF." One of the best resources for this tool can be found in *Narrative Means to Therapeutic Ends* (White & Epston, 1990).

As in the previous arch construction, the keystone is dropped in place only after evidence of the new or recovered story has clearly emerged. An earlier attempt to obtain historical evidence of the reclaimed story might at worst threaten the client's identity, and at best it might frustrate her as she is unable to see the evidence. It is at this point that

the "history of the alternative present has become more deeply rooted than the problem story" (M. White, personal communication, October 11, 1996).

The Therapist's Narrative

My work using narrative therapy has involved collaborating with clients to claim lost stories of power and hope in the midst of their dominant stories of defeat and hopelessness. From the foundation to the final keystone, the construction of the arch requires patient, insistent deconstruction of taken-for-granted discourses and the reclamation of forgotten stories hidden in the shadows. The arch is finally held together with this recovered story that reaches back to the past and extends forward into the future with a discourse that is identity-congruent. While we have taken the arch supports off with the laying of the keystone, the arch will need community to maintain the story, to tell the story, and to retell the story.

The tradition of narrative therapy requires rethinking standards of practice, terms, and worldviews, including psychological paradigms. This work has been for me as much about liberating myself from limiting practice narratives as it has been about collaborating with clients as they free themselves from the dominant discourses about SSA. This challenge is ongoing as I continue to be pressured by dominant understandings that the therapist owns the privileged discourse.

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The Impact of Neurophysiologic Development on the Regulation and the Management of Homosexual Impulses[2]

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Abstract

An understanding of central and autonomic nervous system (CNS/ANS) development is foundational for understanding many human behaviors. The purpose of this article is to explore challenges to the development of these systems and the impacts of these challenges on behavior, specifically on the development of gender identity and same-sex attraction. In situations of good-enough development, the CNS and ANS work in a coordinated effort to manage environmental input (audio and visual) to maintain a *steady-state.* When development of the CNS and ANS are inadequate, the individual can face challenges in managing auditory and visual input and experience an accompanying need to act in some way to restore balance. This article hypothesizes that the developed inability to manage visual, auditory, and other sensory input is a key factor in individuals suffering from unwanted same-sex attraction issues. Learning to modify or even avoid disruptive sensory inputs is helpful in overcoming some of the negative outcomes associated with the development of these—and any other—unwanted behaviors.

Introduction

A bio-psycho-social model of development has been proposed as the best current explanation for understanding how persons come to experience SSA—homosexual (same-sex) attractions (American Psychological Association, 2008; Byrd, 2008). As a biomedical scientist who leads a support group for men dealing with unwanted SSA, I have found that there is a need to demystify the nature and origin of homosexual impulses. Group members have found it helpful to understand that same-sex impulses are in and of themselves morally neutral inputs to (stimulations of) the central nervous system (CNS) through the brain's limbic structures and connections of the limbic structures with the autonomic nervous system (ANS).

Visual and Auditory Stimulation May Influence One's Actions by Impacting the CNS

The ANS is comprised of the sympathetic and parasympathetic nervous systems. These systems allow the body to regain its accustomed, familiar level of body tension or activation—in other words, its steady-state regulation. It does this either by revving up the body (the sympathetic branch causes the body to become more "aroused" and ready for possible reaction) or calming down the body (the parasympathetic branch causes the body to be less aroused and more comfortable with not reacting) (Guyton, 1991; Schore, 1994). Overall, these systems work to maintain the emotional and physiological balance of the body (Carroll, 2009). In other words, sensory inputs or arousals perceived as pleasant or unpleasant to the body are managed by the various nervous systems.

Stimulation and regulation of the CNS and ANS are in one sense influenced by, but in another sense independent of, the meaning—including the "moral" meaning—of any desire, impulse, thought, imagination, memory, or appetite, including sexual appetite. On the one hand, one cannot escape the physiology of the body. For example, in times of stress,

strong stimulation of the sympathetic nervous system provides extra activation—mass or body-wide arousal and a need for discharge of energy—in order for the body to perform far more strenuous physical activity than would otherwise be possible (Guyton, 1991).

In and of themselves, physiological (neurologically reflexive) impulses have no moral significance, but they may lead a person to act in ways that are morally—consciously, cognitively, and volitionally—significant (Guyton, 1991; Schore, 1994).

As mentioned, the sympathetic nervous system revs the body up and the parasympathetic calms the body down (Carroll, 2009; Guyton, 1991). Inputs to these nervous systems come in many different forms. Visual and auditory stimulation have a profound impact on the immediate and long-term structure and function of the nervous system (Schore, 1994). Sights and sounds—as well as touches, smells, and tastes—are internalized as memory; however, they are also internalized as nervous system structure (Schore, 1994). Chronic activation of the limbic system may lead to structural changes in the circuitry of the nervous system—the growth and habitual, coordinated stimulation and functioning of relevant nerves. Such chronic activation is significant, especially if traumatic interactions occur during critical periods when the CNS is developing (Schore, 1994; Schore, 2003a).

Problems can arise when sympathetic and parasympathetic systems become imbalanced due to the chronic activation of the limbic system (Schore, 1994; Schore, 2003a; Schore, 2003b). In these instances, structural problems—for example, neuronal development and habits of arousal or the lack of arousal—may become part of the architecture of the brain (in other words, become "hard-wired") and may inhibit or suppress future functional areas of the limbic and autonomic nervous systems (Schore, 1994; Schore, 2003a).

For example, the sympathetic nervous system may dominate the parasympathetic (or vice versa), leading the body to become chronically or typically over- (sympathetic) or under-(parasympathetic) stimulated. This would lead to a child's

inability to maintain a physiological steady-state, which in turn leads to physical and/or emotional "discomfort" (Carroll, 2009; Schore, 2003a). In effect, the CNS cannot then function optimally because of its challenged architecture (in other words, the habitually over- or under-stimulated nerves); therefore, the child's nervous system becomes inefficient at metabolizing visual and auditory input. In other words, the child becomes over- or under-aroused by what he or she sees and hears (Schore, 1994; Schore, 2003b).

Inhibited Structure-Function of the Nervous System

Inhibited structure-function of the nervous system can begin to develop during infancy (Schore, 1994). This means that an infant who experiences too much or too little stimulation may develop chronic difficulties in how his or her brain and nervous system function. For example, when an infant's excitement (sympathetic arousal) is met with indifference or disapproval by a parent, the child may respond with parasympathetic activation that is experienced as a downward fall into shame, grief, disappointment, and/or guilt (Carroll, 2009; Schore, 1994).

If this mode of communication is reinforced by continued perceived parental rejection, the child's sympathetic structure-function—his or her ability to become excited—may become inhibited. If this happens, the child's parasympathetic structure-function—his or her ability to reduce or avoid physiological/emotional arousal—may become the child's dominant regulator or arousal (Carroll, 2009; Schore, 1994). As mentioned above, if a child's physical and emotional arousal are subject to excessive, habitual parasympathetic control, then his or her emotional life will be dominated by feelings such as depression, shame, grief, disappointment, and/or guilt.

It is important to understand that structural changes in the ANS—such as habitual patterns of nervous arousal—originate in the limbic system (Schore, 2003a). The limbic system is the part of the brain that responds to all external stimuli, but especially to any stimulus—sight, sound, touch, and so on—that is perceived as a threat, such as the loss

of a valued experience or the threat of an aversive experience (Guyton, 1991; Rothschild, 1998; Schore, 2003a). If the child is unable to escape a threat (for example, the separation from his or her mother as in cases of hospitalization), the limbic system may respond with the parasympathetic response of freezing or dissociation (Rothschild, 1998; Schore, 2003a). Bowlby (1960) described this type of behavior as a response in a child who was separated from his mother during hospitalization; the child went through a sequence of behaviors observed as protest, despair, and detachment.

The freezing or dissociated response is mediated by the secretion of hormones involved in the response to a perceived threat. The CNS stimulates hormone secretion from the endocrine system (Guyton, 1991; Morris, 2004; Schore, 1994). Endocrine regulation is a major function of the limbic system and has a long-lasting influence on CNS growth and development (Guyton, 1991; Nolte, 2002; Schore, 1994). If perceived threats persist, the absence of normal hormonal regulation during critical developmental periods causes permanent physical changes and profound structural anomalies in the limbic system and the ANS (Schore, 1994; Schore, 2003a). When a child's limbic system is using its resources to defend against threat, there may be too few resources left for his or her growth and development (Lee, Ogle, & Sapolsky, 2002; Sapolsky, 2003).

During times of extreme threat (for example, a prolonged or even brief stay in the hospital), the child's limbic system sacrifices the secretion of hormones that stimulate growth in exchange for the secretion of hormones that protect the individual against threat—such as those that help the child deal with the aversive arousal of separation from his or her mother (Bowlby, 1973; Sapolsky, 2003). If the infant otherwise survives the threat (for example, endures the separation from his or her mother), an overall negative consequence of this experience can be a lack of development of sufficient neuronal connections between the CNS and ANS that may appear as a parasympathetic over-activation (depression) as the child continues to develop and mature (Sapolsky, 2003; Schore, 1994; Schore, 2003a). In this scenario, the parasympathetic nervous system

becomes the dominant peripheral nervous system regulator. In layman's terms, the child develops an inordinate need for emotional "self-soothing" to ease the uncomfortable, parasympathetic overactivation.

A Compromised Ability to Differentiate One's Gender

During critical developmental stages of the infant nervous system, other CNS structures and functions may be inhibited or suppressed. Since gender identity is also developing during infancy, the neurobiological structures that impart a sense of one's gender may also be inhibited by experiences such as separation anxiety between a child and his or her mother. Traumatic interactions during critical developmental periods may damage the developing structural links (neurobiological circuitry) between the brain (CNS/ limbic system) and the body (ANS) so that a child's sense of his or her gendered body is challenged or even lost. In this situation, the primary and secondary characteristics of gender (in other words, male/female sex) are intact—biological males look like men, and biological females look like women. But what is challenged is the child's—and if it persists, the adolescent's and adult's—ability to differentiate gender (male/female) in his or her own ANS (in other words, in his or her body). In such situations, a neurological/physiological sensory deficit has developed. This may be caused by the suppression or death of neuronal circuitry between the limbic system and the ANS.

Another cause of such a neurological/physiological sensory deficit may be a compromised limbic system. In addition to functions described above, the limbic system controls reproductive behavior (Aggleton, 1992; Guyton, 1991; Sapolsky, 2000). Changes in the limbic structure due to traumatic stress may potentially leave the infant with an inability to differentiate his or her gendered body. Dissociation from one's body becomes a function of neuronal death or suppression due to traumatic interactions—for example, experiencing an inadequate attachment to one's caregivers—on the developing CNS and ANS (Schore, 2003a). The infant is fundamentally left "body-less" with respect to gender

identity because of structural changes in the traumatized CNS and ANS. Bowlby (1969) hypothesized that some neurological impairments caused by separation anxiety may have varying functional consequences that range from total absence to dormancy, in which the underlying structures are partially or completely developed yet remain nonfunctional (Bowlby, 1969). If gender is in—and of—the body (ANS) and if one dissociates from one's body, then one's sense of gender identity can be irrevocably impaired.

How Immature and/or Nonheterosexual Arousal May Develop

A potential arousal and behavioral consequence of this type of impairment of gender identity may be that the infant will learn or imitate gender characteristics from the closest body to it, usually the mother. This may account for the preponderance of cross-gender behavior seen in prehomosexual male children (Green, 1975; Zucker, 1992). As these children reach physiological sexual maturity, the capacity for reproductive behavior (copulation) remains intact, because reproduction is bound to survival behavior, which is also a major function of the limbic system (Sapolsky, 2003). However, the absence or inhibition of certain neuronal circuitry between the brain (CNS) and body (ANS) may leave these individuals with the inability to differentiate not only their own gendered bodies, but also other objects of reproductive significance—in other words, whether one is sexually attracted to a person with a body whose gender would allow reproductive copulation.

This confusion of reproductive objects may manifest itself as attempts to copulate with objects of the same sex, immature objects of the same or different sex, and even inanimate objects. This type of behavior has been demonstrated in animal models and is known as the Kluver-Bucy syndrome, a syndrome in which cell death in specific areas of the limbic system produces atypical copulation behaviors (Aggleton, 1992; Guyton, 1991). This type of confusion may likely be the foundation for homosexual feelings and behaviors in humans.

One consequence of this type of CNS/ANS derailment is that individuals have difficulty processing visual and auditory cues of their gendered self. What he or she may interpret as sexual feelings is really a lack of synchrony between the CNS and ANS. For example, visual input—such as a picture of partially clad males—can lead men who experience SSA to experience "emotionally unbalanced" or overactivated parasympathetic arousal. Instead of perceiving the visual input and subsequent arousal as an indicator of CNS and ANS detachment, a man may interpret this stimulation—or himself—as intrinsically "homosexual." Such an interpretation is unfortunate, because it confuses or mystifies the underlying causes of any subsequent same-sex "reproductive" behavior, as well as the person's self-identification.

Understanding and "Neutralizing" Homosexual Feelings

Some people who experience "homosexual" feelings (same-sex attraction) would rather not. Regardless of whether one wants to experience SSA, persons with SSA may find it helpful to understand such feelings as a challenge to—in other words, a need for—CNS/ANS steady-state regulation. Using the example above, when a man sees a picture of partially clad males and experiences homosexual arousal, it is possible for the man who is aroused to understand how this visual input has affected his nervous system. If and when he is able to see such input and subsequent arousal as a challenge to his steady-state regulation, he is able to neutralize—in other words, normalize or render understandable and commonplace—this visual "input" and the subsequent arousal. Put simply, he can see the same-sex arousal for what it really is—and isn't.

This neutralization—or proper understanding—of visual, auditory, tactile, and other stimuli transforms the input from a "purely" sexual stimulus to an impulse that must be discarded and/or digested (processed) by the CNS/ANS. In this light, the input may come to be understood as not really a sexual cue but a "reflexive" indication of the asynchrony—functional imbalance—between the CNS and ANS. However, the power of

the input (the external stimuli) cannot be underestimated because the processing of the input is bound to the survival behavior of reproduction.

It is important to emphasize that the homosexual "reflex" (SSA) is not about someone else's body, but about one's own—in other words, the CNS/ANS disconnection in one's own body. This disconnection is part of the ever-present, ongoing functioning of the central and peripheral nervous systems and how these systems are accustomed to metabolizing (processing) input from the environment. Just as some foods may give a person a stomachache, some stimuli (such as visual nudity) may give someone's nervous system an overwhelmingly uncomfortable physiological challenge, such as arousal in need of calming or other resolution.

A key ingredient to maintaining steady-state regulation, including reacquiring a measure of internal comfort or peace, is to discard stimuli that we have experienced that can negatively impact steady-state regulation—in other words, that can leave one tense or otherwise uncomfortable. Continued exposure to some stimuli reinforces the positive or negative physiological and emotional consequences on the CNS and ANS, maintaining and/or intensifying one's physical and emotional arousal. Lessening the exposure to such stimuli has value in decreasing physiological discomfort. A teacher once said, "If the eye offends thee, cut it out and throw it away" (Matthew 5:29). Of course, it may be easier to just avoid (as much as possible) stimuli that have a powerful negative impact on one's nervous system regulation than to stop attending to the stimuli. For example, it may be easier to never look at stimulating pictures than to stop looking or recalling what one looked at. But ceasing to look as well as never looking to begin with are both possible.

For persons who find homosexual feelings troublesome, the mere avoidance of stimuli (such as pornographic pictures or videos) that impact the CNS and ANS in a negative way can be extremely helpful to maintaining steady-state regulation. However, keeping oneself physiologically/emotionally calm may require further vigilance, such as

learning to be more cautious about activities as simple as going to the grocery store or spending a day at the beach. Maintaining and restoring steady-state regulation is the goal.

My group members' overall goal is to lessen the impact of all challenges to their steady-state regulation—in other words, experiences of SSA resulting from visual and auditory stimulation—by reducing or limiting such stimulation. In doing so, they hope to learn how to return to a more physiologically and emotionally balanced (less tense and more comfortable) state.

Group members also have found it helpful to recognize the potential root causes of their SSA. Realizing, understanding, feeling, and dealing with emotional trauma that they experienced early or later in their development appears to have a profound influence on gender identity for some of the men. It appears that my group members' efforts to intentionally become aware of the consequences of these traumatic life experiences have enabled the CNS of some of these men to rebound from this trauma. In general, the men in my group have been helped by understanding their experience of SSA in this way.

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Is First Same-Sex Attraction a Developmental Milestone?

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Abstract

This paper combines the well-known concept of developmental milestones with standard statistical analysis of their spread in time to gauge the milestone status/genetic influence on the timing of first same-sex attraction (SSA) by comparison with timing of puberty. SSA is not a developmental milestone, nor does its timing have high genetic influence. The relative standard deviation (RSD) of the average age of first SSA is 40%, which is very high compared with the approximately 7% for milestones with very high known genetic influence, such as puberty. As reported in many studies over a period of thirty years, first attraction occurs at a mean age of ten for both sexes, both orientations, and cross-culturally. While it is commonly claimed in the literature that first SSA is a genuine sexually related attraction and biologically preprogrammed, both of these claims are doubtful. First attraction is on average about two years before puberty; hence it is mostly not puberty-driven. The age of ten is possibly connected with peak awareness of social gender differences. Alternatively but much less probably, the age of first SSA is connected with adrenarche (maturing of the adrenal glands). Age of first attraction turns out to be a poor choice to illustrate alleged innateness. Very few individuals have SSA as their earliest memories, which is hence a false stereotype.

Introduction

It is rather common to hear gay people say, "Oh, I've always been this way. My earliest memories are of feeling different, and attracted to males" (Hillier, Turner, & Mitchell, 2005). In context this usually means that their earliest memories are of SSA, and it implies that such individuals must have been born with those feelings. This is even claimed to be the case cross-culturally (McLelland, 2000). It is still possible to find academic statements implicitly or explicitly suggesting that one is born gay. For example, LeVay (2010) declares that "I am inclined to place most of the developmental control in the hands of prenatal hormones" (p. 279), and *Born Gay* is even the title of one book (Wilson & Rahman, 2005). By this, the authors mean that SSA is influenced predominantly by prenatal factors.

Clearly, people with SSA are not "born that way"—immediately after birth, such individuals cannot even differentiate between themselves and their mothers, let alone distinguish between the genders. The phrase "born that way" therefore means in this context *predestined*, or bound to develop SSA. If this were true, the development of SSA would be a milestone event, like puberty or gestation, which is biologically programmed to occur in a set developmental sequence. The term *milestone* has been applied to various stages in the "coming out" process of GLB people (Floyd & Bakeman, 2006), and first same-sex sexual attraction is one of the milestones included. As the balance of this paper shows, this term is applied inaccurately, since no evidence of biological programming for SSA has been documented.

Statistics of Developmental Milestones

Developmental milestones are tabulated in the literature for things like fetal growth, motor skills development, social skills, teeth eruption, puberty, and menopause. Failure or delay in reaching a milestone may be an important indicator of an underlying medical problem. As typical with a biological system, there will be a range of ages for a particular milestone derived from surveys of normal individuals. There will be a mean, and then a measure of age-spread, normally confidence intervals or the standard deviation, finally tabulated and used by medical professionals. These are generally larger, the later the milestone.

For example, there is a 3.8y standard deviation on the timing of menopause, but only a 0.023y standard deviation on gestation length (Table 1). Clearly the two measures are not directly or usefully comparable. The standard mathematical measurement that avoids this problem uses the coefficient of variation, or the *relative* standard deviation (RSD). The RSD is the standard deviation divided by the mean—in this case, the mean age. If an RSD exceeds 50%, the event is not a milestone. The RSD is used extensively in this paper for comparisons, and it should be noted that some are close to the 50% cutoff. RSDs for selected postnatal milestones are given in Table 1. The literature for first same-sex attraction is treated later (see Table 3). RSD is calculated using time since conception. *First heterosex/homosex* is first sexual experience/initiation.

Table 1. Postnatal Milestones

Milestone	*Reference*	*RSD%*
Gestation length	(Kieler, Axelsson, Nilsson, & Waldenström, 1995)	3.0
First crawling, walking	(Adolph, Vereijken, & Denny, 1998)	7.6
First word, sentence	(Neligan & Prudham, 1969)	5.5, 3.8 (M/F)
Teeth eruption	(Hägg & Taranger, 1985)	8
Puberty	(Kaltiala-Heino, Marttunen, Rantanen, & Rimpela, 2003)	8.6
First heterosex	(Laumann, Gagnon, Michael, & Michaels, 1994)	7.1
First homosex	(Savin-Williams & Diamond, 2000)	33, 27 (M/F)
Hetero-marriage	(Laumann et al., 1994)	6.2
First birth	(Martin et al., 2002)	25
Graying	(Keogh & Walsh, 1965)	26
Balding	(Paik, Yoon, Sim, Kim, & Kim, 2001)	28
Menopause	(de Bruin et al., 2001) (Hayakawa et al., 1992)	7.3
Lifespan	(CDC, 2008)	25[a]

We notice that same-sex initiation seems to have a much larger RSD than opposite-sex initiation or other milestones. High milestone variability is the result of a combination of genetic influences, family/social influences, and random events. These act to increase

the RSD, so it might be a natural interpretation to say that many other influences are involved. It is not very surprising that the RSD for age of first birth to a mother is large, because many more factors enter into this than marriage, including deliberate postponement, difficulties conceiving, and so on. It is no surprise that lifespan has a larger RSD because many factors, such as accidents and lifestyle choices, are involved.

However, things might not be so simple. Sometimes a societal stricture or legal requirement may actually decrease the RSD; for example, all Swedish children must start school at age seven, and the RSD of the exact age is only about 4%. Similarly, it might be thought rather strange that age of marriage is so tightly constrained, but there are many social factors that reduce the spread and tend to produce similarity. If all of one's friends are getting married, there is pressure to get married at a similar time. Because graduation from tertiary education is a normal transition point, age at first marriage might also converge then, and the RSD might be small.

The rule of thumb is that most environmental influences act to increase differences and enlarge the RSD, and that probably also applies to first SSA attraction. Since the degree of environmental influence increases a great deal after birth; one of the clearest illustrations of minimum milestone variability (i.e., relatively small RSD) is prenatal development. Such data is available and can be calculated now from MRI scans and ultrasounds, as shown in Table 2.

Table 2. Prenatal Milestones

Milestone	*Reference*	*Mean Years*	*RSD%*
Size of 10 mm fetal sac	(Creighton University Medical Center, 2006)	0.115	4.1
First head rotation	(Creighton University Medical Center, 2006)	0.200	4.6
Singular sulcus development	(Garel et al., 2001)	0.433	2.2
First arm movement	(Kurjak et al., 2006)	0.538	3.8

RSD expressed as time since conception.

The mean of these relative standard deviations (RSDs) is 3.7%, which is less than the lowest *postnatal* milestones in Table 1.

For purely genetic influence, there is evidence from colonies of laboratory mice that the degree of timing-spread might be even lower (Murray et al., 2010). For laboratory mice, with environmental conditions held very constant by researchers, the timing of gestation has a relative standard deviation of about 1.9%. This varies a little depending on the particular mouse strain. This is lower than the prenatal RSDs for humans in Table 2, but for a fuller comparison with humans, more research is needed.

First Attraction Conceptual Difficulties

The concept of first sexual attraction is now discussed in light of the above background. The concept of attraction is more fundamental than sexual identity, because the latter will have a significant social input; similarly, a behavioral criterion is possibly unreliable. The first attraction data under consideration, although apparently more fundamental, do not necessarily involve genuine erotic arousal and may be less clear-cut than one might imagine. The answers obtained to questionnaires designed to gather data

on first attraction depend on how the questions are framed (Rich Savin-William, personal communication, June 2009). The first attraction may consist of admiration, fascination, or hero worship, and may only later become sexualized. It is assumed here that any reported first attraction has at least a sexualized tinge (Herdt, McClintock, Henderson, Lehavot, & Simoni, 2000).

Another criticism of the attraction data is that adult memories of age of first attraction may be imprecise and unreliable. However, it is reassuring that the test-retest reliability of first attraction age is good (Schrimshaw et al., 2006) and little different from those for sexual identity realization and first same-sex encounter, which are likely to be better remembered.

First Attraction Literature Data

Kinsey, Pomeroy, and Martin (1948) and Kinsey, Pomeroy, Martin, and Gebhard (1953)—the first to investigate sexuality on a really large scale—give lots of sexual data with age, but ironically none on first attraction. They accumulated data on first arousal instead, and by this they explicitly meant physiological arousal, not just attraction. In a review of the literature, Herdt and colleagues (2000) cite the first published calculation of a first-attraction age (ten years) as a long time after the work of Kinsey et al. (Saghir & Robins, 1973).

Since Saghir and Robins (1973), there have been many subsequent studies that measured first attraction (see Table 3). Some studies give only an estimate of the age, while others also give the standard deviation of the age, or enough information so that a standard deviation may be calculated.

Table 3. Mean Ages for First Same-Sex Attraction

Reference	*Mean First Attraction*	*Comment*
Remafedi, Farrow, & Deisher (1991)	10	Both sexes combined
Savin-Williams (1995)	9.6±3.6, 10.1±3.7	Male/female
Bailey & Oberschneider (1997)	10.4	
D'Augelli, Hershberger, & Pilkington (1998)	10±4	Both sexes combined
Savin-Williams (1998)	7.5±3 10.5±6	Male/female
D'Augelli et al.(2005)	10±3.4	Both sexes combined
Schrimshaw et al. (2006)	10.9±3.8	Both sexes combined
Floyd & Bakeman (2006)	11.4±4.8 15.3±6.9	Male/Female
McCabe, Hughes, Bostwick, Morales, & Boyd (2012); McCabe et al. (2012)	10	
Grossman (2008)	12.9± ca. 7, and 9.8±3.5	Two estimates: men only
Corliss, Cochran, Mays, Greenland, & Seeman, (2009)	16±8	Women only. May include attractions other than first.

The mean and standard deviation of the measurements for age at first same-sex attraction for the twelve studies listed in Table 3 is 10.0±4.0 years for both sexes.

The Whitam and Mathy (1986) study of males and the Whitam, Daskalos, Sobolewski, and Padilla (1998) study of females give cross-cultural data that is consistent

with the studies cited in Table 3. In the Witam et al. studies (see Tables 4 and 5), standard deviations for first same-sex attraction were calculated from age ranges provided rather than from year-by-year data. Note that the measured ages of first opposite-sex attraction (OSA) also is included. Comments about the comparison between age of first SSA and OSA are offered in the technical appendix.

Table 4. Age for First SSA for Males

	Brazil	*Guatemala*	*Philippines*	*USA*
SSA	10.6±5.5	8.2±4.9	11.4±3.4	10.9±4.5
OSA	11.6±2.9	9.1±4.2	11.8±3.3	10.3±4.8

(Whitam & Mathy, 1986) Values are years, and errors are one standard deviation

Table 5. Age for First SSA for Females

	Brazil	*Peru*	*Philippines*	*USA*
SSA	14.8±6.9	14.7±7.2	15.2±6.1	13.7±7.3
OSA	12.5±2.8	12.4±3.7	15.1±3.2	9.9±3.6

(Whitam et al., 1998) Values are years and errors are one standard deviation.

Overall, the RSDs are similar to the data in Table 3—that is, the standard deviations are a large fraction of the ages rather than a small fraction.

In their review of the literature, Herdt et al. (2000) describe data from various primitive and sophisticated cultures and estimate that the first attraction (for both SSA and OSA) occurs at age ten. This is interpreted as evidence of a biological origin for first

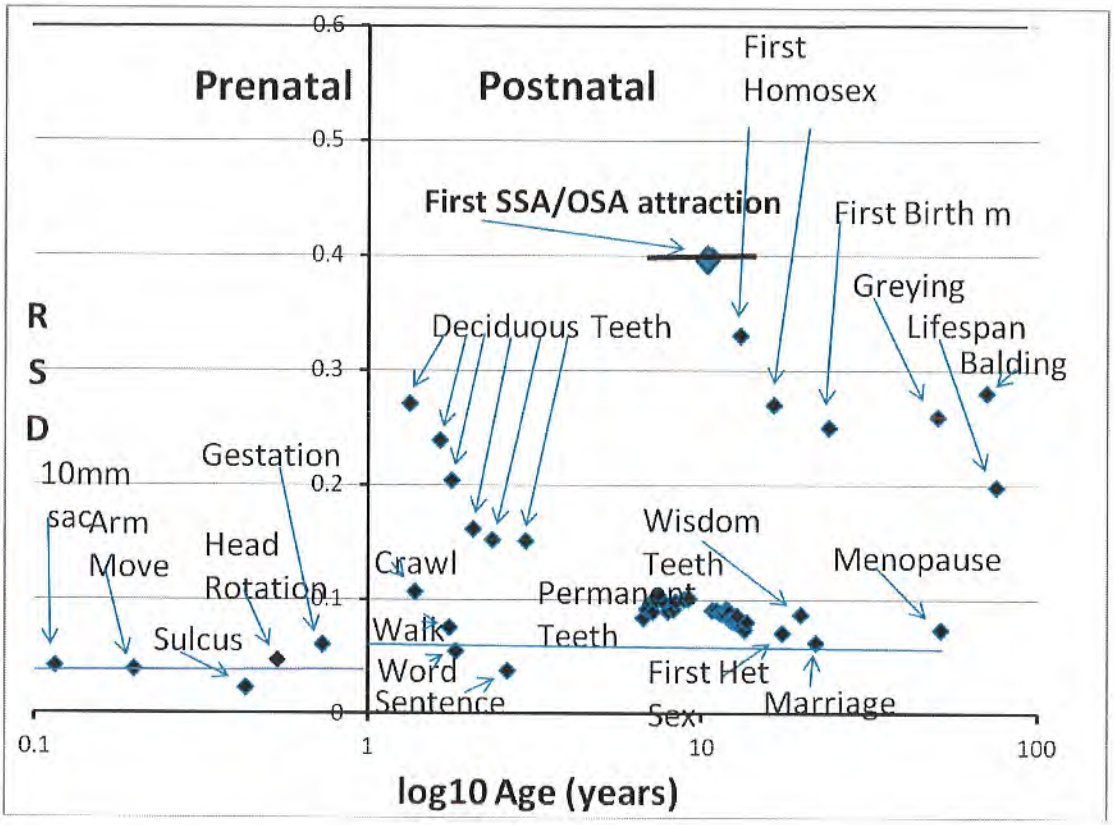
attraction. The title of their paper is the memorable phrase: "The Magical Age of 10." Significantly, the age tabulated in their work does not correlate with the measured age of puberty. This is problematic as evidence for the biological origin of first attraction.

At least in the United States, in more than thirty years of studies—from Saghir and Robins (1973) to Corliss et al. (2009)—measured age of first attraction has changed little. While the age of puberty in the West has decreased considerably over several decades (Katiala-Heino et al., 2003; Kinsey et al., 1948, 1953), in some of the primitive cultures, normal puberty occurs as late as age 19. Herdt et al. (2000) claim that since the age of first attraction is not changing, this must mean that first SSA (and OSA) are biologically programmed and occur independent of puberty and culture. In effect, they assert that age of first attraction is much more tightly biologically constrained than the age of puberty itself, which is very unlikely. The data in the present paper refute this interpretation because the spread in the timing of first attraction is much too large when compared with the age of puberty.

Comparison of Developmental Milestones with First SSA and OSA and First SS and OS Sexual Initiation

The RSD for all of the previously tabulated data on developmental milestones and first SSA (see Tables 1–5) are compared below in Figure 1. The larger the RSD, the wider the spread in the data.

Figure 1. Developmental Milestone RSDs Combined with RSD for First SSA



In the figure, *First Homosex* and *First Het Sex* are data points for first intercourse/ initiation for homosexual and heterosexual respectively.

The highest horizontal thick line for *First SSA/OSA Attraction* emphasizes the 40% relative standard deviation, compared with other lesser relative standard deviations elsewhere in Figure 1; the enlarged diamond is merely for emphasis. This figure shows visually the point in this paper that most biological events are more tightly clustered in age than first attraction. For example, menopause occurs over a restricted age range, but graying of hair is much more variable in age. Lines indicating approximate lowest RSDs for prenatal and postnatal developmental events are included. The OSA first attraction RSD point, which is the same as for SSA, was derived from Tables 4 and 5.

In Figure 1 the values for the relative standard deviation statistic are much higher for deciduous (baby) teeth than for permanent teeth. This is reasonable, because it is less important that deciduous teeth erupt at fixed times.

It is interesting that even walking and first verbal production seem restricted in time to a surprising extent. In contrast, events like balding and lifespan are much more heavily influenced by the environment. Any genetic heterogeneity is included in the table/ figure data and could increase some RSD results.

The same-sex milestones have much larger RSDs than the heterosexual ones. It would be tempting to say that this is the result of societal pressures interfering with SSA, and making the ages at which milestones occur more variable, but this is not correct because the OSA first attraction RSD is similar to the SSA first attraction RSD (and very different from the other OSA milestones). This means either that the concept of "first attraction" is quite unsuitable as a measure of sexual orientation, or similar influences are impacting both.

Comparison of Relative Genetic Influence of Specific Developmental Milestones

Table 6 shows the genetic influence on milestone timing, where known.

Table 6. Percentage Genetic Influence from Twin Studies

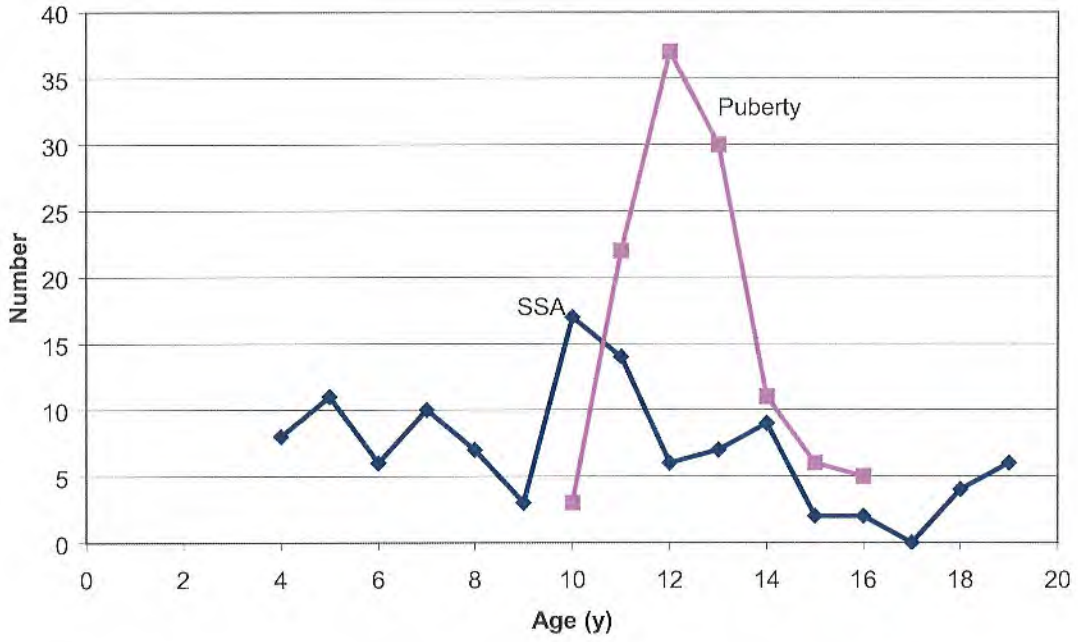
Milestone	*Reference*	*% Genetic Influence*
Gestation length	(Clausson, Lichtenstein, & Cnattingius, 2000)	31[a]
First crawling, walking	Not found	
First word, sentence	Not found	
Teeth eruption timing	(Townsend, Hughes, Luciano, Bockmann, & Brook, 2009)	94
Puberty timing	(Silventoinen, Haukka, Dunkel, Tynelius, & Rasmussen, 2008)	91
First heterosex	(Dunne et al., 1997)	72, 49 (M/F)
Marriage	(Trumbetta, Markowitz, & Gottesman, 2007)	27[d]
Graying	Not found	
Balding	(Rexbye et al., 2005)	79[b]
Menopause timing	(de Bruin et al., 2001)	86
Lifespan	(Hjelmborg et al., 2006)	26[c]

(a) Mother gene influence only—there is also a contribution from the fetus. (b) To a mean baldness criterion rather than age. (c) For 96-year-olds. (Similar results for 2 individual decades previous.) (d). Maximum from ages 20–40, but is RSD on marital status, not RSD on age.

We now compare the RSD on points with a known high genetic influence (more than 50%) from Table 6, such as teeth eruption, puberty, first heterosexual intercourse, balding, and menopause. The mean and standard error of the mean for RSD of these selected milestones are 0.120±0.031. This is very statistically different from the 0.40 for RSD of first attraction ($P<0.001$) so presumably both SSA and OSA first attraction do not have a predominant genetic component.

For a more specific example, the data for first SSA and puberty for males—derived and redrawn from Hamer, Hu, Magnuson, Hu, and Pattatucci, (1993)—are particularly clear, because they are given separately for each year of age rather than as summary statistics. In Figure 2, note that the data for first SSA are very spread out, compared with the data for puberty.

Figure 2. Male First SSA Attraction (Hamer et al, 1993) The numbers are per year.



From Figure 2, SSA age-occurrence is not like the genetically influenced shape of puberty. The two means and standard deviations are respectively 10.0±4.1 years, and 12.5±1.4 years; very different at the $p<0.001$ level by either a t-test or the Levene test for homogeneity of variance.

Using the known very strong genetic influence on puberty timing, the likely genetic influence on first SSA is calculated in the technical appendix. However, the conclusion from the comparison as seen in the figures is that the genetic influence is low and other influences predominate. There is no support for the idea that first attraction is an innate, or inevitable, developmental milestone.

The Possible Involvement of Adrenarche (Full Adrenal Maturity)

Herdt et al. (2000) speculate that the "magical age of 10" may be due to adrenarche, which is a biological milestone. Adrenarche is the first achievement of full adrenal maturity, the point at which androgenic hormones are produced to mature levels and which has been observed to occur also at age ten (Auchus, 2011). Adrenal maturity occurs independent of puberty. It is possible to have puberty without adrenarche (as in the case of adrenal failure), and adrenarche without puberty (as in Turner's syndrome), and sexual attraction will still develop in either case (this example is for OSA). Auchus mentions that adrenarche is not an abrupt and signaled process occurring in mid childhood but rather a continuous process since birth. It therefore is not only independent of puberty but a different type of process and very spread out over time.

One possibility is that first attraction might be due to some prolonged genetic influence connected with hormones from the adrenal gland, which theoretically might explain the spread-out nature of first attraction. However, this seems very unlikely, given the example of girls with congenital adrenal hyperplasia and OSA (Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Such girls have grossly excessive androgen production from well before birth, but not excessive attraction to the opposite sex; in

fact, they have less attraction to the opposite sex. A small but increased proportion of girls with this condition is attracted to the same sex. These girls are not born precociously attracted to the opposite sex; rather they become attracted to the opposite sex in a way similar to those exposed to normal hormone levels. This suggests adrenarche is likely to be a quite minor influence on first attraction.

A Social Hypothesis

An alternative hypothesis is that social environmental factors strongly influence the development of first same- (and opposite-) sex attraction. As described (Whitehead & Whitehead, 2010), the age of ten also coincides with an approximate peak in the differential social gender-development of each sex. For several years after birth, boys and girls have been following the diverging psychological trajectories appropriate to their sex (or for SSA children, often not following them). Having developed social gender characteristics that differ from the opposite sex, boys and girls commonly begin to be interested in those differences, and even attracted to those who are different. This is essentially the "exotic becomes erotic" idea of Bem for OSA, as well as SSA (Bem, 1996). Some of the spread in age at first attraction could simply derive from the variability in time required for encountering a person who is perceived as attractive. Twin studies have shown that romantic opposite-sex attraction has zero genetic influence for adults (Zietsch, Verweij, Heath, & Martin, 2011). Work using a quite large sample of adolescent twins found the same for same-sex attraction in teenagers, i.e., no genetic influence (Bearman & Brueckner, 2002). There seems little doubt that a similar survey for first attraction prepuberty would have a similar result.

A strength of the current paper is that the standard combination of the concept of genetically influenced developmental milestones and the variation of their age-spread has a large and well-established literature but has never before been applied to SSA. This is a fresh approach to the problem of genetic influence that is normally tackled by twin

studies or family studies. First SSA has such a wide relative standard deviation compared to other clearly genetically influenced milestones that it seems clear the appearance of first SSA is only weakly influenced by genetics. This means that the common belief that people with SSA are "born that way" is not supported by the literature on first attraction.

A possible limitation to this conclusion is that measuring first attraction is commonly done by asking only one question in a retrospective, self-report survey. Also, since the concept of "attraction" is so multifaceted, more research is needed to allow for a fuller exploration of this topic. For the present comparison, puberty was not too different in age from first attraction, but other comparisons with wider age disparities may introduce extra mathematical uncertainty.

Conclusions

Although it is common to hear that first same-sex attraction coincides with earliest memories, numerous surveys show this is a very misleading generalization—half of all reported first attractions are later than age ten. It is doubtful whether this attraction is more than a possible harbinger of possible future sexualized attraction, particularly for SSA. Its very spread-out occurrence in time (about 40% relative standard deviation) makes it nearly impossible that it is predominantly biologically influenced. Human post-natal events that are known to be biologically preprogrammed have a much smaller relative standard deviation of about 7% and prenatal events of about 4%. It is also doubtful that adrenarche—adrenal maturity—is an adequate explanation for this "magical age of 10." A social explanation based on the development of psychosexual gender differences is more plausible.

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Technical Appendix

In this appendix, data from tables in the body of the paper are used to estimate the genetic and other influences on timing of first attraction. This method is a minor novelty in the literature, but follows from the mathematics used. Comparison of variances is universally employed, but rarely applied to milestones.

The data for timing derived from Figure 2 are 10.0±4.1 years, and 12.5±1.4 years for first SSA and puberty respectively. The variance of these measures, which is the square of the standard deviation of each mean, is used. Therefore, variances of 4.1^2 and 1.4^2 or 16.81 and 1.96, were compared. The genetic contribution to the timing of puberty from Table 6 is 0.91 or 1.96*0.91 or 1.78 (because the genetic contribution to puberty is only 91% instead of 100%). Other things being equal, we compare 1.78 units of variance contribution for timing of puberty with 16.81 units of variance for first SSA. This means that the genetic contribution to first SSA is about 10%. It could possibly be somewhat less, because the mean age of 10 for first SSA is less than the mean age of 12.5 for puberty (see Figure 2). For a general conclusion, it is enough to know that the genetic contribution to the variance of first same-sex attraction timing is weak rather than overwhelming. The result is similar to a previous estimation from twin studies by a quite different method (Whitehead, 2011).

Figure 2 does not give information we could use to repeat the calculation for OSA. Some first attraction ages (standard deviation in parentheses) can be used from Tables 4 and 5, though they are less precise than the Figure 2 data, i.e., OSA(m) 10.3 (47%) OSA(f) 9.9 (36%).

These two results for OSA again indicate a weak effect of genetics, for both males and females and in the order of 10%.

It may surprise readers that the genetic contribution to OSA timing is apparently so low. While it is quite widely assumed that one is "born OSA," there has been only

one other quantitative test of this hypothesis (Hershberger, 1997). Hershberger tested the existence—not the timing of first appearance—of OSA contrasted with other sexual orientations and found that the genetic contribution to OSA was 18 to 26%. This is a weak to modest influence and puzzling in light of the general assumption that heterosexual orientation is genetically inherited. But this finding apparently has received no subsequent comment. The present finding is reasonably consistent with Hershberger's work, though for the measurement of the timing of appearance rather than the perceived existence of the orientation itself. This implies that nongenetic factors, such as the role of family and society in developing OSA, are much greater than usually thought and the role of genetics much less (Whitehead & Whitehead, 2010). An alternative interpretation is that "first attraction" is not a reflection of adult sexual orientation and either should not be used, or should be used only with caution.

What *Did* Make Me Do It? A Review and Summary of Neil Whitehead and Briar Whitehead's *My Genes Made Me Do It!—Homosexuality and the Scientific Evidence*

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My Genes Made Me Do It!—Homosexuality and the Scientific Evidence, authored by Neil Whitehead, biochemist and science researcher/consultant, and edited by Briar Whitehead, journalist and author of *Craving for Love* (2003)—is a facetious title for a book whose main point is that *our genes don't and can't make us do anything*! That includes feeling or acting on homosexual or same-sex attractions (SSA).

The 2010 version of *My Genes* is a thorough revision of the original 1999 edition. For more than twenty years, Neil Whitehead has personally dedicated himself to reviewing the historical and current professional and scholarly papers relevant to the development and enactment of SSA. By his conservative estimate, he has reviewed more than "10,000 scientific papers" (back cover). The updated 2010 version alone involves the citation of more than 460 scientific and professional papers and publications, almost 200 more than the 1999 edition. These additional citations include the most up-to-date literature from the past decade that is relevant to understanding the origins and outcomes of homosexuality (SSA).

Where to Start Reading

While we agree that the book is a reasonably "comprehensive and accessible" book (back cover), we submit that the Whiteheads cover so many topics and cite so many studies and reports that at times the writing may be daunting for nonscientists. We strongly encourage readers to *begin at the end* with the book's summary (pp. 264–273). This final chapter lists all of the major conclusions of the preceding twelve, including sound-bite conclusions about the evidence for the changeability of SSA and evidence from the twin studies that SSA is *not* genetically determined. In addition to summaries at the end of each chapter, particular bullet-point summaries throughout the text are worth reading before tackling the chapters themselves (see, for example, pp. 36–37, 80–81, 144, and 159–160).

In the following ten sections, the reader will find further commentary on the idea that *our genes can't and don't make us do anything* and on other major ideas specifically concerning homosexuality.

Section 1. Our genes do *not* make us *do anything*!

In spite of a cultural bias that human beings are genetically determined to behave in certain ways, the Whiteheads' review of the biogenetic literature leads them to assert otherwise. In Chapter 1 ("Can genes create sexual preferences?"), they offer a brief review of introductory genetics and conclude that *while genes have an influence in and on* all *human behavior*—making it possible to live and act in and through our bodies—*genes themselves do not make or compel* any *behavior*.

The Whiteheads explain that while the concept of genetic influence is a valid scientific phenomenon, genetic effects are indirect. In other words, genes create an individual who can grow, adapt, and evolve in his environment; however, genes do not dictate behavior. In fact, they represent no more than 10 to 15% of the factors that *do* influence human sexual behavior, whether toward a person of the same or the opposite gender.

The summary at the end of Chapter 1 (pp. 36–37; cf. pp. 265–267) offers not only a clear and simple presentation of the authors' comprehensive review of the scientific literature on genetics, but also a good introduction to the breadth and depth of the research evidence and the scientific logic that they employ throughout the book.

Section 2. While genetic factors are not irrelevant, *neither* heterosexuals *nor* homosexuals are "born that way."

The major part of Chapter 3 ("Are heterosexuals 'born that way'?") reviews research on the development of heterosexuality. The Whiteheads finally conclude that genes do not determine heterosexuality, just as they do not determine homosexuality. Rather, they conclude that heterosexuality also develops in response to environmental stimuli.

To further support the assertion that no one is born with any specific sexual preference, the Whiteheads review in Chapter 9 the reported evidence that claimed a

scientist had found a gay gene. Beginning in 1993, the public was inundated with news reports from the Western media that "a gene determining homosexuality" had been found, even though scientists responsible for the study (Hamer et al., 1993) had reported otherwise.

Attempts to replicate these and other studies to confirm findings of a gay gene have largely failed to show the same results (pp. 164–171). The Whiteheads note that with "the availability now of thorough 'whole genome' scans, gene linkage studies are now becoming rather passé" (p. 164). Also, as the authors discuss in Chapters 1 and 8, we now know that literally thousands of genes may be involved in a single trait. In addition, scientists have observed and believe that the environment may influence the expression of these genes. In other words, *genes provide the blueprints for the formation of the human body, but they seldom dictate particular characteristics of human behavior.*[7]

The study of how genes may influence the behavior of a person—"the way in which the expression of heritable traits is modified by environmental influences or other mechanisms without a change to the DNA sequence"—is called *epigenetics* by biologists (Dictionary.com). Behavioral, social, and developmental psychologists, and other researchers commonly use interaction theory (Magnusson, 1985) to explain the ways that genetic and biological factors affect and are affected by environmental and nonbiological factors (i.e., how "nature" affects and is affected by "nurture"). The Whiteheads' use of *epigenetics* to explain the real but limited influence of genes on sexual behavior may be also—and to professionals in the arts and sciences, perhaps better—explained using interaction theory.

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[7] An example of how to understand this comes from understanding how people develop oral language. Persons with normal, healthy genes and otherwise benign pre- and post-natal physical and psychosocial influences will learn to speak and hear language. The language(s) they learn will be the one(s) used by those with whom they interact while growing up. In this sense, the genes themselves do not determine whether a person learns a language, or which language he or she learns. But the genes are necessary—even if not sufficient—for a particular language to be learned.

However, *the fact that both heterosexuality and homosexuality are not genetically determined does not mean that genetic factors are irrelevant to their development.* The Whiteheads describe such influences as "indirect random genetic factors" (p. 12). Throughout the book, the authors maintain that "in any human behavior . . . any genetic influence is weak and indirect" (p. 10). Consistent with their estimate in the summary of the first edition of *My Genes*, the Whiteheads conclude that genetic factors represent no more than 10% of the total influence on sexuality and emphasize that everyone has about that amount for all kinds of behaviors.

Section 3. Nongenetic (epigenetic) biological factors also do not *make* us develop or act on SSA.

Epigenetic Factors

A number of nongenetic, biological factors (such as fetal developmental disorder, instincts, pre-/postnatal hormones, sex-atypical brain structures) have been either speculated or reported as contributing to the development of SSA, but a careful review and consideration of relevant research shows such claims are unsupported and unlikely, if not implausible. Such factors generally are called *epigenetic*, meaning nongenetic (see above). Figure 5 (p. 32) shows a graphic comparison of the frequency of occurrence of SSA compared with the frequency of actual developmental (epigenetic) disorders. This comparison reveals that "the occurrence of SSA is [five times or more] higher than any [other] single occurrence of epigenetic abnormality, and hence is very unlikely to arise from some random developmental disorder before birth" (pp. 32–33). In brief, SSA occurs too frequently compared with such nongenetic, biological disorders that occur much less frequently.

Hormonal Factors

Chapter 7 ("Prenatal hormones? Stress? Immune attack?") discusses whether homosexuality might be attributable to abnormal prenatal hormonal levels in the mother. Studies of various factors such as exposure to diethylstilbestrol, adrenogenital syndrome,

finger length ratios, other prenatal hormone effects, adult exposure to sex hormones, maternal stress, and the maternal immune hypothesis have shown that the evidence to support this hypothesis is weak.

"Gay" Brains?

In Chapter 8 ("Are brains gay?"), the Whiteheads review older as well as recent research and scientific thinking about how homo- or heterosexuality might in some manner be hardwired in the internal structures of the brain. In addition to older and recent research—which in general has failed to find consistent, innate anatomical/structural differences between male and female brains at birth and beyond (pp. 143–148)—the authors consider the studies undertaken in the nineties, including the LeVay (1991) hypothalamus study.

A consistent pattern exists: when one study claims to have found anatomical brain differences between the brains of persons *presumed* to be homosexual and heterosexual, subsequent studies have failed to replicate the findings. Also, even well-conducted studies have failed to rule out that any differences in brain structure among people who clearly practice homosexual behavior are not the result of "learning." In other words, such differences, if they exist, could be the result—and not the cause—of homosexual behavior. This point is consistent with recent research concerning brain *neuroplasticity*—how the brain can physically change over the lifespan, and the way in which repeated new behaviors can cause predictable changes (e.g., Doidge, 2007).

What if SSA Is an Instinct or a Reflex?

In Chapter 4 ("How strong are instincts?"), the Whiteheads respond to the argument that homosexuality may be "like a powerful instinct" or reflex, meaning that it is so much a part of a person that it is instinctual. Those who support that argument believe that SSA behavior is so deeply rooted in the personality that it is difficult, if not impossible, to change. The Whiteheads consider this speculation in light of what is known about other instincts.

Among the "strong instincts" or "reflexes" humans have are the fight/flight response, a mother's concern for an infant, the need to eat and sleep, yawning, sneezing, pulling a hand away from a flame, and digestion, to name just a few. As powerful as any and all of these instincts or reflexes are, none is so powerful that it cannot be "trained"—in other words, brought under some degree of conscious control.

Considering what this means for the desire to engage in heterosexual behavior, the authors write that even though the desire to reproduce is instinctual, it can be trained and brought under control. Considering homosexuality in this light, the Whiteheads point out that unlike heterosexuality, homosexuality is certainly not connected to reproduction of the human species. Yet even if SSA deserved to be called an "instinct" of any kind, "it is no less malleable than any other of the powerful instincts that man experiences, which, we have seen, are subject to a huge degree to man's will and other environmental influences" (p. 102).

Section 4. Environmental (family and social) factors *are* influential, but they do *not,* in and of themselves, determine SSA.

(This section reviews only what *My Genes* reports about the environmental and social factors that may influence the development of a given person's SSA and behavior. Neil Whitehead has written two articles that address these topics at greater length, both of which are cited in the reference section of this review.)

As discussed above in Section 2, studies of identical twins reveal that postbirth environmental factors contribute to one twin being homosexual while the other is usually not. These factors include the individual's family and social environment, as well as his or her personal psychology.

Developmental Struggles

In Chapter 3 ("Are heterosexuals 'born that way'?"), the Whiteheads review the stages of development that result in heterosexuality and conclude that those who have a

homosexual orientation often have had struggles with different stages of psychosexual development. These stages include a lack of attachment and weak identification with the same-sex parent and lack of bonding with same-sex peers. Such developmental "breakdown(s)" lead "to needs for same-sex affection and affirmation that become eroticized" (p. 90; cf. pp. 82–85). Sexual abuse, which can cause trauma, can also play a role. The Whiteheads note that "rates of male sexual abuse are higher in homosexuals and lesbians than in heterosexuals" (p. 90; cf. pp. 85–86). While such factors are significant for *some* persons who develop SSA, the Whiteheads emphasize that *not all* persons with SSA report these experiences.

As previously mentioned, studies of identical twins in which one twin is homosexual reveal that the identical co-twin is usually *not* homosexual. Therefore, we can conclude that the predominant things that create homosexuality in one identical twin (and not in the other) have to be *postbirth* factors (p. 174; cf. Whitehead, 2011a). As the authors point out, most people indicate that multiple factors led to the development of their SSA, and that no one factor can be considered primary.

Path analysis studies do not *identify unique or individual pathways into SSA*[8]

In Chapter 11 ("Path Analysis: Social factors do lead to homosexuality"), the Whiteheads review studies by Bell, Weinberg, and Hammersmith (1981); Van Wyk and Geist (1984); and Bem (2000). All of those studies used the statistical tool called *path analysis* to try to identify the most common path(s) leading to SSA. Notably, the results of these path analyses—especially in the Bell et al. (1981) study—have been interpreted as failing to support social causes for SSA. The path analysis approach works by statistically minimizing or eliminating "those factors that do not apply to everyone in

[8] For a more extensive explanation and discussion of the results of the studies of homosexuality that have used path analysis, see Whitehead (2011b) elsewhere in this volume.

the sample in the simple attempt to find common factors" (p. 218). Unfortunately, this means that "unique experiences" or individualistic pathways to developing SSA are not identified in the process (p. 218).

The Whiteheads maintain that a proper interpretation of Bell et al. (1981) and other path analyses actually provides evidence that social factors do influence the development of SSA (cf. Whitehead, 2011b). The Whiteheads explain that while path analysis is not the preferred tool for studying homosexuality, it has proven useful when accurately interpreted. While it's true that the development of homosexuality cannot be attributed to a few common causes, multiple identifiable causes have been observed in many different clients, with gender nonconformity being the predominant one. According to the Whiteheads, Bell et al. actually found that social factors are significant; however, no one social factor can be identified as the sole or primary influence in the development or practice of homosexuality. Again, this is consistent with the modern understanding of interaction theory.

In the Van Wyk and Geist (1984) study, the strongest precursors of SSA were found to be "intense sexual experiences and feelings of arousal and pleasure or discomfort associated with those experiences" (p. 219). In particular, males with SSA reported having had childhoods characterized by poor relationships with their fathers during the teenage years, more female companions at age ten, fewer male friends at ages ten and sixteen, avoidance of sports activities, and predominant sexual experiences with males. The exact opposite has been found for females with SSA (pp. 219–220).

Finally, the path analysis done by Bem (2000) also found that childhood gender nonconformity was an important factor in the later development of SSA, a finding that confirmed Bell et al.'s (1981) finding. Bem also concluded that compared to childhood gender nonconformity, "genetic influence is near zero" (p. 221).

Section 5. Idiosyncratic responses to "chance" or "random" life experiences have the greatest influence on who does—and doesn't—develop SSA.

It must be acknowledged that postbirth factors include not only influences that come from a person's family and social environment, but also the psychological and behavioral responses that he or she has in response to these influences. One goal of psychology as a science is to investigate such individual differences in response to the experiences of one's environment. The importance of individual, unique, or idiosyncratic perceptions of and responses to common factors—for example, circumstantially similar family or social events to and with which a person interacts—are discussed in this section.

Those who accept that SSA develops primarily through *psychogenesis*—the interaction of psychological factors and processes, notably psychopathological—may find this section, if not the entire book, disappointing. While the Whiteheads do examine some of the historical issues surrounding this understanding of SSA as the result of a personal interactive process—including some of the work of current clinicians and theoreticians who have championed primarily or exclusively psychological theories of causation—the authors do not attempt to present these professionals' views comprehensively. It is not that understanding the evidence from psychotherapeutic experience is unimportant; the authors specifically criticize the American Psychiatric Association and the American Psychological Association for ignoring these reports (see Section 10). Rather, it was simply not the intent or scope of the book to discuss them (see Section 7).

Concerning the material discussed in Section 4, the authors emphasize that what is of paramount importance in the development of SSA are the idiosyncratic cognitive and emotional reactions to particular environmental events, many of which have been identified as pathways to the development of SSA. Whether it happens within

or outside the family, an experience proves influential if it both catches and keeps a person's attention. The influence increases if the person also responds behaviorally to the experience and his or her response becomes a *habit* (see Section 6).

Chance, Random, One-off Experiences

Along with the consistent conclusion that a person's genes didn't and couldn't make him or her feel or act on SSA, the most significant idea of the Whiteheads is their repeated mention that idiosyncratic responses to chance, random, or one-off (British-English synonym for the preceding terms) events are *the* most significant factor in the development of SSA. The use of terms like *chance* and *random* warrants further explanation.

The Whiteheads define *chance* as "an individual's reaction to random life events" (p. 16). Their definition includes two assumptions. 1. Everyone in a given age group does *not* have the same objective experience or event. 2. Everyone who *does* share an objective experience does not have the same personal, idiosyncratic, subjective experience and/or will not respond to the experience in the same way. (See Section 6 for a further discussion of subjective, individualistic responses.)

As seen in Section 4, twin studies research (Chapter 10) offers good illustrations of chance or random experiences. For example, research shows that perceptions among even identical twins can be erratic even though both twins witnessed or participated in the same objective experience of their parent(s). Furthermore, individual chance events can affect one child in unique ways. For example, a child who stumbles across pornography during adolescence may react in a way that his brother does not. It is not unlikely that an initial experience of pornography or sexual arousal by another means *may* lead to repeated similar experiences and, eventually, a tenacious habit.

Though not primarily related to SSA, another example helps illustrate this. All persons of a certain age have not experienced and will not ever experience sexual abuse.

Of those who have experienced sexual abuse, some will be more distressed than others, and their distress will last for a longer time. Some, but not all, of those abused will abuse others or might develop SSA. In statistical terms, this may be called an *interaction effect*—the combination of one or more unusual, attention-getting, nonuniversal (chance, random, one-off) experiences with certain personal, internal, and external responses. The main effect—the experience of sexual abuse—alone does not determine how the person is affected by the event (having been sexually abused).

Section 6. Early sexual experience that becomes habituated appears to significantly influence the persistence of SSA into adulthood.

Sexual Habits

Along with the message that same-sex and opposite-sex attractions are *not* genetically determined, the Whiteheads emphasize throughout their book that patterns of sexual feelings and behaviors—heterosexual as well as homosexual—are learned habits of thinking, feeling, fantasizing, and behaving. They state, "According to Gebhard (1965) of the Kinsey Institute, unusual behaviors and preferences can often be traced back to *one-off incidents* of this nature" (i.e., "*chance incidents—random circumstances* unique to the individual that are in some way associated with sexual arousal") (p. 79; emphasis added). As discussed in Section 3, the authors report that sexual behaviors are developed by episodes of training or habit.

It is not the random experience itself but the person's "random reaction" to the experience that matters most. Random reaction, if it structures itself into self-image, can become a significant contributor to homosexuality, as twin studies show. The overriding outcome is a homo-emotional focus on people of the same sex that, at puberty, gets confused or melded with genital sex. This begins to finds expression in sexual acts with others of the same sex that become habitual and often (particularly in males) addictive (p. 272, emphasis added).

Section 7. SSA (or homosexual orientation) is *not* immutable. People *can* and many *have* changed, some spontaneously and others with assistance.

Based on their review of the literature, the Whiteheads summarize: "There is nothing fixed or final about the homosexual orientation and its natural expression—homosexual behavior" (p. 10). In fact, numerous reports in the scientific literature over many decades reveal that a significant amount of orientation change occurs during the lifespan, some of it spontaneously and some of it through the medium of counseling. Many persons who once felt same-sex attractions and/or acted to gratify them have diminished or ceased doing so, and some of these have developed opposite-sex attractions and behaviors. A similar number of persons who once categorized themselves as OSA (opposite-sex attracted) develop SSA, but this number constitutes only one-seventeenth of heterosexuals (instead of half of all homosexuals). This change illustrates that homosexuality is not hard-wired in the brain nor is it the result of predetermined genetic factors.

In Chapter 12 ("Can sexual orientation change?"), the Whiteheads review the clinical and research literature on both *assisted* (professionally or pastorally aided) and *unassisted* (spontaneous) change in sexual orientation. They note that research shows that change occurs in both directions—from homosexual to heterosexual and from heterosexual to homosexual (pp. 224–231).

In answer to the question posed by the heading of Chapter 12 ("Can sexual orientation change?"), the Whiteheads summarize:

> There is abundant documentation that people with SSA do move toward a heterosexual orientation, often with therapeutic assistance, but mostly without it. Some achieve great change, some less, but it is clear that sexual orientation is fluid, not fixed. (p. 259)

The Whiteheads make special mention of the fact that if we can find even one person whose sexual orientation has changed, that alone will disprove the theory that sexual orientation is immutable.

Areas for Future Research

At times, the Whiteheads mention findings or offer impressions about changes in SSA and behavior that warrant further research. For example, the authors advocate more thorough study of how those who change without assistance do so and under what conditions professional assistance is necessary or warranted. Another important area for further research is clarifying which factors are most helpful for those who do seek assistance.

Section 8. Science provides a basis for encouragement and hope for those who experience unwanted SSA and for those who care about and for them.

Section 7 documents that many persons who once experienced unwanted SSA no longer do so, to various degrees. Such persons have reported—or it has been reported by others—that they have changed in satisfying ways, either through their own efforts alone or with professional or other assistance. Although the primary purpose of *My Genes* is to review what the scientific evidence does—and does not—show about what may influence the small minority of persons who do experience SSA, the Whiteheads offer more. At times, they write more as humanitarians, offering words of compassionate encouragement, hope, and challenge to those who experience SSA and their parents.

Section 9. It is unrealistic to expect that future research will change any of the preceding conclusions.

Many ask the question: Is it possible for science to find some biological link to SSA that resolves its etiology once and for all? The Whiteheads answer: "No!"

The Whiteheads offer the current body of empirical knowledge and scientific logic as a basis for asserting that future research will *not* someday prove that people with SSA *were* "born that way" and that their genes *did* make them do it after all. The authors mention several reasons for their confidence. First, most of these scientific findings have been clearly established from facts that will not change (p. 271).

Second, the strongest reason for confidence that the conclusions in *My Genes* will not be contradicted by future research comes from the studies of identical twins. As already discussed in Sections 2 and 4, MZ twins have identical genes—but in most cases, if one is homosexual, the identical brother or sister usually isn't. There is only an 11 to 14% chance that an identical twin is also homosexual. Involved in this are all the influences we know about now as well as those we have yet to discover. Added together, all those influences have only a rather weak effect on what leads a given person to feel and experience SSA (p. 271). We can reasonably conclude that future research will enter new fields and come up with new links, but none of them will be definitive (p. 271).

Even if scientists one day *were* to discover a gene that all persons who experience SSA have and that persons who do *not* experience SSA lack, it would not mean that such a gene *makes* those who have it feel and behave accordingly. The point of Chapter 1 (and Section 1 of this review) is that genes simply don't work that way in human beings. In all but the most primitive living organisms, including humans, single or multiple genes may influence but do not dictate behavior. Such influence may be cooperated with or transcended. The Whiteheads offer an insightful challenge:

> DNA *is* a measure of what you are . . . but depending on what you *do*, and the *choices* you make, you may end up merely letting your genes *define* you, or totally *transcending* them. The staircase upwards only *starts* at the genetic level. (p. 37, emphasis added)

While future research will undoubtedly further clarify the relationship between genetic and biological factors and the development of SSA and behaviors, it is *not* realistic to expect future research to change the truth that the feelings, thoughts, fantasies, and behaviors of SSA are not determined wholly or primarily by one's genes or biology.

Section 10. Current professional, political, and social cultures make it difficult to research, educate about, and provide professional care for unwanted SSA.

Along with reviewing relevant scientific research, the Whiteheads at times engage in professional and social criticism and advocacy. Along with their humanitarian comments, which are reviewed in Section 8, their attempts at social commentary and advocacy may be seen primarily in the introduction and toward the end of Chapter 12 (pp. 241–254). At the outset, they assert that for the last two to three decades, the West has been bombarded with propaganda and misinformation about SSA. This misinformation has affected everything from public institutions, such as legislatures and courts, to churches to mental health institutions.

In writing the book, the Whiteheads were both mindful that political correctness and fashion have allowed misinformation and disinformation about SSA to trump scientific accuracy and determined to clearly and responsibly state what scientists can and cannot say about these matters. They voice particular concerns about the politically—instead of scientifically—grounded positions and activities of the mental health professions about matters related to SSA (cf. pp. 5–6, 241–246).

The current gay-activist climate within the mental health professions makes the responsible conduct of research and therapy difficult. For example, mental health professionals in many jurisdictions in the West are prohibited by law from offering therapies that assist individuals in changing their sexual orientation.

What Did *Make Me Do It? A Review and Summary of* My Genes Made Me Do It!

The Whiteheads criticize particular pronouncements and other activities by both the American Psychiatric Association (2000) and the American Psychological Association (2009) (pp. 241–246). Both organizations have demanded "a level of proof" that is not required of therapies for other problems that efforts to change SSA works (p. 243).

Why Persons with SSA May Attempt to Make It More Difficult for Others *to Change*

Of particular interest are the Whiteheads' speculations about why gay activists *resist* change (pp. 248–250). For example, among gay activists are those who attempt to discredit others who claim that they have changed and actually become enraged when mental health professionals claim that change is possible. The Whiteheads speculate that many may have tried alone for years to change but have failed.

Others feel that by admitting to the possibility of change, they may end up surrendering political gains made in the area of human rights. Still others may not want to give up the gratification of their sexual activities now that such activities have become mainstream. Finally, some gay activists believe that those who desire change have been pressured by others and are acting out of shame or guilt for having same-sex attractions.

The Whiteheads take issue with the hypothesis that societal attitudes have made gays and lesbians commit suicide more than heterosexuals. Research doesn't support this notion. The authors note that Bell and Weinberg (1978) found that "gay suicide attempts, when they are directly related to homosexuality, are often over the break-up of a [SSA] relationship" (p. 257). Likewise, more current studies that have tried to establish a link between societal oppression and discrimination have failed to do so (p. 257).

Concluding Comments

As a fitting conclusion to this review of the 2010 edition of *My Genes,* two important ideas from the last chapter of the book suffice. First, the Whiteheads inform us that our genes can't and don't make us do anything. Next, they tell us that SSA is

multifactorial—that is, the causes of SSA cannot be reduced to one or two variables. In the end, a person who develops SSA does so for a variety of reasons, none of which are determinative but all of which are influential as he or she interacts with these factors in individual—even if at times commonly shared—ways as a unique human being.

Professionals, scholars, parents, pastors, legislators, and especially those who experience SSA—or who are concerned that they do or will—will find it well worth the time to read the scientific data and reasoning that allow the Whiteheads to form their conclusions.

Finally, the reader of this review is encouraged to visit the Whiteheads' website (http://www.mygenes.co.nz/). In addition to a copy of their 2010 book that is available for download, additional reviews of reports of studies concerning "homosexuality and the scientific evidence" that were published after *My Genes* may also be found.

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California Senate Bill 1172: A Scientific and Legislative Travesty—A Look at the Bill's Misuse of Science[9]

May 7, 2012

Christopher H. Rosik, PhD

[9] Editor's note: This document was a response to an early version of SB 1172 that included language prohibiting mental health professionals from engaging in SOCE with adults as well as minors.

California Senate Bill 1172 is a first-of-its-kind legislative effort to usurp the role of professional mental health associations and ban change-oriented psychological care to minors. This legislation assumes that sexual-orientation change efforts (SOCE) constitute a form of family rejection that will likely result in harm.

In reality, however, there is virtually no evidence to support this claim. In fact, the SOCE literature reporting harm among youth is extremely scarce and conducted only with nonrepresentative samples. A single study was used by the bill's supporters to support their claim—and it is remarkable that the authors of SB 1172 could even conceive that this particular study had any relevance to their legislative aims.

Furthermore, National Association for Research and Therapy of Homosexuality (NARTH) clinicians have long advocated that parents with traditional values need not "reject" their child. Parents can be encouraged to love and accept their children, even when they disapprove of their child's sexual lifestyle choices.

Secondarily, SB 1172 will also dictate the content of consent forms in SOCE therapy with adults and will create the threat of legal action against therapists. Despite the existence of a substantial body of research evidence that some clients can change, and the lack of any research showing that harm is likely, clinicians will be required to tell their clients that the therapy they offer has no scientific validity and often results in harm.

While NARTH opposes this bill on many counts (see http://narth.com/2012/04/narth-statement-on-california-sb-1172-sexual-orientation-change-efforts/), this legislation is particularly worrisome in its use of scientific research. The bill cites only one study to support its claims—a study that is presumably the most scientifically important research from the perspective of the sponsors of the bill (a group called "California Equity"). The use of a single study as justification to create new civil law can serve to clarify how activist agendas and politicians who are ignorant of research methods can work together to distort science and dictate a particular partisan outcome.

In the case of SB 1172, the specific aspect of the bill suited for this analysis regards the effects of SOCE on minors.

Claims of SB 1172

In Section 1, following a laundry list of quotes from professional organizations handpicked to directly or indirectly discourage SOCE, the bill states in item (i):

> Minors who experience family rejection based on their sexual orientation face especially serious health risks. In one study, lesbian, gay, and bisexual young adults who reported high levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection. This is documented by Caitlin Ryan, et al., in their article entitled Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults (2009), 123, Pediatrics, 346.

This is followed by item (j):

> California has a compelling interest in protecting the lives and health of lesbian, gay, and bisexual people.

NARTH is clearly on record in its *Practice Guidelines* (http://narth.com/2011/12/narth-practice-guidelines/) as being very concerned that minors who engage in SOCE and

the parents who bring them to treatment are provided with a high level of professional care. Such care extensively evaluates the clinical and motivational context of all parties to minimize any risk of harm.

In my own clinical work, I have told several parents upon initial evaluation that their teenage child was not invested in change at that time, and therefore their best path forward was to love their child and keep the lines of communication as open as possible. Yet SB 1172 appears to be engaging in a guilt-by-association argument, whereby SOCE with minors is *by definition a marker of family rejection* that endangers the lives and well-being of these youth.

The rhetoric coming from the office of Senator Ted W. Lieu, who introduced this bill, certainly seems to confirm this assertion (see http://sd28.senate.ca.gov/news/2012-04-23-senate-panel-cracks-down-deceptive-sexual-orientation-conversion-%E2%80%98therapies). It asserts, among other things, that:

- "[SOCE] . . . has resulted in much harm, including a number of lesbian, gay, bisexual and transgender youth committing suicide."
- "Some individuals perceived that they had benefited from sexual orientation change therapy, but the *vast majority* of participants perceived that they had been harmed."
- "Sexual orientation change therapies . . . are the types of sham therapies that California law does not protect against for minors."
- "These bogus [SOCE] efforts have led in some cases to patients later committing suicide, as well as severe mental and physical anguish. This is junk science and it must stop."

These quotes, not to mention the greater content of the bill, make it painfully obvious that the sponsors of this legislation believe that licensed clinicians who engage

in SOCE are placing significant numbers of their minor clients in serious physical and psychological danger.

To bolster their case with research, the sponsors cite a study by Ryan, Huebner, Diaz, and Sanchez (2009) in the respected journal *Pediatrics* that provides the genuinely sobering statistics noted above. But does this study really support the bill's implication that SOCE constitutes a form of family rejection that results in increased risk of negative health outcomes for minors? To answer this question, it's imperative to take a closer look at the actual research.

Methodological Analysis of Ryan et al. (2009)

In order to provide a certain degree of objectivity to this analysis, I will refer to the standards for conducting research outlined in the *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (2009). Keep in mind that these are the standards that the APA used in its report to justify the nearly complete dismissal of the vast body of research literature supporting the effectiveness of SOCE. Thus, it is appropriate and highly relevant to examine the Ryan et al. (2009) study through the APA's own analytical lens, since in this instance research is being cited not to support, but rather to ban, SOCE.

Sampling issues. The Ryan et al. (2009) study described its sample procedure as one of "participatory research" whereby the researchers "advised at all stages . . . the population of interest (LGB adolescents, young adults, and family members), as well as health care providers, teachers, and advocates" (p. 347). However, as the APA report (2009) noted, "Knowing that one is being studied and what the experimenter hopes to find can heighten people's tendencies to self-report in socially desirable ways and in ways that please the experimenter" (p. 32).

This same standard of avoiding potential demand characteristics was clearly violated in the Ryan et al. (2009) study, where "providers, youth, and family members

met regularly with the research team to provide guidance on all aspects of the research, including methods, recruitment, instrumentation, analysis, coding, materials development, and dissemination and application of findings" (p. 347).

Recruitment issues. Ryan et al. (2009) described their procedure for recruitment of participants as follows:

> Participants were recruited conveniently from 249 LGB venues within 100 miles from our office. Half of the sites were community and social organizations that serve LGB young adults, and half were from clubs and bars serving this group. Bilingual recruiters conducted venue-based recruitment from bars and clubs and contacted each agency to access all young adults who use their services. (p. 347)

A main methodological critique of the SOCE literature offered by the APA report (2009) concerned the limitations of convenience sampling. The task force that authored the report (2009) warned that "additionally, study respondents are often invited to participate in these studies by [therapists] who are proponents of SOCE, introducing unknown selection biases into the recruitment process" (p. 34). Furthermore, the APA observed that since "study recruiters were open proponents of the techniques under scrutiny, it cannot be assumed that the recruiters sought to encourage the participation of those individuals whose experiences ran counter to their own view of the value of these approaches" (p. 34).

Although the Ryan et al. (2009) study had an admittedly different focus than the APA report (family rejection of LGB young adults versus outcomes of SOCE), the APA's warnings are relevant here: selection bias in recruitment is certainly a plausible risk. While it no doubt appears probable that LGB youth face higher risks of family rejection that can contribute to negative health consequences, Ryan et. al.'s recruitment methods make their findings unreliable for generalization to LGB youth as a whole and provide

no scientifically relevant information for assessing perceptions of family rejection among SOCE minor clients. In fact, SOCE-related family rejection experiences were not even assessed in Ryan et al.'s study.

Generalization difficulties are also created by the sample composition of Ryan et al. (2009). The sample is limited to young adult non-Latino and Latino LGB persons. The APA report (2009) noted that research on SOCE has "limited applicability to non-Whites, youth, or women" (p. 33), further stating, "No investigations are of children and adolescents exclusively, although adolescents are included in a very few samples" (p. 33). This means that even had Ryan and colleagues assessed for SOCE backgrounds among participants, it would be inappropriate to generalize their findings in a manner that would cast aspersions on all SOCE experiences of minors—which, again, is precisely what SB 1172 is determined to do.

The SOCE literature pertaining to harm among youth is extremely scarce and is conducted only with nonrepresentative samples. I am unaware of any studies assessing specifically for family rejection among SOCE with minors. This may be why the authors of SB 1172 had to set aside all pretensions of scientific restraint in their citation of Ryan et al. (2009).

Measurement issues. Finally, the inapplicability of Ryan et al. (2009) as demonstrable support for SB 1172 can be questioned on measurement grounds as well. The APA task force (2009) severely critiqued the SOCE research on measurement grounds, observing that "overreliance on self-report measures and/or measures of unknown validity and reliability is common" (p. 31). Even more to the point, "people find it difficult to recall and report accurately on feelings, behaviors, and occurrences from long ago, and with the passage of time, will often distort the frequency, intensity, and salience of things they are asked to recall" (p. 29).

It appears that these cautions could equally apply to the Ryan et al. (2009) study, since participants averaged just under twenty-three years of age—in other words,

they were recalling experiences that occurred on average three to ten years earlier. Furthermore, psychometric information on reliability and validity was not provided by Ryan et al. for some of the measures they developed (for example, substance use and abuse and sexually risky behavior).

In addition, Ryan et al. (2009) acknowledge that "given the cross-sectional nature of this study, we caution against making cause-effect interpretations from these findings" (p. 351). Presumably, this caution alone should have been enough to prevent the authors of SB 1172 from employing the Ryan study. Even had the study findings been generalizable, they would have not been able to indicate whether SOCE caused the negative health outcomes or if youth with negative health markers disproportionately sought SOCE.

Other problematic aspects of Ryan et al.'s (2009) construct development include the dangers of losing important interpretive information by dichotomizing continuous variables, the limitations of using perceptions of family rejection (such as being blamed by a parent) versus objectively verifiable variables (such as registration at a homeless shelter), and the lack of a measure of impression management.

The question is not why the designers of SB 1172 failed to report such limitations of the Ryan study. Rather, it is how the authors could even conceive that this research had relevance to their legislative aims.

SB 1172: A Legislative Solution in Search of a Clinical Problem

This analysis of the science behind SB 1172's intention to ban SOCE to minors should in no way be construed to imply that psychological injury does not occur from family rejection for some GLB youth. NARTH clinicians share a concern for the welfare of GLB youth and therefore take great care to determine if coercive influences are implicated when minors present for SOCE. While some opponents no doubt view SOCE with minors *by definition* as reflecting family rejection, there is no data to back up this

claim, and the experience of NARTH professionals is that parents can be assisted to love and accept their child without having to sacrifice their traditional values regarding sexual expression.

My intent in this brief investigation of the Ryan et al. (2009) study through the lens of the methodological standards of the APA report (2009) is simply to demonstrate how science appears to have been hijacked in the service of concocting an authoritative-sounding link between SOCE, family rejection, and negative health outcomes.

Based on this analysis, there appears to be no scientific grounds for referencing the Ryan et al. (2009) study as justification for a ban on SOCE to minors. The study's findings, while likely reflecting some underlying connection between family rejection and mental health outcomes, are not reliable and have no scientific justification for being generalized to minors who engage in SOCE with licensed therapists. It is troubling that SB 1172 would utilize Ryan et al.'s work when the internal and external validity limitations of the study make such claims profoundly misguided, as underscored by the APA task force that authored the report (2009). SB 1172 therefore supports its attempt to ban SOCE for minors with a study that cannot be generalized. Additionally, its authors cherry-picked citations from several mental health associations, *none of which* have banned SOCE with minors.

By way of conclusion, it needs to be pointed out that an unmistakable implication of SB 1172 is that the California licensing agencies and mental health associations are so derelict in their protection of GLB youth that politicians must step in and do their work for them. How else should we understand the complete absence of licensure revocations or membership suspensions among California therapists who provide SOCE when suicides and severe mental and physical anguish are so presumably widespread among GLB youth and attributable to this form of psychological care? Either these agencies and professional associations are incredibly negligent and inept, or SB 1172 is an ideological agenda masquerading as a legislative solution to a clinical problem that

simply does not exist. Citing research that cannot be generalized and making professional pronouncements in the absence of censorious actions against SOCE professionals cannot, by any reasonable measure, provide sufficient justification for the ban on SOCE with minors that SB 1172 sponsors seek.

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Fact-Checking California Senate Bill 1172[1]— Serious Inaccuracies and Distortions Abound: Are Politicians Willing to Listen? May 18, 2012

Christopher H. Rosik, PhD

The same week California governor Jerry Brown announced that the state was now $16 billion over budget, with the implication that more social-welfare cutbacks affecting thousands of children would be necessary, SB 1172 was passed by the California Senate Judiciary Committee. It will now enter deliberation by the full California Senate with a stated purposed to protect an unknown number of minors and others from the "dangers" of sexual orientation change efforts (SOCE).

Even the *L.A. Times*, not known to be a voice of conservatism, has come out against this legislation, saying it constitutes unnecessary government intrusion into what should be mental health association policy matters. (On matters of science, however, the *Times* naively accepted the picture spun by the sponsors of SB 1172; see htttp:// articles.latimes.com/2012/may/11/opinion/la-ed-0511-therapy-2012051).

But will this legislation really do much to protect minors and adults who might otherwise avail themselves of SOCE? When we examine some of the contentions SB 1172 touts as "facts," greater clarity can be obtained regarding the partisan nature of this bill.

SB 1172: States that SOCE practitioners use aversive treatments such as electric shock or nausea-inducing drugs.

Fact: Aversive treatments were common for a wide variety of psychological conditions in the 1960s and 1970s, including sexual orientation (see http://narth.com/2011/05/facts-and-myths-on-early-aversion-techniques-in-the-treatment-of-unwanted-homosexual-attractions/). However, aversive treatments were eventually determined to be ineffective in addressing sexual orientation and have not been utilized for decades. In fact, in a quick analysis of the psychological and medical databases, I could find no published new research on aversive treatments and homosexuality after 1981. Similarly, the APA's (2009) *Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation* did not identify any such studies after 1981. Even the bill's authors had to

rely on a 1994 report from the American Medical Association, a nearly twenty-year-old document.

The linking of SOCE practitioners with aversive and shock treatments is a favorite smear tactic of SOCE opponents, but it has not had any basis in fact for more than thirty years. Moreover, NARTH is on record as *not* recommending these practices due to ethical and efficacy concerns (NARTH, 2010). The fact that this inaccuracy is highlighted so prominently in SB 1172 certainly lends credence to the suspicion that the primary aim of the bill's sponsors is to demonize SOCE and the clinicians who engage in this practice.

SB 1172: Claims that SOCE can be harmful or carry some risk of harm and that this is something SOCE practitioners deny.

Fact: SOCE, as is the case with all forms of psychological care, carries some risk of harm. No professional therapist engaged in SOCE would deny this. The question is whether SOCE carries an exceptionally greater risk than all other forms of psychological intervention—and the answer is that no studies exist that can truly speak to this issue. The studies cited by the APA task force (2009) concerning harm are unable to be generalized beyond their specific samples, and the task force report concluded, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" (p. 42). For the sponsors of SB 1172 to use this literature as a means of casting aspersions on all SOCE is an act of scientific dishonesty.

The most popularly cited study regarding harm from SOCE (Shidlo & Schroeder, 2002) *specifically warns* readers about generalizing from their research, which did not distinguish licensed professionals and religiously based providers of SOCE in their reports of harm. Furthermore, the authors of the study advertised for respondents with this notice: "Help Us Document the Harm." To be able to know the exact prevalence

of harm in SOCE and the significance of this prevalence rate, we would need to see prospective, longitudinal studies using representative samples, *not* personal anecdotes or samples that were advertised as being sought to "help" the researchers achieve a desired outcome. Such studies would need to track harm in other forms of psychological intervention (such as marital therapy) for interpretive comparison. The fact that an intervention might be harmful in the absence of any scientific data that speak to the prevalence and significance of this harm is not a sufficient justification for banning or marginalizing an intervention. An ideologically based political activism rather than an objective scientific outlook appears to again be lurking in the background of SB 1172.

SB 1172: Claims that the bill will protect minors from the potential, harmful effects associated with SOCE, including severe mental or emotional problems such as suicide.

Fact: Notwithstanding the considerations regarding claims of harm noted above, there is reason to believe that *this bill* will likely *increase* harm to minors through its unintended consequences.

Here's how I come to this very plausible conclusion. It would appear quite likely that the majority of parents who bring their children to therapists for SOCE are conservatively religious. SB 1172 sponsors assume that if SOCE is prohibited among licensed mental health professionals, these parents would then bring their children to clinicians who would provide only that care aimed at encouraging their children to embrace their GLB identity and behavior.

I think the more likely scenario is that these parents, many of whom are already suspicious of the mental health professions, will simply pursue SOCE for their children from unlicensed, unregulated, and unaccountable religious counselors who do not fall under the jurisdiction of this bill. The vast majority of anecdotal accounts of harm to minors from SOCE seem attributable to these types of counselors and to religiously

oriented programs. Parents who receive professional care by SOCE clinicians whom they sense are understanding of and sympathetic to their worldview will be receptive to their guidance, especially when their child is not interested in SOCE. It is highly unlikely that the average unlicensed conservatively religious counselor will be as sensitive to the contextual and motivational considerations licensed therapists must assess when determining if change-oriented intervention is appropriate for a minor client. This is a prescription for an increased risk of harm. It would indeed be a tragic but foreseeable irony if the sponsor's zeal to ban SOCE for minors via SB 1172 ends up actually increasing the harm these youth experience.

SB 1172 makes it clear that SOCE includes "psychotherapy aimed at altering the sexual or romantic desires, attractions, or *conduct* of a person toward people of the same sex so that the desire, attraction, or *conduct* is eliminated or *reduced* or might instead be directed toward people of a different sex" (Article 15. 865 [d]; emphases added). This language seems to imply that psychotherapeutic intervention to reduce same-sex behaviors among minors is to be prohibited. It is worth asking whether such broad language will have a chilling effect on even non-SOCE therapists who are asked to help minors reduce or manage their addictive or compulsive same-sex behaviors. It seems quite conceivable that a minor at some later point could feel retrospectively slighted by this treatment and therefore be enticed by SB 1172 to file legal action against the therapist to the tune of up to $5,000.

So again, another unintended consequence of this bill could be to reduce the pool of non-SOCE therapists willing to wade into the incredibly murky clinical waters that SB 1172 would create, thus increasing harm by reducing the availability of any psychological services to LGB youth in California.

One last observation that can provide further perspective: One wonders what the sponsors of SB 1172 would say about a widespread intervention for minors that carries the following warning: *"[This intervention] increased the risk of suicidal thinking and*

behavior (suicidality) in short-term studies in children, adolescents, and young adults with major depressive disorder (MDD) and other psychiatric disorders." This is, in fact, the warning for the antidepressant Prozac. You can check out the potential side effects for other medications at www.pdf.net. It seems to me that if we are going to begin to ban certain types of psychological interventions on the basis of real (as opposed to uncertain) harms to minors, the sponsors of SB 1172 should be spending a lot more time focusing on the millions of youth (including GLB youth) currently being prescribed these powerful psychoactive medications (I say this as a therapist who thinks medications can have a place in treatment but are currently being overprescribed).

SB 1172: Defines informed consent for adult clients as having to include four statements from mental health organizations about SOCE.

Fact: The statements used in SB 1172 are actual pronouncements, but the lack of context is clearly meant to depict SOCE in deceptively unflattering terms. The degree to which these four statements have been cherry-picked to provide an unduly negative picture of SOCE can be seen in their publication dates. Three of the four were published between 1993 and 1997, which makes me wonder if these associations have in nearly twenty years said nothing that the sponsors of SB 1172 found sufficient for their purposes. Only the APA's (2009) task force report was recent in origin. Unfortunately, the task force consisted only of psychologists who were against SOCE from the start and excluded several excellent scholars sympathetic to SOCE (Jones, Rosik, Williams, & Byrd, 2010).

This fact raises the curtain on the sociopolitical culture within the major professional mental health associations. While they do good work on many fronts, when it comes to social issues being debated in the culture, the APA and other associations are reliably left of center in their outlook. One example suffices: In 2011, the APA council of representatives voted **157-0** to support gay marriage. This is not a typographical

error. *Not a single vote* in favor of the keeping the male-female definition as the social ideal. This is a statistically impossible lack of diversity. Whatever one believes about this issue, it stretches incredulity to contend that such a vote does not reflect a mix of political activism and political correctness. In a similar fashion, I believe that many of the pronouncements concerning SOCE cited in SB 1172 represent what occurs in professional mental health organizations when science is allowed to stagnate in the absence of support for viewpoint diversity.

Former APA president Dr. Nicholas Cummings observed that while unsuccessful attempts have been made in the APA to ban SOCE, the APA refused to take a stand on "rebirthing therapy," which resulted in the suffocation death of one child when the birth process was simulated with tight blankets (Cummings, 2008). Cummings then concluded, "If the APA rushes to judgment in the matter of sexual reorientation therapy while remaining derelict in its silence toward proven harmful techniques, therapists will be intimidated and patients will lose their right to choose their own treatment objectives. The APA, not the consumer, will become the de facto determiner of therapeutic goals" (p. 208). This sentiment is equally valid for SB 1172—only in this case California politicians, not the California consumer, will dictate which goals for psychological care are acceptable.

SB 1172: Says that SOCE assumes that homosexual orientation is both pathological and freely chosen.

Fact: SB 1172 provides no documentation to support this claim. In fact, NARTH represents many professional SOCE providers and is on the record as taking the position that same-sex attractions are usually *not* something people choose in some volitional manner (NARTH, 2010). Though historically many SOCE providers (not to mention most mental health professionals in general) viewed homosexuality as psychopathological, this

is typically not the case today. NARTH's position is rather that same-sex attractions and behavior may reflect a developmental adaptation to certain biological and/or psychosocial environments, possibly in conjunction with a weak and indirect genetic predisposition. And while this adaptation may not constitute psychopathology per se, it does appear to place these individuals at greater risk for mental illness and physical disease, not all of which is likely to be attributable to social stigmatization.

In conclusion, this quick tour through some of the factual claims made by the sponsors of SB 1172 makes it clear that this legislation is playing fast and loose with its assertions about SOCE. It would be a travesty of immense proportions if the California legislature allows these falsehoods and inaccuracies to be enshrined into California law. It would also constitute a corruption of the political process by activists who would certainly invite a legal challenge.

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The (Complete) Lack of a Scientific Basis for Banning Sexual-Orientation Change Efforts (SOCE) with Minors[10]

Claims by Sen. Lieu and SB 1172 of Widespread Harm to Minors from SOCE Represent Rhetoric, Not Research

August 15, 2012

Christopher H. Rosik, PhD

"The attack on parental rights is exactly the whole point of the bill because we don't want to let parents harm their children," he said. "For example, the government will not allow parents to let their kids smoke cigarettes. We also won't have parents let their children consume alcohol at a bar or restaurant."

—California State senator Ted Lieu, as quoted by the *Orange County Register*, August 2, 2012

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[10] Editor's note: This document was a response to the final version of SB 1172, which no longer included language prohibiting mental health professionals from engaging in SOCE with adults.

Introduction

Sponsored by California State senator Ted W. Lieu (D-Torrance), California Senate Bill 1172, which will prohibit mental health professionals from engaging in sexual orientation change efforts (SOCE) with minors under any conditions, appears on its way to the desk of Governor Jerry Brown and could very well become state law. The most important revision to the bill reads as follows:

> 865.2—Any sexual orientation change efforts attempted on a patient under 18 years of age by a mental health provider shall be considered unprofessional conduct and shall subject a mental health provider to discipline by the licensing entity for that mental health provider.

As is plainly evident, should SB 1172 become law, licensed therapists in California who would otherwise be willing to assist minor clients in modifying their unwanted same-sex attractions and behaviors will be seriously jeopardizing their professional livelihoods. In defense of this bill's clear intent to intimidate therapists and supplant the rights of parents, Sen. Lieu has publicly compared the harm of SOCE to minors with the harm of alcohol and cigarettes. This comparison certainly sounds like a compelling analogy and clearly implies there is a conclusive body of scientific evidence behind the legislation.

But like so many claims of SB 1172 supporters, this analogy seems to have been accepted at face value without the appropriate scientific research to support it. Since Sen. Lieu's claim can be subjected to empirical verification by searching relevant databases, I decided to conduct such a search. Assuming the scientific basis for banning SOCE with minors is similar to that of banning cigarettes and alcohol, we should expect that the number of articles in the scientific literature for each of these health concerns would be roughly equivalent.

Procedure and Results

To test this hypothesis, I conducted a search of the PsycARTICLES and MEDLINE databases. PsycARTICLES is a definitive source of full-text, peer-reviewed, scholarly and scientific articles in psychology, including articles appearing in the nearly 80 journals published by the American Psychological Association. MEDLINE provides authoritative medical information on medicine, nursing, and other related fields and covers articles published in more than 1,470 journals. I searched all abstracts from these databases using combinations of key words best suited to identify studies related to the question of interest.

Below are the totals for articles on cigarettes and alcohol. Words preceding an asterisk indicate that the search included all words with that stem, so that a search for *minor** would include both *minor* and *minors*.

Key Words	Total Articles	Earliest Article
Children & Alcohol	4465	1917
Children & Cigarettes	883	1970
Adolescent* & Alcohol	6180	1917
Adolescent* & Cigarettes	1252	1971
Minor* & Alcohol	2670	1944
Minor* & Cigarettes	356	1973

As is clear from these totals, the literature regarding alcohol and cigarettes as related to youth is extensive, with studies numbering in the thousands. With such a sizeable database, one could reasonably expect that observations relative to the harms of cigarettes and alcohol among youth reflect reliable scientific information that has been replicated in numerous ways. These results, then, form the standard by which we can evaluate the volume of scientific literature from which any claims about SOCE and youth are based.

Since *SOCE* is a relatively new term in the literature, I also conducted searches utilizing the terms *reparative therapy*, *conversion therapy*, and *sexual reorientation therapy*, terms that were in use long before *SOCE* was coined. My extensive search of the databases to identify scientific literature supportive of Sen. Lieu's comparison yielded the following findings:

Key Words	Total Articles	Earliest Article
Children & Sexual Orientation		
Change Efforts	0	—
Children & Reparative Therapy	0	—
Children & Conversion Therapy	0	—
Children & Sexual Reorientation Therapy	0	—
Adolescent & Sexual Orientation*		
Change Efforts	0	—
Adolescent* & Reparative Therapy	1	2010
Adolescent* & Conversion Therapy	0	—
Adolescent* & Sexual Reorientation Therapy	0	—
Minor & Sexual Orientation*		
Change Efforts	0	—
Minor* & Reparative Therapy	0	—
Minor* & Conversion Therapy	0	—
Minor* & Sexual Reorientation Therapy	0	—
Sexual Orientation Change Efforts & Harm	0	—
Reparative Therapy & Harm	1	2010
Conversion Therapy & Harm	1	2002
Sexual Reorientation Therapy & Harm	0	—
Homosexual* & Psychotherapy & Harm	1	1977

Gay & Psychotherapy & Harm	1	1996
Lesbian & Psychotherapy & Harm	0	—
Bisexual & Psychotherapy & Harm	0	—

In stark contrast to the thousands of articles related to alcohol and cigarette usage by youth, my search of the scientific literature for references that would back up Sen. Lieu's claims yielded a total of four articles. Interestingly, three of these articles were not research-oriented. Hein and Matthews (2010) discussed the potential harms of reparative therapy for adolescents but cited no direct research on SOCE with adolescents to support their concerns. They relied instead primarily on adult anecdotal accounts and did not distinguish between the provision of SOCE by licensed clinicians and unlicensed religious practitioners.

Jones (1996) described a case of self-harm by a young gay man in response to "profound" and "thematic" relationship difficulties. The author reported that psychodynamic therapy was beneficial in helping the patient deal with relational conflict without making any mention of internalized homophobia or stigmatization.

Hochberg (1977) discussed her treatment of a suicidal adolescent male who finally disclosed his homosexual experience as termination neared. After this disclosure, Hochberg reported, "Therapy subsequently exposed long-standing inhibitions in masculine assertiveness, longing for a love object that would increase his masculinity, (and allay his homosexual anxiety) and intense fear of physical harm" (p. 428). This article, then, would in some respects appear to provide anecdotal support *for* SOCE, not surprisingly coming in an era before reports of harm gained favored status over reports of benefit within the psychological disciplines.

The only article my database search identified that could be considered quantitative research was Shidlo and Schroeder's (2002) well-known study on reported harms from SOCE. The Shidlo and Schroeder study suffered from many methodological

limitations, including recruiting specifically for participants who had felt harmed by their SOCE, obtaining recollections of harm that occurred decades prior to the study, and failing to distinguish between SOCE provided by licensed mental health professionals and unlicensed religious counselors. As the authors correctly acknowledged, the findings of this study cannot be generalized beyond their specific sample of consumers. This research can therefore tell us nothing about the prevalence of harm from SOCE provided by licensed therapists.

Discussion

In an effort to corroborate the scientific accuracy of Sen. Lieu's comparison between the harm to minors of cigarettes, alcohol, and SOCE, I conducted a search of one major medical database and one main mental health database associated with the American Psychological Association. Results from this analysis revealed that the literature related to youth and cigarettes or youth and alcohol numbered in the thousands, while studies relating directly to SOCE and minors appeared to be nonexistent. While the utilization of different sets of related key words might yield slightly different totals with additional database searches, it seems highly unlikely the results would differ substantively. Consequently, I have to conclude from this investigation that Sen. Lieu's comparison lacks scientific merit, and that SB 1172's prohibition of SOCE on the basis of harm to minors lacks a clear scientific justification.

Some additional observations from this investigation seem worth noting. First, the case against SOCE with minors is typically based on four sets of data: anecdotal accounts of harm (mostly from adults), a very few quantitative studies (compilations of anecdotal accounts from adults with severe methodological limitations), inferences from other research domains of questionable relatedness to SOCE (such as harm from family rejection of gay youth), and citations of the pronouncements on SOCE from professional mental health and medical associations. These various sources tend to cite one another

in an almost symbiotic manner that provides little if any new information relevant to answering important questions about SOCE.

It seems the science pertaining to SOCE is stuck in neutral, and the professional associations and critics of SOCE do not appear interested in doing any cooperative research with proponents of SOCE that might actually move our understanding forward. With SOCE on the defensive, those in government and public university settings in a position to make large-scale scientific contributions to this literature appear content to speak out of both sides of their mouths. On the one hand, they demand rigorous empirical support for SOCE; on the other hand, they display no interest in facilitating bipartisan research that could potentially address their demands. One could make the case that this is hardly a shining moment in the history of social scientific integrity.

Additionally, the lack of a clear and direct grounding in the scientific literature for the claims of harm to youth from SOCE lend credence to the suspicion that political rather than scientific motivations are the driving force behind SB 1172. Reasonable clinicians and mental health association representatives should agree that anecdotal accounts of harm constitute no basis upon which to prohibit a form of psychological care. If this were not the case, the practice of any form of psychotherapy could place the practitioner at risk of regulatory discipline, as research indicates that 5 to 10% of all psychotherapy clients report deterioration and as many as 50% experience no reliable change during treatment (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004).

What may be at play among supporters of SB 1172 is a dislike for how many SOCE therapists view same-sex attractions—as a developmental adaptation. It would certainly be a new and sobering development if approaches to psychological care can now be prohibited on the basis of disputed aspects of its theory rather than on a scientifically established prevalence of harm that significantly exceeds those of other therapeutic approaches.

The (Complete) Lack of a Scientific Basis for Banning SOCE with Minors

Without a basis in the scientific literature, the claims by Sen. Lieu and SB 1172 of widespread harm to minors from SOCE represent rhetoric, not research. My database search suggests this is a superfluous piece of legislation from the perspective of harm. Any harm that might occur from the unprofessional practice of SOCE by licensed therapists can and should be handled within the existing regulatory structures on a case-by-case basis. But rather than take such a rational approach, SB 1172 supporters have politicized the issues in the form of this legislative overreach (*Los Angeles Times*, May 11, 2012), declaring SOCE with minors *ipso facto* unprofessional conduct. They have thrown their anti-SOCE wish list against the proverbial wall in order to see what politicians and mental health associations would let stick. Sadly, the blanket prohibition of SOCE with minors appears to be sticking and may become law in California. If this occurs, the present analysis indicates it will be in the absence of scientific literature and not because of it.

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International Federation for Therapeutic Choice
IFTC Intervention at OSCE/ODIHR 2012 Human Dimension Implementation Meeting—Warsaw, Poland
October 1, 2012

To: The Organization for Security and Cooperation in Europe (OSCE) Office of Democratic Institutions and Human Rights (OHIHR) Human Dimension Implementation Meeting (HDIM)

From: Dr. Philip M. Sutton, PhD, International Federation for Therapeutic Choice (IFTC), USA

Date: October 1, 2012: *Working Session 10*

Re: Freedom of Thought, Conscience, Religion, or Belief

Intolerance and Discrimination against Medical and Mental Health Professionals and Researchers Threaten the Freedom of Professionals to Serve the Health Care Needs of Their Clients; the Right of Clients to Self-Determination in Choosing Wanted Education, Guidance, and Therapy; and the Right of Researchers to Scientific and Academic Freedom

IFTC Intervention at OSCE/ODIHR 2012 Human Dimension Implementation Meeting

This intervention is being given on behalf of the International Federation for Therapeutic Choice (IFTC), which supports the rights of sexual minorities who have unwanted attractions, orientation, behavioral tendencies, behavior, and/or identity to receive competent professional guidance and therapeutic care. The IFTC also supports the rights of medical and mental health professionals to offer that care (www.therapeutic -choice.org).

Central Recommendation to Participating States of the OSCE:

To draft legislation to safeguard the freedom of medical and mental health practitioners, educators, and researchers:

1. to offer professional guidance and therapeutic expertise to persons whose sexual minority behaviors, orientations, and/or identities are unwanted and who freely choose help in order to overcome or diminish their unwanted sexual attractions and behaviors; and

2. to study, publish, and educate other professionals and the public about the possible causes, consequences, and amelioration of sexual minority attractions, behaviors, orientations, and identities.

Some sexual minorities find their attractions, orientation, behavioral tendencies, behavior, and/or identity unwanted. Some of these people *freely choose* or have *freely chosen* to seek professional guidance and therapeutic assistance to avoid basing their relational and sexual lives on their unwanted sexual minority attractions, behaviors, orientations, and/or identifications. More than one hundred years of clinical reports and other research literature document that some persons *have* been successful in achieving this goal *without* undue harm. For detailed information, see the first volume of the *Journal of Human Sexuality*, which reviews the clinical and scientific literature on this

issue (http://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1), or the summary of this volume (http://www.scribd.com/doc/125145105/Summary-of-Journal-of-Human-Sexuality-Volume-1).

Medical and mental health professionals who research, educate, and offer guidance and therapeutic services to people with unwanted sexual minority concerns are experiencing increasing intolerance and discrimination. Those who attempt to train for and conduct their work are often labeled as "homophobic" and are even accused of "hate crimes." This intolerance and discrimination not only impedes the ability of these professionals to do their work but also hinders the freedom of people who want to receive health care, guidance, and education from these professionals.

I offer two recent examples:

- First, on September 29, 2012, Governor Jerry Brown of the state of California in the United States signed SB 1172, a law that had passed both houses of the California Legislature a month earlier. The law declares it illegal for "mental health provider(s)" to engage "in sexual orientation change efforts with a patient under 18 years of age." For the purpose of this law, "sexual orientation change efforts" are defined as any "efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex."

- If allowed to become effective on January 1, 2013, this law formally declares any "sexual orientation change efforts" (SOCE)—even if freely sought by the minor and his or her parents—as "unprofessional conduct" that subjects the "mental health provider to discipline by the licensing entity for that mental health provider."

- This law subjects every "mental health provider" who engages in SOCE in the state of California to disciplinary action—including the potential loss of the state-regulated license to practice one's profession—by the relevant California professional licensing board. (In the United States, each state licenses health care professionals and determines how their practice will be monitored and controlled; such licensing and monitoring is not done by the federal government.) Professionals affected include *anyone* "designated as a mental health professional under California law or regulation," including—but not limited to—all licensed or certified physicians and surgeons specializing in psychiatry, clinical practitioners, counselors, educational and school psychologists, marriage and family therapists, clinical social workers, professional clinical counselors, and all of the assistants, interns, and trainees under their supervision.

- Thus, if enforced, SB 1172 subjects to "disciplinary action" any medical or mental health professional who provides education, guidance, counseling, and/or therapy to minors who themselves *freely* seek *and* whose parents *freely* seek services to resolve unwanted same-sex attractions and/or behaviors. Such professionals face discipline for having engaged in SOCE, which now is considered unprofessional conduct by the state of California.

- This law not only usurps the rights and authority of parents and minors to make decisions about the minor's welfare but also usurps the rights of mental health licensing and certification boards to regulate their professions.

- As its primary rationale, the law cites the 2009 *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*, which concluded "that sexual orientation change efforts

can pose critical health risks to lesbian, gay, and bisexual people." In reality, the task force report actually concluded: "There are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (*Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*, www.apa.org/pi/lgbc/publications/, p. 83; cf. http://narth.com/2012/08/the-complete-lack-of-a-scientific-basis-for-banning/; http://narth.com/2012/05/california-senate-bill-1172-a-scientific-and-legislative-travesty/).

- A second example involves the study on same-sex parenting by University of Texas sociology professor Mark Regnerus, who found that young-adult children of parents who had same-sex relationships had negative outcomes when compared to children raised in intact biological families. (See Regnerus, M. (2012). "How different are the adult children of parents who have same-sex relationships? Findings from the New Family Structures Study." *Social Science Research, 41*(4), 752–777.) Following a rigorous peer review process prior to publication of the study, Regnerus's person and work were subject to unjustified and unacceptable criticism and harassment. Public and professional critiques of his work did point out the unavoidable limitations of his research methods but failed to report that his research design and methods were superior to those of prior studies on this contentious topic that have supported the GLBT ideological and political agenda (cf., http://www.citizenlink.com/2012/07/13/sociologist-comes-under-fire-from-activists-for-gay-parenting-study/; http://chronicle.com/article/Son-of-a-Lesbian-Mother-Backs/133992/).

- Regnerus's employer, the University of Texas, investigated whether the accusations of "scientific misconduct" made by a self-identified "gay blogger"

had merit. The preliminary investigation involved the sequestering of Regnerus's computers, including his e-mails and documents, and the acquisition of all of his grant proposal, correspondence, and IRB protocols. Regnerus was required to respond in writing to the written and oral allegations of his accuser. In addition, an in-depth interview was conducted in which Regnerus was questioned about his responses to his accuser's allegations, and his answers were recorded and transcribed by a court reporter.

- On August 29, it was reported that the university had decided that the accusations did not have merit and that the case was closed (cf., http://blog.heritage.org/2012/08/31/case-closed-at-ut-austin-regnerus-exonerated/ and the links to primary documents).

These examples illustrate just a few of many recent instances of harassment, intolerance, and discrimination toward medical and mental health professionals, researchers, and educators who attempt to study or serve persons with sexual minority attractions, behavioral tendencies, behaviors, and/or identities.

Such intolerant behavior by people who themselves claim to be victims of intolerance violates a number of rights upheld by the Convention on the Rights of the Child (CRD) (http://www2.ohchr.org/english/law/crc.htm) and the Universal Declaration of Human Rights (UDHR) (http://www.un.org/en/documents/udhr/index.shtml#a11). These include the right:

- and responsibility that when adults make decisions that affect children, the best interests of children must be the primary concern (CRD, Article 3)
- of families to be allowed to direct and guide their children so they can grow and

reach their potential and the responsibility of governments to support them in doing so (UCDHR, Articles 4 and 5)

- of children to procure and share information, form and express their opinions, and otherwise be involved in decision-making appropriate to their level of maturity, especially when adults are making decisions that affect the children's welfare (UCDHR, Articles 12 and 13)
- of children to think and believe what they want and to practice their religion, and of parents to provide religious and moral guidance to their children (UCDHR, Article 14)
- of children to have access to information that is important to their health and well-being and the responsibility of governments to encourage mass media—radio, television, newspapers and Internet content sources—to provide information that children can understand and to not promote materials that could harm children (UCDHR, Article 17)
- of parents to provide appropriate guidance to their children and the responsibility of governments to provide support services to parents on doing so (UCDHR, Article 18)
- of children to an education that would develop their personality, talents, and abilities to the fullest (UCDHR, Article 18)
- to freedom for the full development of one's human personality (UDHR, Article 26)
- to medical care and necessary social services (UDHR, Article 25)
- to freedom of thought, conscience, and religion (UDHR, Article 18)
- to freedom of opinion and expression, which includes the freedom to hold opinions without interference, and to seek, receive, and impart information and ideas through any media (UDHR, Article 19)
- to the protection of the law against arbitrary interference with one's privacy or family and attacks on one's honor and reputation (UDHR, Article 12)

In light the aforementioned fundamental rights upheld by the Convention on the Rights of the Child and the Universal Declaration of Human Rights, we therefore recommend to OSCE participating states:

1. to recognize and condemn intolerance and discrimination against sexual minorities who freely choose to receive help in order to overcome or diminish their unwanted sexual attractions, orientation, behaviors, and/or identity.
2. to draft legislation to safeguard the freedom of medical and mental health practitioners, educators, and researchers 1) to study, publish, and educate other professionals and the public about the possible causes, consequences, and amelioration of sexual minority attractions, orientations, behaviors, and identities; and 2) to offer their professional guidance and therapeutic expertise to people whose sexual minority concerns are *unwanted* and who *freely* choose help in order to overcome or diminish their unwanted sexual attractions, orientation, behaviors, and/or identity.

We recommend to OSCE/ODIHR and OSCE Missions:

1. to be aware of and condemn intolerance and discrimination against sexual minorities who freely choose help in order to overcome or diminish their unwanted sexual attractions, orientation, behaviors, and/or identity.

2. to assist OSCE participating states in monitoring and drafting legislation, with special attention to safeguarding the above-mentioned rights upheld by the CRC and the UDHR.

Countering a One-Sided Representation of Science: NARTH Provides the "Rest of the Story" for Legal Efforts to Challenge Antisexual Orientation Change Efforts (SOCE) Legislation[11]

July 26, 2013

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[11] In response to state-sponsored legislation to prohibit the provision of sexual orientation change efforts (SOCE) to minors by licensed therapists, NARTH submitted this document to our attorneys at Liberty Counsel. This document was crafted in particular as preparation for possible legal action against New Jersey's anti-SOCE legislation (AB 3371), and it reflects a similar, but less extensive compilation of the information that was entered into the legal record in NARTH's lawsuit against SB 1172 in California. This document was unanimously approved by the NARTH board of directors on July 26, 2013.

Abstract

NARTH compiled science-based information in this document in response to the proposal, passage, and subsequent adjudication of legislation in California (SB 1171) in 2012 and in New Jersey (AB 3371) in 2013 to prohibit the provision of sexual orientation change efforts (SOCE) to minors by licensed therapists. The information in this document is intended for use in various formats to counter the sometimes faulty and often incomplete presentation of science used to defend such anti-SOCE legislation. The information is presented in four sections under the following themes: I. The objectivity of the *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (hereafter referred to as the *Report*) is demonstrably suspect; therefore, the *Report*'s representation of the relevant literature concerning the efficacy of and harm from SOCE is neither complete nor definitive. II. Nonheterosexual identities, attractions, and behaviors are subject to change for many people, particularly youth. III. There is no scientific basis for blaming SOCE for the harmful stigma and discrimination reportedly experienced by persons with a nonheterosexual sexual orientation. IV. Spitzer's reassessment of his *interpretation* of the results of his 2003 study on SOCE does *not* invalidate the results he reported. Licensed mental health professionals (LMHP) who practice some form of SOCE care deeply about the well-being of sexual minority youth and see SOCE as a valid option for professional care, an option that deserves to be protected by state legislatures. LMHPs who do offer SOCE support the right of *all* clients to self-determination.

Statement of Purpose

Five main objectives animate NARTH's submission of this information to the court:

(1) to counterbalance the one-sided presentation of the science related to harm and efficacy of SOCE by proponents of California SB 1172 and New Jersey AB 3371—a presentation that we will demonstrate is a byproduct of an absence of sociopolitical diversity within professional mental health organizations concerning sexual orientation;

(2) to show thereby that claims of the blanket ineffectiveness and intrinsic harmfulness of SOCE are not ultimately grounded in science but rather advocacy, as evidenced strikingly in the differing rigor utilized by these professional organizations to evaluate efficacy and harm;

(3) to underscore from research that minority sexual orientation, particularly among youth, cannot be considered immutable but instead is fluid and subject to change for many, though not all, persons;

(4) to demonstrate that the realities of stigma and discrimination form a highly incomplete understanding of negative health outcomes among nonheterosexual identities, and applying this literature uncritically to SOCE is scientifically and ethically dubious; and

(5) to argue for the propriety of a scientific and research-based response to the questions that remain regarding SOCE instead of a politically inspired legal prohibition that curtails science, of which California SB 1172 and New Jersey AB 3371 are a quintessential expression.

I. The Objectivity of the *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation* is Demonstrably Suspect; Therefore the *Report*'s Representation of the Relevant Literature Concerning Efficacy of and Harm from SOCE is neither Complete nor Definitive

Bias in Task Force Selection

Although many qualified conservative psychologists were nominated to serve on the APA Task Force (hereafter referred to as the Task Force), all of them were rejected. This fact was noted in a book coedited by a past president of the APA (Yarhouse, 2009). Clinton Anderson—director of the APA's Lesbian, Gay, and Bisexual Concerns Office—offered the following defense: "We cannot take into account what are fundamentally negative religious perceptions of homosexuality—they don't fit into our world view" (Carey, 2007).

It appears that the APA operated with a litmus test when considering Task Force membership—the only views of homosexuality that were tolerated were those that uniformly endorsed same-sex behavior as morally good. From the outset of the Task Force, then, it was predetermined that conservative or religious viewpoints would only be acceptable when they fit within the preexisting worldview of the Task Force. One example of this is the *Report*'s failure to recommend any religious resources that adopt a traditional or conservative approach to addressing conflicts between religious beliefs and sexual orientation. This bias can hardly be said to respect religious diversity and had predictable consequences for how the Task Force addressed its work.

Bias Regarding Statements of SOCE Harm and Efficacy

This bias was particularly evident in the Task Force's highly uneven implementation of standards of scientific rigor in the utilization and evaluation of published findings pertaining to SOCE (Jones, Rosik, Williams, & Byrd, 2010). Of

particular note is the contrast between the exceptionally rigorous methodological standards applied to SOCE outcomes and the considerably less rigorous and uneven standards applied to the question of harm.

With regard to SOCE outcomes, the *Report* dismisses most of the relevant research because of methodological limitations that are outlined in great detail (APA, 2009, pp. 26–34). Studies pertaining to SOCE outcomes that fall short of the Task Force's rigorous standards are deemed unworthy of examination and are dismissed as containing no evidence of value to the questions at hand.

Meanwhile, the *Report* appears to adopt very different evidentiary standards for making statements about harms attributed to SOCE. The standard regarding efficacy is to rule out substandard studies as irrelevant; however, no such standards are employed in considering studies purporting to document harm. In addition, the *Report* uses the absence of evidence to argue that SOCE is unlikely to produce change and thus strongly questions the validity of SOCE, but shows no parallel reticence to endorse affirmative therapy despite acknowledging that "it has not been evaluated for safety and efficacy" (APA, 2009, p. 91).

The six studies deemed by the Task Force to be sufficiently methodologically sound to merit the focus of the *Report* targeted samples that would bear little resemblance to those seeking SOCE today; the studies also used long-outdated methods that no current practitioner of SOCE employs. This brings into question the *Report*'s willingness to move beyond scientific agnosticism (in other words, to admit that we do not know the prevalence of success or failure in SOCE) to argue affirmatively that sexual orientation change is uncommon or unlikely. The *Report* seems to affirm two incompatible assertions: a) we do not have credible evidence on which to judge the likelihood of sexual orientation change, and b) we know with scientific certainty that sexual orientation change is unlikely. However, the absence of conclusive evidence of effectiveness is not logically equivalent to positive evidence of ineffectiveness (Altman & Bland, 1995).

There are places in the *Report* that do seem to acknowledge that, given their methodological standards, we really cannot know anything scientifically definitive about the efficacy of, or harms attributable to SOCE. For example, the *Report* states, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" (APA, 2009, p. 42). Similarly, the *Report* observes, "Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective" (APA, 2009, p. 43). Similarly, "[T]here are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (APA, 2009, p. 83; cf. p. 67, 120).

These expressions of agnosticism are justified by the Task Force but then are not adhered to in the *Report*'s conclusions. Instead, the *Report* argues at length that only the most rigorous methodological designs can clearly establish a causal relationship between SOCE methods and subsequent change, but the *Report* does not hesitate to make such causal attributions consistently regarding harm while repudiating any such claims for efficacy. From this highly uneven application of literature review methodology, the *Report* goes on to assert confidently that the success of SOCE is unlikely and that SOCE has the potential to be harmful. It is also telling that in subsequent references to the *Report*, the potential for harm has morphed into "the potential to cause harm to *many* clients" (APA, 2012, p. 14; emphasis added). The harms from SOCE appear to grow greater the further one gets from the original *Report*.

Bias in Favor of Preferred Conclusions

A few examples adequately illustrate that the Task Force utilized a far lower methodological standard in assessing harm and other aspects of the science than it did in assessing SOCE outcomes. The *Report* references the many varieties of methodological problems deemed sufficient to render useless most of the SOCE research. Yet the *Report* is ready to overlook such limitations when the literature addresses preferred conclusions.

First, consider the work of Hooker (1957), which is routinely touted as groundbreaking in the field; the *Report* and other APA publications affirmed Hooker's work as evidence indicating there are no differences in the mental health of heterosexual and gay men. However, this research contains such serious methodological flaws that it is inconceivable that an evenhanded methodological evaluation by the Task Force would have not have mentioned these problems. Among the many methodological problems noted by Schumm (2012), the control group was told the purpose of the study in advance, and clinical experts were not blind to the objectives of the study. There were other serious problems, including an imperfect matching of participants, low scale reliability, the use of a small and recruited control group rather than existent national standardized norms, the post hoc removal of tests that actually displayed differences, and the screening out of men from the study if they appeared to have preexisting psychological problems. Hooker (1993) herself wrote many years later, "I knew the men for whom the ratings were made, and I was certain as a clinician that they were relatively free of psychopathology."

Despite these serious methodological problems, which would never be tolerated by the Task Force were this SOCE-supportive research, APA experts such as Gregory Herek described Hooker's study as part of the "overwhelming empirical evidence" that there is no association of sexual orientation with psychopathology (Herek, 1991, p. 143; see also Herek, 2010). The point here is not to argue for such an association but to underscore that a consistent application of the methodological standards affirmed in the *Report* should have led to the dismissal of the Hooker study as supportive of the no-differences hypothesis.

Bias Regarding Treatment of the Primary Study on Harm

Perhaps the most egregious example of the Task Force's methodological double standard is evidenced in its heavy reliance on the Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) research regarding harm from SOCE. Several

methodological problems cited to dismiss the SOCE outcome literature complicate these studies:

- These studies were conducted in association with the National Gay and Lesbian Task Force, and researchers were given the explicit mandate to find clients who had been harmed and to document ethical violations by practitioners. This was abundantly clear in the study's original title: "Homophobic Therapies: Documenting the Damage" (see Exhibit A).

- More than 50% of the 202 sample participants were recruited through the GLB media, hardly a random or generalizable sampling procedure.

- Only 20 participants in this study were women, creating significant skew toward accounts and experiences of gay men.

- Twenty-five percent of study participants had already attempted suicide *before* starting therapy, making very dubious the claim that suicide attempts were actually caused by the therapy.

- Finally, these subjects reported their experiences came from a mix of licensed therapists, nonlicensed peer counselors, and religious counselors, leaving open the reasonable suspicion that negative therapeutic experiences might differ significantly by level of training.

The Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) results thus are based on a nonrepresentative sample likely to be heavily biased in the direction of retrospectively reporting negative therapy experiences, some of which occurred decades

ago. The Task Force appears to have ignored the warnings from the study's authors: "*The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy*" (Shidlo & Schroeder, 2002, p. 250; emphases in the original). It is difficult to understand how this research can be cited without qualification or context as demonstrating likely harm from SOCE conducted by licensed medical and mental health professionals. What we *can* say with confidence is that some SOCE clients report harm and others report benefit—and the literature does not specify how often either outcome occurs. While harm may occur with any form of psychological care, the "evidence" provided in this study is essentially nothing more than unverifiable "hearsay." This is hardly a legitimate ground for legal prohibition.

Bias Regarding the Lack of Context Concerning Harm in Psychotherapy

The APA and other professional bodies that utilize the *Report* are negligent if not fraudulent in giving a technically true warning that SOCE may potentially cause harm but failing to do so within a broader context: This warning certainly applies to all forms of psychological care for any and all problems or concerns. For example, regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences appear to be unavoidable for a small percentage of clients, especially those who begin therapy with a severe "initial level of disturbance" (Lambert & Ogles, 2004, p. 117). Clients who experience significant negative counter-transference or whose clinicians may lack empathy or may underestimate the severity of their problem may also be at greater risk for deterioration (Mohr, 1995).

Furthermore, it must be remembered that, on average, persons with same-sex attraction already experience and/or are at greater risk for experiencing a number of

medical and mental health difficulties *prior* to participating in any SOCE (Whitehead & Whitehead, 2010). This makes it extremely difficult to disentangle psychological distress directly attributable to SOCE from that which preceded commencement of SOCE. And since SOCE commonly involves helping clients become more aware of the stress and distress in their lives in order to manage or alleviate it, as do many approaches to mental health care, persons who leave therapy prematurely may have an increased awareness or experience of their (pre)existing stress and distress. In other words, they may "feel worse" as a consequence of not having allowed sufficient time for therapy to help resolve the difficulties. Anecdotal personal stories of harm certainly cannot scientifically establish the proportion of distress derived directly from SOCE, and high-quality research that might be able to distinguish such causation simply does not exist.

Bias in the Omission of Medical Outcomes Associated with Same-Sex Behavior

It should also be mentioned in the discussions of harm and benefit from SOCE that the *Report* makes no mention of the well-documented medical outcomes associated with homosexual and bisexual behavior. For example, men having sex with men (MSM) comprise 48% of all individuals with HIV/AIDS in the United States, but make up only an estimated 2–4% of men in the population (Newcomb & Mustanski, 2011). Despite increasing cultural acceptance, MSM are reporting higher rates of sexual risk behaviors in recent years. Similarly, the prevalence of suicidal ideation and attempts for bisexual and lesbian girls has steadily increased since the mid-1990s (Savin-Williams & Ream, 2007).

Certainly whatever unclear risk of harm that might occur to an individual SOCE minor client must be weighed against the clear medical risks that arise from enacting homosexual behavior, particularly salient among adolescents. Yet a therapist's efforts to change or otherwise discourage even homosexual behavior among minors, if construed

by the client later as SOCE, could jeopardize the license of the therapist under California SB 1172 and New Jersey AB 3371.

Bias Regarding Research on the Origins of Same-Sex Attractions

Another example of the Task Force's uneven application of methodological standards concerns the *Report*'s conclusion that "studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation" (APA, 2009, p. 23). Of the ten studies cited in support of this conclusion, three were not readily accessible on databases; another was a review article that was an interpretation, not an empirical study. An examination of the remaining six studies (Bell, Weinberg, & Hammersmith, 1981; Freund & Blanchard, 1983; McCord, McCord, & Thurber, 1962; Peters & Cantrell, 1991; Siegelman, 1981; Townes, Ferguson, & Gillam, 1976) revealed many of the same methodological flaws cited in the Task Force critique of SOCE (Rosik, 2012). For example, the Freud and Blanchard study is cited as evidence against any role of family dynamics or trauma in the origin of same-sex attractions but contains many serious methodological problems, including unclear scale reliability, participants being known to the researchers as patients, the use of a convenience sample, and a narrow and therefore nongeneralizable sample composed of psychiatric patients. All of these problems were considered to be fatal flaws in the Task Force's appraisal of the SOCE outcome literature for documenting evidence of change.

Given that many of the methodological limitations used by the Task Force to assail the SOCE research exist in the literature exploring the possible causal influences for sexual orientation, questions have to be raised as to why the Task Force members chose to definitively dismiss this literature as "failing to support" developmental theories. It appears, based on the same criteria they used to dismiss SOCE, that their own conclusions have little support in the literature. A fairer rendering of the literature they reference in this regard would appear to be that this research is so methodologically

flawed that one cannot make any conclusive statements concerning the applicability of developmental factors in the origin of homosexuality. Thus by the Task Force's own methodological standards, the literature they cite fails to support *or rule out* a role for these potential developmental influences in the genesis of sexual orientation.

If such ambiguity exists in the SOCE literature on methodological grounds, then by the Task Force's own criteria, this ambiguity is also present in the referenced etiological research. It appears that the Task Force has been inconsistent in the application of its methodological critique to the broader literature on homosexuality, and it has been willing to offer more definitive conclusions about theories it wishes to dismiss than is warranted by its own standards. In a word, there is again the appearance of substantial bias.

Contrary to the repeated claims of the *Report* that it is an established "scientific fact" that "no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma" (APA, 2009, p. 86), there currently exists recent, high-quality, and large-scale studies that provide empirical evidence consistent with the theory that familial or traumatic factors potentially contribute to the development of sexual orientation (Bearman & Bruckner, 2002; Francis, 2008; Frisch & Hviid, 2006; Roberts, Glymour, & Koenen, 2013; Wilson & Widom, 2010). Despite their significant relevance for scientific discussions on the etiology of same-sex attractions, these studies were ignored by the Task Force. It is perfectly reasonable to believe that *not* offering professional SOCE to some minors with unwanted same-sex attractions and behaviors who seek such care *may actually harm* them by *not* helping them deal with what is one of the possible consequences of sexual molestation and abuse.

Bias Regarding Use of the "Gray Literature"

The uneven methodological implementation of standards is again seen in the *Report*'s treatment of the "gray literature," which is dismissed in favor of only peer-reviewed scientific journal articles in the assessment of SOCE. No developed rationale

is offered for this choice. Consequently, a highly scholarly study on SOCE supportive of change for some individuals is dismissed in a footnote (Jones & Yarhouse, 2007; the footnote is found on p. 90 of the *Report*). Yet the Task Force appears to have no compunction in citing the "gray literature" on other subjects, such as the demographics relating to sexual orientation (Laumann, Gagnon, Michael, & Michaels, 1994) or the issue of psychological and familial factors in the development of sexual orientation (Bell et al., 1981), even though the latter book utilizes a sample of questionable representativeness.

Bias in the APA's Broader Treatment of Sexual Orientation

A sixth example of differential application of methodological critique highlights the systemic nature of this problem within the broader literature pertaining to homosexuality. A recent analysis of the fifty-nine research studies cited in the APA's brief supporting same-sex parenting (Marks, 2012) in essence applied methodological standards of similar rigor to those the Task Force applied to the SOCE literature. The Marks study concluded that

> some same-sex parenting researchers seem to have contended for an "exceptionally clear" verdict of "no difference" between same-sex and heterosexual parents since 1992. However, a closer examination leads to the conclusion that strong, generalized assertions, including those made by the APA Brief, were not empirically warranted. As noted by Shiller (2007) in *American Psychologist*, "the line between science and advocacy appears blurred." (p. 748)

While Marks's analysis does not focus on SOCE, it is relevant in that it underscores that the APA's worldview regarding homosexuality appears to result in public policy

conclusions (whether right or wrong) that go beyond what the data can reasonably support. This is precisely what appears to be occurring in linking the *Report* with the banning of professional SOCE as represented in California SB 1172 and New Jersey AB 3371.

Bias Regarding the Use of the Ryan et al. Study in SB 1172 and AB 3371

A final example of the problem of differential rigor in methodological critique can in fact be found in AB 3371 itself. The bill cites a study by Ryan, Huebner, Diaz, and Sanchez (2009) in the respected journal *Pediatrics*, presumably as its best support for claims that SOCE with minors results in serious harm. It is evident that this study also contains many of the methodological limitations cited by the Task Force to invalidate the SOCE literature, including participants not being blind to the study purposes, apparent biases in the participant recruitment process, and the reliance on self-report measures that had participants recalling experiences from the distant past.

Generalization difficulties are also created by the sample composition of Ryan et al. (2009). The sample is limited to young-adult non-Latino and Latino LGB persons. The APA Task Force (2009) noted that research on SOCE has "limited applicability to non-Whites, youth, or women" (p. 33) and "no investigations are of children and adolescents exclusively, although adolescents are included in a very few samples" (p. 33). This means that even had Ryan and colleagues assessed for SOCE backgrounds among participants, it would be inappropriate to generalize their findings in a manner that would cast aspersions on all SOCE experiences of minors, which again is precisely what AB 3371 is determined to do. In addition, Ryan et al. (2009) acknowledge that "given the cross-sectional nature of this study, we caution against making cause-effect interpretations from these findings" (p. 351).

Presumably, this caution alone should have been enough to prevent the authors of AB 3371 from employing the Ryan et al. study. Even had the study findings been applicable to SOCE consumers, they would not have been able to indicate whether SOCE caused

the negative health outcomes or if youth with negative health markers disproportionately sought SOCE. Based on this analysis, there appear to be no scientific grounds for referencing the Ryan study as justification for a ban on SOCE to minors. The study's findings, while likely reflecting some underlying connection between family rejection and mental health outcomes, are not reliable and have no scientific justification for being generalized to minors who engage in SOCE with licensed therapists. It is troubling that AB 3371 utilizes Ryan et al.'s work when the internal and external validity limitations of the study make such claims profoundly misguided, as underscored by the APA Task Force.

The Task Force concludes that "none of the recent research (1999–2007) meets methodological standards that permit conclusions regarding efficacy or safety" (APA, 2009, p. 2). Taking this statement at face value—which is arguable, as noted above—nevertheless only serves to underscore the enduring validity of comments from Zucker (2003), longtime editor of the *Archives of Sexual Behavior*, who observed:

> From a scientific standpoint, however, the empirical database remains rather primitive and **any decisive claim about benefits or harms really must be taken with a grain of salt and without such data it is difficult to understand how professional societies can issue any clear statement that is not contaminated by rhetorical fervor**. Sexual science should encourage the establishment of a methodologically sound database from which more reasoned and nuanced conclusions might be drawn. (p. 400; emphasis added)

A scientific response as opposed to a response based largely on advocacy would encourage research that will allow for more nuanced conclusions about SOCE, not create a new law that sets the precedent of placing a blanket prohibition on an entire category of psychological care.

II. Nonheterosexual Identities, Attractions, and Behaviors Are Subject to Change for Many People, Particularly among Youth

Central to the notion that some individuals can and do report change on a continuum in their sexual orientation is the issue of *immutability*. Were all same-sex attractions and behaviors fixed and not subject to change, then sexual orientation would indeed be an enduring trait and SOCE would be a futile exercise, including among minors. However, there is solid data to suggest that same-sex attractions and behaviors are not fixed and are subject to varying degrees of change. As summarized by Ott et al. (2013), "Reported sexual identity, attraction, and behavior have been shown to change substantially across adolescence and young adulthood" (p. 466). This viewpoint has long been maintained within scientific circles. Klein, Sepekoff, and Wolf (1985) decades earlier affirmed "the importance of viewing sexual orientation as a process which often changes over time" and noted "the simplicity and inadequacy of the labels heterosexual, bisexual, and homosexual in describing a person's sexual orientation" (p. 43).

Nonheterosexuality Is Not a Fixed Trait

The definitive study by Laumann, Michael, and Gagnon (1994), cited by the Task Force, involved several thousand American adults between the ages of eighteen and sixty. This report contains the most careful and extensive database ever obtained on the childhood experiences of matched homosexual and heterosexual populations. One of the major findings of the study that surprised even the authors was that homosexuality as a fixed trait scarcely seemed to exist (Laumann et al., 1994). Sexual identity is not fixed at adolescence but continues to change over the course of life. For example, the authors report:

> This implies that almost 4 percent of the men have sex with another male before turning eighteen but not after. These men, who report same-gender sex only before they turned eighteen, not afterward, constitute 42

> percent of the total number of men who report ever having a same-gender experience. (Laumann et al., p. 296)

They also note that their findings comport well with other large-scale studies:

> Overall we find our results remarkably similar to those from other surveys of sexual behavior that have been conducted on national populations using probability sample methods. In particular two very large-scale surveys . . . one in France [20,055 adults] and one in Britian [18,876 persons]. (p. 297)

This data seem to suggest that heterosexuality is normative even for those who at one point in the past reported a nonheterosexual sexual orientation. Sexual orientation stability appears to be greatest among those who identify as heterosexual (Savin-Williams, Joyner, & Rieger, 2012): "This limited empirical evidence based on four large-scale or nationally representative populations indicates that self-reports of sexual orientation are stable among heterosexual men and women, but less so among nonheterosexual individuals" (p. 104).

Heterosexuality likely exerts a constant, normative pull throughout the life cycle upon everyone. While admittedly Laumann attributes this reality to American society, the same findings have been found in other societies where it has been studied. A simpler explanation might look to human physiology, including the physiology of the nervous system, which is overwhelmingly sexually dimorphic—in other words, heterosexual. Therefore it is not surprising that the brain would self-organize behavior in large measure in harmony with its own physiological ecology, even if not in a completely deterministic fashion.

Whether measured by action, feeling, or identity, Laumann and colleagues' (1994) data concerning the prevalence of homosexuality before and after age eighteen reveal that

its instability over the course of life occurred in one direction toward heterosexuality and reflected significant decline in nonheterosexual identities. This evidence of spontaneous change with the progression of time among both males and females is hardly the picture of sexual orientation stasis in adolescence assumed by California SB 1172 and New Jersey AB 3371. To be fair, we cannot tell from this data how many, if any, of those reporting change pursued SOCE. However, the data do provide a developmental context for the plausibility that SOCE could aid some individuals (including minors) in modifying same-sex attractions and behavior. It appears that the most common natural course for a young person who develops a nonheterosexual sexual identity is for it to spontaneously disappear unless such is discouraged or interfered with by extraneous factors. Conceivably, non-SOCE therapies that obstruct this process (in other words, those that are "gay-affirmative") could be interfering with normal sexual development.

Diamond's longitudinal studies of women with nonheterosexual identities revealed that 67% reported changing their identities over a ten-year period of time (Diamond, 2005, 2008). Diamond noted that, "hence, identity *change* is more common than identity *stability*, directly contrary to conventional wisdom" (p. 13; emphasis in original). While changes in same-sex physical and emotional attractions among these women were admittedly more modest, they nevertheless occurred to the point where the findings "demonstrate considerable fluidity in bisexual, unlabeled, and lesbian women's attractions, behaviors, and identities and contribute to researcher's understanding of the complexity of sexual-minority development over the life span" (Diamond, 2008, p. 12). Clearly, change in sexual attractions and behaviors on a continuum of change would appear possible for many women and adolescent girls, leaving no rational reason to preclude professionally conducted SOCE as one option for minor girls experiencing unwanted same-sex attractions and behaviors, provided parental and informed consent. Finally, echoing the earlier observation by Laumann et al. (1994), Diamond (2005) concluded that "in light of such findings, one might argue for an end to sexual categorization altogether, at least within the realm of social scientific research" (p. 125).

Change Not Limited to Sexual Behavior

A New Zealand study by Dickson, Paul, and Herbison (2003) further questions the claim that change might affect same-sex *behavior* but *not* same-sex *attraction*. This study found large and dramatic drops in homosexual attraction that occurred spontaneously for both sexes, a finding underscored even more by its occurrence in a country with a relatively accepting attitude toward homosexuality. Interestingly, the results also indicated a slight but statistically significant net movement toward homosexuality and away from heterosexuality between the ages of twenty-one and twenty-six, which suggests the influence of environment on sexual orientation, particularly for women. Specifically, it appears likely that the content of higher education in a politically liberal environment contributed to the upswing in homosexuality in this educated sample of twenty-somethings. This notion is further supported by the fact that this increase in homosexuality follows a much larger decrease that would have to have taken place in the years prior to twenty-one in order to account for the above findings. Additionally, once the educational effect wears off, the expected decline in homosexual identification resumed. The authors conclude that their findings are consistent with a significant (but by no means exclusive) role for the social environment in the development and expression of sexual orientation.

Change Particularly Evident for Youth and Bisexuals

A large longitudinal study by Savin-Williams and Ream (2007) is also noteworthy, as it focused on the stability of sexual orientation components for adolescents and young adults. Three waves of assessment began when participants were on average just under sixteen years of age and concluded when participants were nearly twenty-two years old. The authors observed a similar decline in nonheterosexuality over the time of the study, specifying that "all attraction categories other than opposite-sex were associated with a lower likelihood of stability over time" (p. 389). For example, sixteen-year-olds

who reported exclusive same-sex attractions or a bisexual pattern of attractions are approximately twenty-five times more likely to change toward heterosexuality at the age of seventeen than those with exclusively opposite-sex attractions are likely to move toward bisexual or exclusively same-sex attractions (Whitehead & Whitehead, 2010). Over the course of the study, 98% of sixteen- to seventeen-year-olds moved from homosexuality or bisexuality toward heterosexuality.

To be fair, such changes were more pronounced among bisexuals and women. But keep in mind that California SB 1172 and New Jersey AB 3371 do not discriminate in their prohibition between SOCE provided for exclusively same-sex-attracted minors and those whose unwanted same-sex attractions are part of a bisexual attraction pattern. Nor does the bill's ban distinguish between boys and girls. Savin-Williams and Ream observed that "the instability of same-sex attraction and behavior (plus sexual identity in previous investigations) presents a dilemma for sex researchers who portray non-heterosexuality as a stable trait of individuals" (p. 393). They acknowledged that developmental processes are involved even as they focused mostly on problems with measurement. The reality of such spontaneous changes in sexual orientation among teenagers is not in accord with a bill whose defenders contend sexual orientation is a universally enduring trait. In fact, these data suggest it is irresponsible to legally prevent access to SOCE and allow only affirmation of same-sex feelings in adolescence on the grounds that the feelings are intrinsic, unchangeable, and therefore the individual can be only homosexual.

The intent of SB 1172 and AB 3371 for a blanket prohibition on SOCE for all minors with unwanted same-sex attractions and behaviors is akin to doing heart surgery with a chainsaw: it is unable to address the complex realities of sexual orientation. For example, a study by Herek, Norton, Allen, and Sims (2010) reported that "only" 7% of gay men reported experiencing a small amount of choice about their sexual orientation and slightly more than 5% reported having a fair amount or great deal of choice. Lesbian

women reported rates of choice at 15% and 16%, respectively. It is worth noting that these statistics, which are not inconsequentially small, do suggest that sexual orientation is not immutable for all people and again suggest the plausibility that modification of same-sex attractions and behaviors could occur in SOCE for some individuals.

Even more important, however, are the findings for bisexuals: 40% of bisexual males and 44% of bisexual females reported having a fair amount or great deal of choice in the development of their sexual orientation. This is in addition to 22% of male bisexuals and 15% of female bisexuals who reported having at least a small amount of choice about their sexual orientation. Other studies confirm the particular instability of a bisexual sexual orientation (Savin-Williams et al., 2012). These numbers create a significantly different impression about the enduring nature of sexual orientation than the picture often painted by proponents of SB 1172 and AB 3371. At a minimum, such data suggest that proponents of this legislation would have done better to exclude bisexuality from the scope of this bill. If such a large minority of individuals (albeit mostly bisexuals) experience a self-determinative choice as being involved in the development of their sexual orientation, why would it not be conceivable that SOCE might augment this process for some individuals with unwanted same-sex attractions and behaviors?

Identification of the Mostly Heterosexual Orientation

Further evidence that SB 1172 and AB 3371 ignore distinctions in sexual orientation relevant to SOCE is the recent identification of the "mostly heterosexual" orientation. This orientation has been reported by 2 to 3% men and 10 to 16% of women over time, and constituted a sexual orientation larger than all other nonheterosexual identities combined (Savin-Williams et al., 2012). Moreover, it appears to be a highly unstable sexual orientation in comparison to other nonheterosexual identities. The reality of the "mostly heterosexual" orientation category has been additionally supported by recent physiological evidence in a sample of men (Savin-Williams et al., 2013). This

apparently viable and unique group of nonheterosexuals raises serious questions for the scope of AB 3371—for example, are "mostly heterosexual" minors exempt from the law's ban on SOCE? The fact that SB 1172 and AB 3371 appear to have been outdated even before they were signed into law highlights the folly of politicians attempting to adjudicate the complex scientific matters surrounding SOCE at the behest of activists within and outside of professional organizations.

All of the above evidence of fluidity and change in sexual orientation strongly suggests that change in the dimensions of sexual orientation does take place for some people (and likely more so for youth). It also suggests that this change is best conceptualized as occurring on a continuum and not as an all-or-nothing experience. The experience of NARTH clinicians is that while some clients report complete change and some indicate no change, many clients report achieving sustained, satisfying, and meaningful shifts in the direction and intensity of their sexual attractions, fantasy, and arousal as well as behavior and sexual orientation identity.

Descriptions of licensed SOCE therapists as trying to "cure" their clients of homosexuality are either ignorant or willfully slanderous of how these therapists conceptualize their care (National Association for Research and Therapy of Homosexuality, 2010). Professional SOCE practitioners recognize that change of sexual orientation typically occurs on a continuum, and this is consistent with how change is understood to occur for most, if not all, other psychological and behavioral conditions addressed in psychotherapy.

Genetics and Biology Are at Best Partial Explanations for Same-Sex Attractions

Moreover, such fluidity and change makes clear that simple causative genetic or biological explanations are inappropriate. The later development of same-sex attractions and behaviors is not determined at birth, and there is no convincing evidence that biology is

decisive for many, if not most, individuals. The American Psychiatric Association has observed that "to date there are no replicated scientific studies supporting any specific biological etiology for homosexuality" (American Psychiatric Association, 2013). Peplau, Spalding, Conley, and Veniegas (1999) earlier summarized, "To recap, more than 50 years of research has failed to demonstrate that biological factors are a major influence in the development of women's sexual orientation. . . . Contrary to popular belief, scientists have not convincingly demonstrated that biology determines women's sexual orientation" (p. 78).

It is important to note in this regard that the APA's own stance on the biological origin of homosexuality has softened in recent years. In 1998, the APA appeared to support the theory that homosexuality is innate and people were simply "born that way": "There is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, play a significant role in a person's sexuality" (APA, 1998). But in 2008, the APA described the matter differently:

> There is *no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation.* Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that *nature and nurture both play complex roles.*" (APA, 2008a; emphasis added)

Yet the APA has made minimal effort to publicize the change in its official position on such causation or to correct the accompanying popular misconception—often promoted by the media—that persons with same-sex attractions are simply "born that way." It is difficult not to perceive this as significant professional neglect.

The absence of genetic or biological determinism in sexual orientation is underscored and clarified by large-scale studies of identical twins. These studies indicate that if one twin sibling has a nonheterosexual orientation the other sibling shares this orientation only about 11% of the time (Bailey, Dunne, & Martin, 2000; Bearman & Bruckner, 2002; Langstrom, Rahman, Carlstrom, & Lichtenstein, 2010). If factors in common like genetics or conditions in the womb overwhelmingly caused same-sex attractions, then identical twins would *always* be identical for same-sex attraction. These studies instead suggest that the largest influence on the development of same-sex attractions are environmental factors that affect one twin sibling but not the other, such as unique events or idiosyncratic personal responses.

Causatively, then, sexual orientation is by no means comparable to a characteristic—such as race or biological sex—that is thoroughly immutable. Thus, while same-sex attractions may not be experienced as chosen, it is reasonable to hold that they can be subject to conscious choices, such as those that might be facilitated in SOCE. Same-sex attractions and behaviors are not strictly or primarily determined by biology or genetics and are naturalistically subject to significant change, particularly in youth and early adulthood. This should raise serious questions about the legitimacy of SB 1172's and AB 3371's portrayal of same-sex attractions and behaviors as static traits to be embraced only by those minors who might otherwise pursue SOCE.

III. There Is No Scientific Basis for Blaming SOCE for the Harmful Stigma and Discrimination Reportedly Experienced by Persons with a Nonheterosexual Sexual Orientation

Proponents of California SB 1172 and New Jersey AB 3371 frame a significant degree of their arguments concerning harm and SOCE on the negative consequences of stigma and discrimination. While these factors certainly can have deleterious

consequences for those with nonheterosexual sexual orientations, this possibility must be placed within a broader context and balanced by additional considerations.

The Limited Understanding of the Dynamics of Stigma and Discrimination

From an overall perspective, the meta-analytic research (that 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). Furthermore, research into what influences this association has most typically found no significant role for theoretically linked factors such as social support and identification with one's group. For example, data suggest that the impact of "internalized homophobia" for understanding risk behavior among 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. Such findings should be sufficient to indicate that there is a great deal left to be understood about this entire field of study.

Other lines of inquiry suggest that stigma and discrimination alone are far from a complete explanation for greater psychiatric and health risks among nonheterosexual orientations. Mays and Cochran (2001) reported that discrimination experiences attenuated but did not eliminate associations between psychiatric morbidity and sexual orientation. In Holland, 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, despite that country's highly tolerant attitude toward homosexuality (de Graaf, Sandfort, & ten Have, 2006; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006).

Research in this area is almost entirely reliant on self-reports of *perceived* discrimination, and the relation of this to objective discrimination is not well understood. Recent literature also finds that particular emotion/avoidant-based coping mechanisms

used by people reporting SSA almost entirely account for the effects of this perceived discrimination (Whitehead, 2010). For example, 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 et al., 2009).

Some Health Outcomes Are Likely Based in Anatomy More Than Stigma

In addition, some health risks, such as HIV transmission among gay men, may be influenced by stigma but are ultimately grounded in biological reality. A recent 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). Recent CDC statistics indicate the rate of new HIV diagnoses in the United States among men who have sex with men is more than forty-four times that of other men (Centers for Disease Control, 2011). Young gay and bisexual men age thirteen to twenty-nine 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). 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.

SOCE Not a Proxy for Stigma or Discrimination

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. 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 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. 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, 2012, p. 5).

Referral for SOCE therefore cannot be designated as a proxy for harm-inducing family rejection and stigma, as the proponents of SB 1172 and AB 3371 seem to assume. Only a few studies have directly examined the link between family rejection and health risk among minors (Saewyc, 2011). The derived findings from those studies 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). Even more importantly, no studies have examined family relationships in the context of SOCE participation (APA, 2009). Thus, SB 1172 and AB 3371 would unnecessarily and without scientific warrant eliminate the potential role of conservative religious values for ameliorating the effects of stigma in the context of SOCE. 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).

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

Finally, new research is raising the possibility that some widely accepted theories germane to the discussion of stigma, discrimination, and health outcomes may in fact have gotten things backward. A longitudinal study of gay and bisexual men by Heubner, Neilands, Rebchook, and Kegeles (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)

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 SB 1172 and AB 3371: A law that allows only 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 SOCE.

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 SOCE 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 SOCE that links 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 SOCE is portrayed by mental health associations. SOCE practitioners and consumers are associated with poor practices as a matter of course (APA, 2009, 2012; Jones et al., 2010). This arguably is a form of stigma and discrimination toward practitioners of SOCE, who have ironically developed their own set of practice guidelines that, when followed, can be expected to reduce the risk of harm to SOCE consumers (NARTH, 2010).

IV. Spitzer's Reassessment of His *Interpretation* of the Results of His 2003 Study on SOCE Does *Not* Invalidate the Results He Reported

Finally, proponents of New Jersey's AB 3371 have understandably pointed out that Robert Spitzer, MD—author of one of the primary studies conducted on SOCE (Spitzer, 2003)—has recently changed his assessment of the study and believes that it does not provide clear evidence of sexual orientation change (Spitzer, 2012). It appears that he may have originally wished to retract the 2003 study, but Kenneth Zucker, PhD—the editor of the journal in which the study was published—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 his 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, an assertion made by others at the time of the study. Instead, he now asserts that participants' accounts of change may have involved "self-deception or outright lying" (Spitzer, 2012).

It is curious that Spitzer's (2012) apology seems to imply that he earlier claimed his researched proved the efficacy of SOCE. As was understood at the time, the design of Spitzer's study ensured his research would not definitively *prove* that SOCE 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?

Since nothing has changed regarding the scientific merit of the Spitzer 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. 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.

In fact, the reasonableness of this position has been bolstered recently 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. (p. 1336)

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.

Concluding Statements

There should be no doubt that licensed mental health professionals who practice some form of SOCE care deeply about the well-being of sexual minority youth and see SOCE as a valid option for psychological care, while simultaneously affirming the client's right to pursue gay-affirmative forms of psychotherapy. While it is not possible here to respond to all the accusations that are typically leveled against SOCE, the information in the present document should be sufficient to question the scientific (not to mention Constitutional) merits of California SB 1172 and New Jersey AB 3371.

As we noted at the outset:

(1) The science as pertains to SOCE efficacy and harm is not nearly as conclusive and definitive as proponents of SB 1172 and AB 3371 portray them to be. Their one-sided presentation of the science is a byproduct of a pervasive lack of viewpoint diversity within professional organizations and their constituent social scientists regarding sexual orientation research.

(2) Professional activism and related advocacy interests have superseded allegiance to the process of scientific discovery regarding SOCE, as is evident in the highly discrepant methodological standards professional organizations have utilized to evaluate efficacy and harm.

(3) An impressive body of scientific data indicates that nonheterosexual sexual orientations should not be viewed as always immutable but are often, though not always, subject to change, especially among youth.

(4) The role of stigma and discrimination on negative health outcomes among nonheterosexual identities is real but provides only a small and partial understanding of these concerns. Most importantly, applying this literature uncritically to SOCE is scientifically and ethically dubious.

(5) The proper course of action for politicians and the courts to take given the current limited scientific base of knowledge regarding SOCE should be to encourage further and ideologically diverse research, not to place a ban on its professional practice that supersedes existing regulatory oversight and may create unintended consequences for licensed therapists.

As this brief has documented, there is reasonable evidence to suggest that professional associations such as the APA do not approach the SOCE literature in an objective manner, but rather with an eye to their advocacy interests. This is seen in the purposeful exclusion of conservative and SOCE-sympathetic psychologists from the APA Task Force as well as the clearly uneven application of methodological standards in assessing evidence of SOCE efficacy and harm.

As the Task Force noted, the prevalence of success and harm from SOCE cannot be determined at present. Anecdotal accounts of harm, which are a focal point of attention by supporters of SB 1172 and AB 3371, cannot serve as a basis for the blanket prohibition of an entire form of psychological care, however meaningful they may be on a personal level. While such "hearsay" evidence is "not nothing," it is negligent if not fraudulent that APA and other professional organizations accept such unverified claims that experiences of SOCE were "harmful" while dismissing much better-documented claims that experiences of SOCE were "beneficial" and were not "harmful" (Phelan, Whitehead, & Sutton, 2009). Indeed, it is not difficult to find counterbalancing anecdotal accounts of benefit from SOCE (see http://www.voices-of-change.org/). Furthermore, accounts of harm cannot tell us if the prevalence of reported harm from SOCE is any greater than that from psychotherapy in general, where research demonstrates that 5 to 10% of clients report deterioration while up to 50% experience no reliable change during treatment (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004).

The normative occurrence of spontaneous change in sexual orientation among youth, the nontrivial degree of choice reported by some in the development of sexual orientation, and the questionable blanket application of the literature on stigma and discrimination to SOCE further bring into question the appropriateness of SB 1172 and AB 3371. Sexual orientation is not a stable and enduring trait among youth, and this lends plausibility to the potential for professionally conducted SOCE to assist in change in unwanted same-sex attraction and behaviors with some minors. Granted, high-quality research is needed to confirm this suspicion. However, it should be mentioned in this regard that SB 1172 and AB 3371 would make further research on SOCE with minors impossible in California and New Jersey, respectively, despite the APA Task Force's clear mandate that such research be conducted (APA, 2009).

Any genuine harm that results from SOCE practice with minors can most appropriately be remedied by the application of ethical principles of practice, including

informed consent, and addressed through the existing oversight functions of state regulatory boards and state mental health associations. It is questionable and unlikely that the tangible, prosecutable harms from SOCE are as widespread as SB 1172 and AB 3371 sponsors claim. If such harms did exist, why have we heretofore not seen SOCE practitioners losing their licenses and mental health association memberships in droves? Both SB 1172 and AB 3371 are a legislative overreach that takes an overly broad and absolute approach to SOCE harm and success despite evidence suggesting age, gender, and nonheterosexual sexual orientation differences in the experience and degree of change in sexual orientation. In particular, it is fair to ask whether bisexual and mostly heterosexual youth are well served by SB 1172 and AB 3371, a distinction these laws do not make.

Proponents of SB 1172 and AB 3371 reason that because homosexuality is no longer considered to be a disorder, providing professional SOCE to minors with unwanted same-sex attractions and behaviors is at best unnecessary and at worst unethical. However, this reasoning betrays a profound misrepresentation of the scope of psychotherapeutic practice, as there are numerous examples of professionally sanctioned targets of treatment that are not considered to be disorders. These include relationship distress, normal grief reactions, and unplanned pregnancy. Clients often pursue psychological care for such difficulties due to deeply held religious and moral beliefs—such as beliefs that divorce or abortion are wrong—and may experience significant emotional distress in addressing these issues. In this context, the selective attention that SB 1172 and AB 3371 give to SOCE again hints at political advocacy rather than science as a primary inspiration for this law.

The religiously conservative faith community will not be well served if SOCE among minors is judged *never* to be an appropriate modality for psychological care, especially when the affirmative interventions include the correction of the client's "false assumptions." Should the court agree with this line of argument, then the court

is unconstitutionally taking a stand on the validity of certain forms of religious belief. By implying that there is always a better method than any form of SOCE, backers of SB 1172 and AB 3371 presume to know what form of psychological care for unwanted same-sex attractions and behaviors is best for the religiously motivated minor clients and their parents. Neither the courts nor the APA should be substituting their judgment for that of a seventeen-year-old who is calculating a cost-benefit analysis in deciding whether to undergo SOCE despite the risks. The APA is quite clear that it supports the competence of a seventeen-year-old girl to give consent to an abortion. Why does the seventeen-year-old lose competence when it comes to SOCE? Similarly, the APA is on record as supporting the availability of sexual reassignment surgery for adolescents (APA, 2008b), and AB 3371 explicitly protects this option. Is it reasonable that seventeen-year-olds who believe themselves to be the wrong biological sex be allowed to surgically alter genitalia while others with unwanted same-sex attractions and behavior be prohibited from even *talking* to a licensed therapist in a manner that could be construed as promoting the pursuit of change? This question is especially relevant in light of recent high-quality longitudinal research that suggests sexual reassignment surgery does not remedy high rates of morbidity and mortality among transgendered individuals (Dhejne et al., 2011).

The Task Force *Report* (APA, 2009) and the mental health associations that subsequently relied on it for their resolutions on SOCE provide one viewpoint into research and reasoning that likely has some merit but must be considered incomplete and therefore not definitive enough to justify a complete ban on SOCE with minors. Currently, there is a lack of sociopolitical diversity within mental health associations (Redding, 2001) that has an inhibitory influence on the production of scholarship in controversial areas such as SOCE that might run counter to preferred worldviews and advocacy interests. An authentically scientific approach to a contentious subject must proceed in a different direction in order to give confidence that the relevant database is

a sufficiently complete one on which to base public policy. As Haidt (2012) observed, genuine diversity of perspective is absolutely necessary:

> In the same way, each individual reasoner is really good at one thing: finding evidence to support the position he or she already holds, usually for intuitive reasons. . . . This is why it's so important to have intellectual and ideological diversity within any group or institution whose goal is to find truth (such as an intelligence agency or a community of scientists) or to produce good public policy (such as a legislature or advisor board). (p. 90)

Such diversity is precisely what is currently lacking in professional mental health organizations and their associated scientific communities when it comes to the study of contested social issues related to sexual orientation, including SOCE (Wright & Cummings, 2005). If this were not true, it would be hard to understand how the American Psychological Association's leadership body—the Council of Representatives—could vote 157-0 to support same-sex marriage, a result that undoubtedly represents a "statistically impossible lack of diversity" (Jayson, 2011; Tierney, 2011).

To repeat a final time, a truly scientific response to the concerns of the sponsors of California SB 1172 and New Jersey AB 3371 would be to encourage bipartisan research into SOCE with minors that could provide sound data to answer questions of harm and efficacy that currently are only primitively understood. SOCE practitioners would assuredly embrace such an opportunity (Jones et al., 2010). Unfortunately, the approach taken by SB 1177 and AB 3371 sponsors represented only one political and legislative perspective on how to best address the challenges that come with the psychological care of unwanted same-sex attractions and behaviors. That approach is therefore a scientifically premature—and unjust—curtailment of the rights of current and potential SOCE consumers, their parents, and their therapists and should not be allowed to stand.

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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.	)	
	)	

DECLARATION OF CHRISTOPHER ROSIK, PH.D.

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

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I. ENGAGEMENT AND QUALIFICATIONS.

1. I am over the age of 18 and am submitting this Declaration as expert testimony in support of Plaintiffs. I have been asked to offer my analysis and opinions regarding the state of science on the issues of sexual orientation and gender identity, with a focus on the published quantitative literature, specifically with respect to the claimed scientific justifications for City of Tampa Ordinance 2017-47, An Ordinance Of The City Of Tampa, Florida, Relating To Conversion Therapy On Patients Who Are Minors (hereinafter "Ordinance 2017-47"). The facts in this Declaration are true and correct, and if called upon to testify to them I would and could do so competently.

2. I hold a Ph.D. in clinical psychology from an APA-approved program at Fuller Graduate School of Psychology in Pasadena, California. I have been a licensed clinical psychologist for over thirty years, and I currently practice at the Link Care Center in Fresno, California, where I am also the Director of Research. Attached hereto as Exhibit A is a copy of my curriculum vitae, which includes my qualifications and publications, including all publications I have authored in the previous ten years. I have not testified at trial or by deposition in any case during the previous four years.

3. In preparing this report, I relied on the case filings and academic, scientific, and other reference materials identified in the table of References attached hereto as Exhibit B.

4. My compensation for this engagement will be $450 per hour for deposition and trial testimony, $200 per hour for travel time, and actual expenses. I provide the remainder of my time for this engagement *pro bono*.

II. SUMMARY AND PRELIMINARY CONSIDERATIONS.

5. With reference to legislation banning licensed therapists from engaging in therapies that allow for change in the components of sexual orientation generally, and specifically regarding Ordinance 2017-47, I offer below several considerations. I note at the outset that the terminology of sexual orientation change efforts (SOCE) and "conversion therapy" are in many ways misnomers. These terms imply that categorical change (from exclusive same-sex attraction to exclusive opposite sex attraction) is the goal and the focus, although change typically is on a continuum and can occur without a direct therapeutic focus on sexuality. SOCE also is not clear about what constitutes an "effort" and whether this effort is that of the client and/or the therapist. However, ethical change-allowing talk therapy is client-directed and does not impose goals on the client, but seeks instead to facilitate the voluntary goals of the client which sometimes include change. "Conversion therapy" gives the false impression that there is a singular exotic therapy being practiced when in fact ethical practitioners in this area utilize a variety of mainstream therapeutic approaches, all centered on and delivered through speech. Finally, these terms do not always distinguish between professionally conducted psychotherapy and religious or other forms of counseling practice, a blurring of categories that carries immense significance for accurately representing change-allowing professional therapies. Unfortunately, SOCE terminology is the current standard vernacular so I will employ it at times in this declaration to signify change-allowing professional talk therapies, though I recognize that licensed therapists in this area of

practice find the language of sexual attraction fluidity exploration or therapy-assisted fluidity to be more accurately descriptive of their work.

6. There should be no doubt that licensed mental health professionals who practice some form of SOCE care deeply about the well-being of sexual minority youth and see change-allowing therapies as a valid option for psychological care, while simultaneously affirming as well the client's right to pursue gay affirmative forms of psychotherapy. While it is not possible here to respond to all the accusations that are typically leveled against professional SOCE, the information in the present declaration should be sufficient to question the scientific (not to mention constitutional) merits of Ordinance 2017-47.

7. To summarize my main points:

(1st) The science as pertains to SOCE efficacy and harm is not nearly as conclusive and definitive as proponents of Ordinance 2017-47 portray it to be. Their one-sided presentation of the science is a byproduct of a pervasive lack of viewpoint diversity within professional organizations and their constituent social scientists as pertains to sexual orientation research. Notwithstanding this demonstrable bias, the scientific literature does not support the conclusion that voluntary, speech-based SOCE causes harm. In fact, the actual research studies reject causal attribution of harm to SOCE as an empirical matter, rendering any pro-SOCE-ban position statements based on the studies at best unreliable and at worst dishonest.

(2nd) Given the empirically determined fact that all therapy includes some risk of harm, and the absence of any empirical data on harm specifically from SOCE therapy, the actual degree of harm attributable to SOCE is unknowable at this time. This is a critical fact of basic research methodology.

(3rd) Professional activism and related advocacy interests have superseded allegiance to the process of scientific discovery as pertains to SOCE, as is evident in the highly discrepant methodological standards professional organizations have utilized to evaluate efficacy and harm.

(4th) An impressive body of scientific data indicates that non-heterosexual sexual orientations should not be viewed as always immutable but are often fluid and subject to change, especially among youth and young adults. Assertions to the contrary should be considered in light of Diamond and Rosky's (2016) observation that, in spite of its scientific inaccuracy, "Some advocates clearly believe that immutability claims are necessary to advocate effectively for sexual minorities" (p. 372).

(5th) The proper course of action for politicians and the courts to take given the current limited scientific base of knowledge regarding SOCE should be to encourage further and ideologically diverse research, not place a ban on its professional practice that supersedes existing regulatory oversight and may

create unintended consequences for licensed therapists who work with non-heterosexual clients.

III. ANALYSIS AND OPINIONS.

A. The Objectivity of the 2009 APA Task Force Report on SOCE Is Demonstrably Suspect; Therefore the Report's Representation of the Relevant Literature Concerning Efficacy of and Harm from SOCE Is Neither Complete nor Definitive.

i. Bias in Task Force Selection.

8. Although many qualified conservative psychologists were nominated to serve on the task force that published the 2009 Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (the "Report"), all of them were rejected. This fact was noted in a book co-edited by a past-president of the APA (Yarhouse, 2009). The director of the APA's Lesbian, Gay and Bisexual Concerns Office, Clinton Anderson, offered the following defense: "We cannot take into account what are fundamentally negative religious perceptions of homosexuality—they don't fit into our world view" (Carey, 2007). It appears that the APA operated with a litmus test when considering task force membership—the only views of homosexuality that were tolerated are those that uniformly endorsed same-sex behavior as a moral good. Thus, from the outset of the task force, it was predetermined that conservative or religious viewpoints would only be acceptable when they fit within their pre-existing worldview. One example of this is the Report's failure to recommend any religious resources that adopt a traditional or conservative approach to addressing conflicts between religious beliefs and sexual orientation. This bias can hardly be said to respect religious diversity and had predictable consequences for how the task force addressed its work.

ii. Bias Regarding Statements of SOCE Harm and Efficacy.

9. This bias was particularly evident in the task force's highly uneven implementation of standards of scientific rigor in the utilization and evaluation of published findings pertaining to SOCE (Jones, et al., 2010). Of particular note is the contrast between the exceptionally rigorous methodological standards applied to SOCE outcomes and the considerably less rigorous and uneven standards applied to the question of harm. With regard to SOCE outcomes, the Report dismisses most of the relevant research because of methodological limitations which are outlined in great detail (APA, 2009, pp. 26-34). Studies pertaining to SOCE outcomes that fall short of the task force's rigorous standards are deemed unworthy of examination and dismissed as containing no evidence of value to the questions at hand. Meanwhile, the Report adopts very different evidentiary standards for making statements about harms attributed to SOCE. The standard as regards efficacy is to rule out substandard studies as irrelevant; however, no such standards are employed in considering studies purporting to document harm. In addition, the Report uses the absence of evidence to argue that SOCE is unlikely to produce change and thus strongly questions the validity of SOCE, but shows no parallel reticence to endorse affirmative therapy despite acknowledging that, "...it has not been evaluated for safety and efficacy" (APA, 2009, p. 91).

10. The six studies deemed by the task force to be sufficiently methodologically sound to merit the focus of the Report targeted samples that would bear little resemblance to those seeking SOCE today and used long outdated methods that no current practitioner of change-allowing talk therapies employs. This brings into question the Report's willingness to move beyond scientific agnosticism (i.e., that we do not know the prevalence of success or failure in SOCE) to argue affirmatively that sexual orientation change is uncommon or unlikely. The Report seems to affirm two incompatible assertions: a) we do not have credible evidence on which to judge the likelihood of sexual orientation change and b) we know with scientific certainty that sexual orientation change is unlikely. However, the absence of conclusive evidence of effectiveness is not logically equivalent to positive evidence of ineffectiveness (Altman & Bland, 1995).

11. There are places in the Report that do seem to acknowledge that, given their methodological standards, we really cannot know anything scientifically definitive about the efficacy of or harms attributable to SOCE. For example, the Report states, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" (APA, 2009, p. 42). Similarly the Report observes, "Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective" (APA, 2009, p. 43). Similarly, "[T]here are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (APA, 2009, p. 83; cf. p. 67, 120).

12. These expressions of agnosticism are justified by the task force but then are not adhered to in the Report's conclusions. Instead, the Report argues at length that only the most rigorous methodological designs can clearly establish a causal relationship between SOCE methods and subsequent change, but the Report does not hesitate to make such causal attributions consistently regarding harm while repudiating any such claims for efficacy. From this highly uneven application of literature review methodology, the Report goes on to assert confidently that success of SOCE is unlikely and that SOCE has the potential to be harmful. It is also telling that in subsequent references to the Report the potential for harm has morphed into "the potential to cause harm to *many* clients" (APA, 2012, p. 14, emphasis added). The harms from SOCE appear to grow greater the farther away one gets from the original Report.

iii. Bias in Favor of Preferred Conclusions.

13. That the task force utilized a far lower methodological standard in assessing harm and other aspects of the science than it did in assessing SOCE outcomes can be demonstrated by a few examples. The Report references the many varieties of methodological problems deemed sufficient to render useless most of the SOCE research. Yet the Report is ready to overlook such limitations when the literature addresses preferred conclusions. First, consider the work of Hooker (1957), which is routinely touted as groundbreaking in the field and affirmed in the Report and other APA publications as evidence indicating no differences in the mental health of heterosexual and gay men. However, this research contains such serious methodological flaws that it is inconceivable that an even-handed methodological evaluation by the task force would not have mentioned these problems. Among the many methodological problems noted by Schumm (2012), the control group was told the purpose of the study in advance, and clinical experts were not blind to the objectives of the study. There also was an imperfect matching of participants, low scale reliability, the use of a small and recruited control group rather than existent national standardized

norms, the post hoc removal of tests that actually displayed differences, and the screening out of men from the study if they appeared to have pre-existing psychological troubles.

14. As Hooker (1993) wrote many years later, "I knew the men for whom the ratings were made, and I was certain as a clinician that they were relatively free of psychopathology." Despite these serious methodological problems, which would never be tolerated by the task force were this SOCE-supportive research, APA experts such as Gregory Herek described Hooker's study as part of the "overwhelming empirical evidence" that there is no association of sexual orientation with psychopathology (Herek, 1991, p. 143; see also Herek, 2010). Furthermore, the APA has cited Hooker's "rigorous" study in several of its recent amicus briefs (Schumm, 2014). The point here is not to argue for an association between homosexuality and pathology, but to underscore that a consistent application of the methodological standards affirmed in the Report should have led to the dismissal of the Hooker study as supportive of the no differences hypothesis.

iv. Bias Regarding Treatment of the Primary Study on Harm.

15. Perhaps the most egregious example of the task force's methodological double standard is evidenced in their heavy reliance on the Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) research in conclusions about harm from SOCE. Several methodological problems cited to dismiss the SOCE outcome literature complicate these studies:

- These studies were conducted in association with the National Gay and Lesbian Task Force, initially with the explicit mandate to find clients who had been harmed and document ethical violations by practitioners. This was abundantly clear in the study's original title: "Homophobic therapies: Documenting the damage".

- Over 50% of the 202 sample participants were recruited through the GLB media, hardly a random or generalizable sampling procedure.

- Only 20 participants in this study were women, creating significant skew toward gay male accounts.

- Twenty-five percent of study participants had already attempted suicide *before* starting therapy, making very dubious the claim that suicide attempts were actually caused by the therapy.

- Finally, these subjects reported their experiences came from a mix of licensed therapists, nonlicensed peer counselors, and religious counselors, leaving open the reasonable suspicion that negative therapeutic experiences might differ significantly by level of training.

The Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) results thus are based on a non-representative sample likely to be heavily biased in the direction of retrospectively reporting negative therapy experiences, some of which occurred decades prior. The task force appears to have ignored the warnings from the study's authors: "*The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical*

violations in conversion therapy" (Shidlo & Schroeder, 2002, p. 250, emphases in the original). It is difficult to understand how this research can be cited without qualification or context as demonstrating likely harm from change-allowing talk therapies conducted by licensed medical and mental health professionals.

16. Again, what we can say with confidence is that some SOCE clients report harm and others report benefit and we do not know from the literature how often either outcome occurs. While harm may occur with any form of psychological care, the "evidence" provided in this study is essentially nothing more than unverifiable "hearsay." This is hardly a legitimate ground for legal prohibition.

v. Bias Regarding the Lack of Context Concerning Harm in Psychotherapy.

17. The APA and other professional bodies that utilize this Report, including those identified in the Ordinance, are negligent if not fraudulent in giving a warning that SOCE may potentially cause harm but failing to do so within the broader context that this warning certainly applies to all forms of psychological care for any and all forms of presenting problems or concerns. For example, regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences appear to be unavoidable for a small percentage of clients, especially those who begin therapy with a severe "initial level of disturbance" (Lambert & Ogles, 2004, p. 117). Clients who experience significant negative counter-transference or whose clinicians may lack empathy or underestimate the severity of their problem may also be at greater risk for deterioration (Mohr, 1995).

18. It should be noted in this regard that there is not a single study which provides prevalence estimates of harm from SOCE using a representative and population-based sample. The APA Report does not make this fact clear and has no way of knowing if the prevalence of reported harm from SOCE is any greater than that from psychotherapy in general, where research demonstrates 5-10% of clients report deterioration while up to 50% experience no reliable change during treatment (Hansen, Lambert, & Forman, 2002; Lambert, 2013; Lambert & Ogles, 2004; Lambert & Ogles, 2004; Nelson, Warren, Gleave, & Burlingame, 2013; Warren, Nelson, Burlingame, & Mondragon, 2012). In addition to psychotherapy deterioration rates, 40-60% of youth drop out of all forms of psychological treatment early (Kazdin, 1996; Nelson, et al. 2013; Wierzbicki & Perkarik, 1993).

19. These facts have considerable implications for contextualizing the alleged reports of harm and efficacy from SOCE. Deterioration rates significantly beyond 20% would need to be established for professionally conducted SOCE in order for claims of approach-specific harms among youth to be substantiated. Otherwise, Ordinance 2017-47 proponents are simply targeting one approach to psychological care on ideological and not scientific grounds.

20. Further, the high dropout rates among youth in all forms of psychotherapy add insight to the risk of premature termination in SOCE, wherein emotional distress arising from initial discussions of difficult issues may not be allowed sufficient therapeutic process to be adequately resolved. This could result in a feeling of harm that would be attributable to the premature termination and not SOCE per se.

21. Furthermore, it must be remembered that, on average, persons with same-sex attraction already experience and/or are at greater risk for experiencing a number of medical and mental health difficulties *prior* to participating in any SOCE (Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016; Pakula, Shoveller, Ratner & Carpiano, 2016; Whitehead & Whitehead, 2010). This makes it extremely difficult to disentangle psychological distress directly attributable to SOCE from that which preceded commencement of SOCE. And since change-allowing talk therapies commonly involve helping clients become more aware of the stress and distress in their lives in order to manage or alleviate them, as do many approaches to mental health care, persons who leave therapy prematurely may have an increased awareness or experience of their (pre-) existing stress and distress. Thus, they may "feel worse" as a consequence of not having allowed therapy sufficient time to help resolve the difficulties. Anecdotal personal stories of harm certainly cannot scientifically establish the proportion of distress derived directly from SOCE, and high quality research that might be able to distinguish such causation simply does not exist.

vi. Bias in the Omission of Medical Outcomes Associated with Same-Sex Behavior.

22. It should also be mentioned in the discussions of harm and benefit from SOCE that the Report makes no mention of the well-documented medical outcomes associated with homosexual and bisexual behavior. For example, men having sex with men (MSM) comprise 48% of all individuals with HIV/AIDS in the U.S., but make up only an estimated 2-4% of men in the population (Newcomb & Mustanski, 2011). This is occurring in a context where MSM are reporting higher rates of sexual risk behaviors in recent years in spite of increasing cultural acceptance. Similarly, the disparities in emotional distress, suicidal ideation, and suicide attempts between non-heterosexual and heterosexual persons have persisted since the 1990s and even appear to be getting worse for bisexual and lesbian girls (Peter, Edkins, Watson, Adjei, Homma, & Saewyc, 2017; Porta, Watson, Doull, Eisenberg, Grumdahl, & Saewyc, 2018; Savin-Williams & Ream, 2007). Certainly, whatever unclear risk of harm that might occur to an individual SOCE minor client must be weighed against the clear medical risks that arise from enacting homosexual behavior, particularly salient among adolescents. Yet desires of the client to change attractions or even homosexual behavior could jeopardize the license of the therapist under Ordinance 2017-47.

vii. Bias Regarding Research on the Origins of Same-Sex Attractions.

23. Another example of the task force's uneven application of methodological standards concerns the Report's conclusion that, "Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation" (APA, 2009, p. 23). Of the ten studies cited in support of this conclusion, three were not readily accessible on databases and one was a review article, which is an interpretation and not an empirical study. An examination of the remaining six studies (Bell, Weinberg, & Hammersmith, 1981; Freund & Blanchard, 1983; McCord, McCord, & Thurber, 1962; Peters & Cantrell, 1991; Siegelman, 1981; Townes, Ferguson, & Gillam, 1976) revealed many of the same methodological flaws cited in the task force critique of SOCE (Rosik, 2012). For example, the Freud and Blanchard study is cited as evidence against any role of family dynamics or trauma in the origin of same-sex attractions but contains many serious methodological problems, including unclear scale reliability, participants being known to the researchers as patients, the use of a convenience sample, and a narrow and therefore non-generalizable sample composed of psychiatric patients. All of these

problems were considered to be fatal flaws in the task force's appraisal of the SOCE outcome literature for documenting evidence of change, but were ignored for conclusions that the task force wanted to draw.

24. Given that many of the methodological limitations used by the task force to assail the SOCE research exist in the literature exploring the possible causal influences for sexual orientation, questions have to be raised as to why the task force members chose to definitively dismiss this literature as "failing to support" developmental theories. It appears, based on the same criteria they used to dismiss SOCE, that their own conclusions have little support in the literature. A fairer rendering of the literature they reference in this regard would appear to be that this research is so methodologically flawed that one cannot make any conclusive statements concerning the applicability of developmental factors in the origin of homosexuality. Thus by the task force's own methodological standards, the literature they cite fails to support *or rule out* a role for these potential developmental influences in the genesis of sexual orientation.

25. If such ambiguity exists in the SOCE literature on methodological grounds, then by the task force's own criteria, this ambiguity also is present in the referenced etiological research. The task force has been inconsistent in the application of their methodological critique to the broader literature on homosexuality and they have been willing to offer more definitive conclusions about theories they wish to dismiss than is warranted by their own standards. In a word, there is again the appearance of substantial bias.

26. Contra to the repeated claims of the Report that it is an established "scientific fact" that "no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma" (APA, 2009, p. 86), there currently exists recent, high quality, and large-scale studies that provide empirical evidence consistent with the theory that familial or traumatic factors potentially contribute to the development of sexual orientation (Bearman & Bruckner, 2002; Francis, 2008, Frisch & Hviid, 2006; Roberts, Glymour, & Koenen, 2013; Wells, McGee, & Beautrais, 2011; Wilson & Widom, 2010). Despite their significant relevance for scientific discussions on the etiology of same-sex attractions, these studies were ignored by the task force.

27. It is perfectly reasonable to believe that *not* offering professional SOCE to some minors with unwanted same-sex attractions and behaviors who seek such care *may actually harm* them by *not* helping them deal with what is one of the possible consequences of sexual molestation and abuse.

28. This is underscored by the much higher prevalence rates of childhood sexual abuse (CSA) among non-heterosexuals (Andersen & Blosnich, 2013; Outlaw et al., 2011; Sweet & Wells, 2012; Xu & Zheng, 2015) and the fact that men experience more distress when sexually assaulted by a man as opposed to a woman (Artime, McCallum, & Peterson, 2014). Across relevant studies, median CSA prevalence among non-heterosexuals is estimated to be 35% for women and 23% for men compared to 3-27% of heterosexual women and 0-16% of heterosexual men respectively (Rothman, Exner, & Baughman, 2011). Furthermore, as Xu and Zheng observe, "It is possible that CSA causes an individual to develop a same-sex sexual attraction" (p. 328). The disparities in CSA between non-heterosexual and heterosexual individuals are in addition to the much greater odds of exposure non-heterosexuals have to multiple adverse developmental factors

beyond physical, sexual, and emotional abuse. Such adverse life events in childhood could reasonably be expected to contribute to attachment insecurity among children, which has predicted atypical gender identity and a lack of gender contentedness (Cooper et al., 2013). These researchers favor the view that attachment insecurity plays a causal role in gender atypicality, though they acknowledge that longitudinal studies are needed to confirm their suspicions. Andersen and Blosnich (2013) reported higher levels of exposure to adverse childhood factors (e.g., mentally ill, substance abusing, or incarcerated family members) for non-heterosexuals that were not likely to be the result of the child's nascent homosexuality, as is sometimes alleged as an explanation for elevated rates of physical and sexual abuse. The authors disagree but acknowledge that, "Some researchers posit that childhood adversity (particularly sexual abuse) may play a causal role in the development of same-sex preferences or sexual minority identity" (p. 5).

29. One example of this is research suggesting a causal role for childhood sexual abuse in the development of same-sexual orientation is based on a developmental and conditioning paradigm (Beard et al. 2013; Bickham et al. 2007; Hoffman, 2012; O'Keefe et al. 2014). For example, O'Keefe et al. (2014) and Beard et al. (2013) studied the effects of brother-brother incest and sister-brother incest in a sample of 1,178 men. They concluded that, "The origins of this increased interest in sex and the origins of bisexual or same-sex sexual orientations as well as the origins of many of the powerful urges to engage in behaviors such as exhibitionism or to use objects sexually can be explained as arising from early childhood experiences through the synergistic actions of critical period learning, sexual imprinting, and conditioning" (O'Keefe, et al., 2013, p. 27). These researchers also observed that such processes could account for much of the data that has been utilized to suggest a dominant biological or genetic explanation for non-heterosexuality.

viii. Bias Regarding Use of the "Grey Literature".

30. The uneven methodological implementation of standards is again seen in the Report's treatment of the "grey literature," which is dismissed in favor of only peer-reviewed scientific journal articles in the assessment of SOCE. No developed rationale is offered for this choice. Consequently, a highly scholarly, prospective, longitudinal study on SOCE supportive of change for some individuals and finding no harm on average and significantly improving psychological symptoms is dismissed in a footnote (Jones & Yarhouse, 2007; the footnote is found on page 90 of the Report; see also Jones & Yarhouse, 2011). Yet the task force appears to have no compunction in citing the grey literature on other subjects, such as the demographics relating to sexual orientation (Laumann, Gagnon, Michael, & Michaels, 1994) or the issue of psychological and familial factors in the development of sexual orientation (Bell, et al., 1981), even though the latter book utilizes a sample of questionable representativeness.

ix. Bias in the APA's Broader Treatment of Sexual Orientation.

31. A final differential application of methodological critique highlights the systemic nature of this problem within the broader literature pertaining to homosexuality. A recent analysis of the 59 research studies cited in the APA's brief supporting same-sex parenting (Marks, 2012) in essence applied methodological standards of similar rigor to those the task force applied to the SOCE literature. The Marks study concluded that,

> "...some same-sex parenting researchers seem to have contended for an 'exceptionally clear' verdict of 'no difference' between same-sex and heterosexual parents since 1992. However, a closer examination leads to the conclusion that strong, generalized assertions, including those made by the APA Brief, were not empirically warranted. As noted by Shiller (2007) in *American Psychologist*, 'the line between science and advocacy appears blurred'" (p. 748).

While Marks' analysis does not focus on change-allowing talk therapies, it is relevant in that it underscores that APA's worldview regarding homosexuality appears to result in public policy conclusions (whether right or wrong) that go beyond what the data can reasonably support. This is precisely what appears to be occurring in linking the APA task force Report with the banning of professional SOCE as represented in Ordinance 2017-47.

x. The APA Report Is Not Definitive Regarding the Risk of Harm from SOCE Due to Its Scientific Shortcomings and Pervasive Bias, and This Undermines All Position Statements Based on It.

32. In addition to the pervasive bias demonstrated above, a fatal scientific flaw in the APA Report and all subsequent studies and position statements based on it is their inability to account 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. 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 et al., 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.

33. To summarize, a proper conclusion regarding the 2009 APA Report and its progeny is that these reports and position statements cannot provide a scientifically sound basis for restricting the rights of individuals to engage in and therapists to provide change-allowing professional psychotherapy. 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.

B. Non-heterosexual Identities, Attractions, and Behaviors Are Subject to Change for Many People and Particularly Among Females and Youth.

34. Central to the notion that some individuals can and do report change on a continuum of change in their sexual orientation is the issue of *immutability*. The APA Task Force Report said one of the "key findings in the research" on which it based its conclusion was that sexual orientation does not change through life events (APA, 2009, pp. 63, 86). Were all same-sex

attractions and behaviors fixed and not subject to change, then sexual orientation would indeed be an enduring trait and SOCE would be a futile exercise, including among minors. However, there is solid data to suggest that same-sex attractions and behaviors are not fixed and are subject to varying degrees of change. As summarized by Ott et al. (2013), "Reported sexual identity, attraction, and behavior have been shown to change substantially across adolescence and young adulthood" (p. 466). Hu, Xu, and Tornello (2016) studied longitudinal data and observed, "In the LGB [lesbian, gay, and bisexual] population, the dominant pattern was change." Dickson, van Roode, Cameron, and Paul (2013) further asserted that, "People with changing sexual attractions may be reassured to know that these are common rather than atypical (p. 762). This viewpoint has long been maintained within scientific circles. Klein, Sepekoff, and Wolf (1985) decades earlier affirmed "...the importance of viewing sexual orientation as a process which often changes over time" and noted "...the simplicity and inadequacy of the labels heterosexual, bisexual, and homosexual in describing a person's sexual orientation" (p. 43).

i. Lack of Agreement Regarding What Constitutes Sexual Orientation.

35. Contrary to the conventional wisdom, there is substantial debate with scientific circles as to what constitutes sexual orientation, and this uncertainty extends to terms such as "sexual orientation change efforts." Sexual orientation may be said to comprise same-sex attractions, fantasies, and behaviors, but this is insufficient to guide change-allowing talk therapists in knowing clearly whether what they are discussing with a client could be considered as a *sexual orientation* change effort. That term is nebulous, and many scholars admit they have no precise means of distinguishing sexual orientation from same-sex sexuality, *i.e.*, same-sex behaviors and attractions that may not signify a same-sex orientation (Diamond, 2003). Relatedly, Savin-Williams (2016) described sexual orientation as being a continuum rather than discreet categories, which theoretically could mean that an isolated same-sex attraction among an otherwise completely heterosexual person might be considered as a separate sexual orientation.

36. Echoing the earlier observation by Laumann, Gagnon et al. (1994), Diamond (2005) concluded that, "In light of such findings, one might argue for an end to sexual categorization altogether, at least within the realm of social scientific research" (p. 125). Finally, Diamond and Rosky (2016) acknowledged these problems when they indicated,

> ....it is important to note that sexual orientation is not easy to define or measure. This obviously poses a problem for research on the causes of sexual orientation, given that the first step in such research is to identify individuals with different sexual orientation. (p. 365).

One could rationally argue that this also poses a problem for the politics of SOCE ban legislation.

ii. Non-Heterosexuality Is Not a Fixed Trait.

37. The definitive study by Laumann, Gagnon et al. (1994), cited by the APA (2009) task force, involved several thousand American adults between the ages of 18 and 60. This report contains the most careful and extensive database ever obtained on the childhood experiences of

matched homosexual and heterosexual populations. One of the major findings of the Laumann, Gagnon et al. study, which even surprised the authors, was that homosexuality as a fixed trait scarcely seemed to exist (Laumann, Michael, and Gagnon, 1994). Sexual identity is not the least fixed at adolescence but continues to change over the course of life. For example, the authors report:

> ...this implies that almost 4 percent of the men have sex with another male before turning eighteen but not after. These men, who report same-gender sex only before they turned eighteen, not afterward, constitute 42 percent of the total number of men who report ever having a same-gender experience. (Laumann, Gagnon, et al., p. 296)

They also note that their findings comport well with other large-scale studies.

> [O]verall we find our results remarkably similar to those from other surveys of sexual behavior that have been conducted on national populations using probability sample methods. In particular two very large-scale surveys...one in France [20,055 adults] and one in Britian [18,876 persons]. (p. 297)

38. This data suggest that heterosexuality is normative even for those who at one point in the past reported a non-heterosexual sexual orientation. Sexual orientation stability appears to be greatest among those who identify as heterosexual (Savin-Williams, Joyner, & Rieger, 2012): "This limited empirical evidence based on four large-scale or nationally representative populations indicates that self-reports of sexual orientation are stable among heterosexual men and women, but less so among non-heterosexual individuals" (p. 104). Moch & Eiback (2010) found that heterosexuality was more stable than homosexuality or bisexuality over a 10-year period in middle aged adults. Nearly half of women with initial bi- or homosexual identity opted for a different label 10 years later. Diamond and Rosky summarize the matter well: "Given the consistency of these findings, it is no longer scientifically accurate to describe same-sex sexual orientation as a uniformly immutable trait" (p. 370).

39. Heterosexuality likely exerts a constant, normative pull throughout the life cycle upon everyone. While admittedly Laumann attributes this reality to American society, the same findings have been found in other societies where it has been studied. A simpler explanation might look to human physiology, including the physiology of the nervous system, which is overwhelmingly sexually dimorphic, i.e., heterosexual. Therefore, it is not surprising that the brain would self-organize behavior in large measure in harmony with its own physiological ecology, even if not in a completely deterministic fashion.

40. Whether measured by action, feeling, or identity, Laumann, Gagnon, et al.'s (1994) data concerning the prevalence of homosexuality before age 18 and after age 18 reveal that its instability over the course of life occurred largely in one direction—toward heterosexuality—and reflected significant decline in non-heterosexual identities. This evidence of spontaneous change with the progression of time among both males and females is hardly a picture of sexual orientation stasis in adolescence that Ordinance 2017-47 seems to assume. To be fair, we cannot tell from this

data how many, if any, of those reporting change pursued SOCE. However, the data do provide a developmental context for the plausibility that change-allowing talk therapies could aide some individuals (including minors) in modifying same-sex attractions and behavior. It appears that the most common natural course for a young person who develops a non-heterosexual sexual identity is for it to spontaneously disappear unless that process is discouraged or interfered with by extraneous factors. Conceivably, therapies disallowing the potential for change (e.g., "gay-affirmative") could be interfering with normal sexual development.

iii. Fluidity of Non-Heterosexual Sexual Attractions and Identity is Commonplace.

41. Diamond's longitudinal studies of women with non-heterosexual identities revealed that 67% reported changing their identities over a ten-year period of time (Diamond, 2005, 2008). Diamond noted that, "Hence, identity *change* is more common than identity *stability*, directly contrary to conventional wisdom" (italics in original, p. 13). While changes in same-sex physical and emotional attractions among these women were admittedly more modest, they nevertheless occurred to the point where the findings "...demonstrate considerable fluidity in bisexual, unlabeled, and lesbian women's attractions, behaviors, and identities and contribute to researcher's understanding of the complexity of sexual-minority development over the life span" (Diamond, 2008, p. 12).

42. Farr, Diamond, and Boker (2014) presented evidence for the existence of subtypes of non-heterosexual women, both in the intensity or degree of their same-sex attractions and in how these attractions change over time. She noted that these women appear more likely than men to specifically report the roles of circumstance, chance, and choice in their sexual identity and orientation, concluding that, "These results support the notion that some degree of plasticity may be a fundamental component of female same-sex sexuality" (p. 1487). Dickson et al. (2013) reviewed the relevant scientific literature and concluded, "These studies demonstrate that there is more change in sexual orientation than would be expected from repeated cross-sectional studies and change appears to be more common among women than men" (p. 754).

43. Clearly, change in sexual attractions and behaviors on a continuum of change would appear possible for many women and adolescent girls, leaving no rational reason to preclude professionally conducted change-allowing talk therapies as one option for minor girls experiencing unwanted same-sex attractions and behaviors, provided adequate assessment to insure voluntary and informed consent. Finally, echoing the earlier observation by Laumann, Gagnon et al. (1994), Diamond (2005) concluded that, "In light of such findings, one might argue for an end to sexual categorization altogether, at least within the realm of social scientific research" (p. 125).

44. Although the general scholarly consensus is that non-heterosexual women are more fluid in their sexual attractions and behaviors than are men, this may not be the case. As Diamond (2017) noted, "Female sexuality was once thought to be more fluid and plastic than men's, but recent research has begun to challenge this view" (p. 1184). This includes research on sexual orientation fluidity by Katz-Wise (2015) and Katz-Wise & Hyde (2015). These researchers studied a sample of young adults (18-26 years of age) who reported a same-gender sexual orientation. They discovered that 63% of the women and 50% of the men reported fluidity in their sexual

attractions, and of these individuals 48% of the women and 34% of the men also reported change in their sexual orientation identity. Of additional import for evaluating the legitimacy of Ordinance 2017-47, participants who reported fluidity indicated that their initial experience of change in sexual attractions occurred on average *before* the age of 18.

45. More recently, Diamond (2016) reviewed relevant studies and concluded,

> The other major conclusion that we can draw from these studies is that change in patterns of same-sex attraction is a relatively common experience among sexual minorities. Across the subgroups represented...between 25% and 75% of individuals reported substantial changes in their attractions over time, and these findings concord with the results of retrospective studies showing that gay, lesbian, and bisexual-identified individuals commonly recall having undergone previous shifts in their attractions. Such findings pose a powerful corrective to previous oversimplifications of sexual orientation as a fundamentally stable and rigidly categorical phenomenon. (p. 253)

46. It is also noteworthy that the Katz-Wise studies reported sexually fluid participants were more likely than sexually non-fluid participants to believe that sexual orientation is changeable. Non-sexually fluid men were more likely than sexually fluid men to believe that sexuality is something an individual is born with, while men who reported experiencing sexual fluidity were more likely than men who did not report sexual fluidity to view sexuality as changeable and subject to environmental influences. These findings may help explain the overwhelming dominance of men who provide testimony and personal anecdotes in favor SOCE bans, suggesting that non-heterosexual men who have not experienced change may assume that this is the case for all non-heterosexuals and support laws that ban professional change-allowing talk therapies for even sexually fluid male youths who freely seek assistance with their pursuit of change.

iv. Change Among Transgendered/Transsexual Individuals.

47. Intriguing research among transgendered persons finds that these individuals often report a change in their sexual orientation (Auer, Fuss, Hohne, Stalla, & Sievers, 2014). These researchers found almost 21% of their sample of 115 transsexual participants reported experiencing a change in their sexual orientation. They noted that, "Transition [surgically from one sex to the other] was not directly involved in this change, since a significant number of participants reported a change in sexual orientation prior to first psychological counseling and prior to initiation of cross-sex hormone treatment. The participants provided diverse individual explanation models, revealing that personal history, social environment as well as autoerotic feelings may impact on a change in sexual orientation" (p. 11). They observed that these changes may even be affected by personal decision, quoting one participant as stating, "While some people think that gender identity is something you acquire or learn, I think this was rather true for my alleged sexual orientation" (p. 9). While this study may raise more questions than it ultimately answers, it further undercuts an understanding of sexual orientation as a stable self-construct that is unchangeable for all persons in all circumstances.

v. Change Not Limited to Sexual Behavior.

48. A New Zealand study by Dickson, Paul, and Herbison (2003) further questions the claim that change might affect same-sex *behavior* but *not* same-sex *attraction*. This study found large and dramatic drops in homosexual attraction that occurred spontaneously for both sexes, a finding underscored even more by its occurrence in a country with a relatively accepting attitude toward homosexuality. Interestingly, the results also indicated a slight but statistically significant net movement toward homosexuality and away from heterosexuality between the ages of 21 and 26, which suggests the influence of environment on sexual orientation, particularly for women. Specifically, it appears likely that the content of higher education in a politically liberal environment contributed to the upswing in homosexuality in this educated sample of twenty-somethings. This notion is further supported by the fact that this increase in homosexuality follows a much larger decrease that would have had to take place in the years prior to 21 in order to account for the above findings. Additionally, once the educational effect wears off, the expected decline in homosexual identification resumed. The authors conclude that their findings are consistent with a significant (but by no means exclusive) role for the social environment in the development and expression of sexual orientation.

49. More recently, similar findings were reported among a sample of 116 polyamorous and monoamorous individuals (Manley, Diamond, & van Anders, 2015). The authors suggest "the prevalence of attraction shifts contradicts notions of attraction as stable and partnering behaviors and sexual identities as more fluid. Attraction shifts were far more common than shifts in either sexual identity or partner gender" (p. 177).

vi. Change Particularly Evident for Youth and Bisexuals.

50. A large longitudinal study by Savin-Williams and Ream (2007) is also noteworthy as it focused on the stability of sexual orientation components for adolescents and young adults. Three waves of assessment began when participants were on average just under 16 years of age and concluded when participants were nearly 22 years old. The authors observed a similar decline in non-heterosexuality over the time of the study: "All attraction categories other than opposite-sex were associated with a lower likelihood of stability over time" (p. 389). For example, 16-year-olds who reported exclusive same-sex attractions or a bisexual pattern of attractions are approximately 25 times more likely to change toward heterosexuality at the age of 17 than those with exclusively opposite sex attractions are likely to move towards bisexual or exclusively same-sex attractions (Whitehead & Whitehead, 2010). Ninety-eight percent of 16 to 17-year-olds moved from homosexuality or bisexuality towards heterosexuality over the course of the study.

51. To be fair, such changes were more pronounced among bisexuals and women. But keep in mind that Ordinance 2017-47 does not discriminate in its prohibition between SOCE provided for exclusively same-sex attracted minors and those whose unwanted same-sex attractions are part of a bisexual attraction pattern. Nor does the bill's ban distinguish between boys and girls. Savin-Williams and Ream observed that, "The instability of same-sex attraction and behavior (plus sexual identity in previous investigations) presents a dilemma for sex researchers who portray non-heterosexuality as a stable trait of individuals" (p. 393). They acknowledged that developmental processes are involved even as they focused mostly on problems with measurement. The reality of such spontaneous changes in sexual orientation among teenagers

is not in accord with a bill whose defenders contend sexual orientation is a universally enduring trait. In fact, these data suggest it is irresponsible to legally prevent access to change-allowing talk therapies and only allow affirmation of same-sex feelings in adolescence on the grounds that the feelings are intrinsic, unchangeable, and therefore the individual can only be homosexual.

52. Ordinance 2017-47's intent for a blanket prohibition on SOCE for all minors with unwanted same-sex attractions and behaviors is akin to doing heart surgery with a chainsaw in its inability to address the complex realities of sexual orientation. For example, a study by Herek et al. (2010) reported that "only" 7% of gay men reported experiencing a small amount of choice about their sexual orientation and slightly more than 5% reported having a fair amount or great deal of choice. Lesbian women reported rates of choice at 15% and 16%, respectively. It is worth noting that these statistics, which are not inconsequentially small, do suggest that sexual orientation is not immutable for all people and again suggest the plausibility that modification of same-sex attractions and behaviors could occur in change-allowing talk therapies for some individuals who voluntarily desire and seek such change. Even more important, however, are the findings for bisexuals: 40% of bisexual males and 44% of bisexual females reported having a fair amount or great deal of choice in the development of their sexual orientation. This is in addition to 22% of male bisexuals and 15% of female bisexuals who reported having at least a small amount of choice about their sexual orientation. Other studies confirm the particular instability of a bisexual sexual orientation (Savin-Williams, Joyner, & Rieger, 2012). These numbers create a significantly different impression about the enduring nature of sexual orientation than the picture often painted by proponents of Ordinance 2017-47. At a minimum, such data suggest that proponents of the Ordinance would have done better to exclude bisexuality from the scope of this bill. If such a large minority of individuals (albeit mostly bisexuals) experience a self-determinative choice as being involved in the development of their sexual orientation, why would it not be conceivable that change-allowing talk therapies might augment this process for some individuals with unwanted same-sex attractions and behaviors?

vii. Identification of the Mostly Heterosexual Orientation.

53. Further evidence that Ordinance 2017-47 ignores distinctions in sexual orientation relevant to SOCE is the recent identification of the "mostly heterosexual" orientation. This orientation has been reported by 2-3% men and 10-16% of women over time and constituted a sexual orientation larger than all other non-heterosexual identities combined (Savin-Williams, Joyner, & Rieger, 2012). Moreover, it appears to be a highly unstable sexual orientation in comparison to other non-heterosxual identities. The reality of the "mostly heterosexual" orientation category has been additionally supported by recent physiological evidence in a sample of men (Savin-Williams, Rieger, & Rosenthal, 2013). This apparently viable and unique group of non-heterosexuals raises serious questions for the scope of Ordinance 2017-47; namely, are "mostly heterosexual" minors exempt from the law's ban on SOCE? The fact that the Ordinance is oblivious to such important nuances highlights the folly of politicians attempting to adjudicate the complex scientific matters surrounding change-allowing talk therapies at the behest of activists within and outside professional organizations.

54. All of the above evidence of fluidity and change in sexual orientation strongly suggests that change in the dimensions of sexual orientation does take place for some people (and likely more so for youth) and that this change is best conceptualized as occurring on a continuum

and not as an all-or-nothing experience. The experience of clinicians who engage in change-allowing talk therapies is that while some clients report complete change, and some indicate no change, many clients report achieving sustained, satisfying, and meaningful shifts in the direction and intensity of their sexual attractions, fantasy, and arousal as well as behavior and sexual orientation identity.

55. Descriptions of licensed therapists engaged in SOCE as trying to "cure" their clients of homosexuality are either ignorant or willfully slanderous of how these therapists conceptualize their care (see Alliance for Therapeutic Choice and Scientific Integrity (ATSCI), 2018). Licensed therapists who provide change-allowing care recognize that change of sexual orientation typically occurs on a continuum of change, and this is consistent with how change is understood to occur for most if not all other psychological and behavioral conditions addressed in psychotherapy.

viii. Genetics and Biology Are at Best Partial Explanations for Same-Sex Attractions

56. Moreover, such fluidity and change make clear that simple causative genetic or biological explanations are inappropriate. The later development of same-sex attractions and behaviors is not determined at birth and there is no convincing evidence that biology is determinative for many if not most individuals (Diamond & Rosky, 2016). The American Psychiatric Association has observed that, "...to date there are no replicated scientific studies supporting any specific biological etiology for homosexuality" (American Psychiatric Association, 2013). Peplau et al. (1999) earlier summarized, "To recap, more than 50 years of research has failed to demonstrate that biological factors are a major influence in the development of women's sexual orientation...Contrary to popular belief, scientists have not convincingly demonstrated that biology determines women's sexual orientation."

57. It is important to note in this regard that the APA's own stance on the biological origin of homosexuality has softened in recent years. In 1998, the APA appeared to support the theory that homosexuality is innate and people were simply "born that way": "There is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, play a significant role in a person's sexuality" (APA, 1998). But in 2008, the APA described the matter differently:

> "There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles...." (APA, 2008a; emphases added).

Yet the APA has made minimal effort to publicize the change in its official position on such causation or to correct the accompanying popular misconception – often promoted by the media – that persons with same-sex attractions are simply "born that way" and "can't change." It is difficult not to perceive this as significant professional neglect.

58. The absence of genetic or biological determinism in sexual orientation is underscored and clarified by large scale studies of identical twins. These studies indicate that if one twin sibling has a non-heterosexual orientation the other sibling shares this orientation only about 11% of the time with upper estimates at 24% (v, Dunne, & Martin, 2000; Bearman & Brueckner, 2002; Langstrom, Rahman, Carlstrom, & Lichtenstein, 2010; Xu, Norton, & Rahman, 2019). If factors in common like genetics or conditions in the womb overwhelmingly caused same-sex attractions, then identical twins would *always* be identical for same-sex attraction. These studies instead suggest that the largest influence in the development of same-sex attractions are environmental factors that affect one twin sibling but not the other, such as unique events or idiosyncratic personal responses. Xu and colleagues (2019) concluded, "Thus, most of the differences between people in their sexual orientation are due to environmental factors (often nonshared) pointing to multiple etiology" (p. 1).

59. Similarly, heritability of sexual orientation is approximately .32, indicating that 32% of the population variability in sexual orientation is due to genetic factors (Diamond & Rosky, 2016). Heritability is the variability between persons in a population, not an indicator of the relative contributions of genetic and environmental influences within individuals. Diamond and Rosky put this in perspective by stating, "...it is helpful to note that higher estimations of heritability (ranging from .4 to .6) have been found for a range of characteristics that are not widely considered immutable, such as being divorced, smoking, having low back pain, and feeling body dissatisfaction" (p. 366). Given these statistics, it is curious that, for example, smoking is a behavior considered subject to change, while proponents of SOCE bans often maintain sexual orientation is an immutable behavioral characteristic.

60. Causatively, then, sexual orientation is by no means comparable to a characteristic such as race or biological sex which are thoroughly immutable. Thus, while same-sex attractions may not be experienced as chosen, it is reasonable to hold that they can be subject to conscious choices such as those which might be facilitated in change-allowing therapies. Same-sex attractions and behaviors are not strictly or primarily determined by biology or genetics and are naturalistically subject to significant change, particularly in youth and early adulthood. This should raise serious questions about the legitimacy of Ordinance 2017-47's portrayal of same-sex attractions and behaviors as static traits only to be embraced by those minors who might otherwise desire the option of exploring change.

C. The Reality of Sexual Fluidity Underscores the Impropriety of Prohibiting Change-Allowing Talk Therapies.

61. Although no reputable scholar can now deny that the components of sexual orientation evidence significant fluidity for many non-heterosexual persons, the adamant contention of SOCE ban supporters is that such naturalistic change occurs spontaneously and hence can never be achieved through the agency of clients in change-allowing talk therapies. This is essentially to contend that sexual orientation change may occur via many influences and in a variety of settings, with the singular exception of involving the assistance of a licensed therapist. Such a stance overlooks the reality that clinicians engaged in change-allowing talk therapies often address these exact influences with their clients. For example, same-sex attraction fluidity is known to sometimes occur in response to changes in emotional and romantic attachments. Hu et al. (2016) reported, "The results suggested that people who report same-sex attractions with no

relationship or an opposite sex partner were more likely to shift their same-sex attractions than those who reported a same-sex relationship" (p. 658). In evaluating neurobiological research, Diamond and Rosky (2016) noted that "...one possibility [for shifts in sexual attractions] is that the formation of emotional attachments may facilitate unexpected changes in sexual desire" (p. 370). Similarly, Manely et al. (2015) assert, "...research on sexual fluidity suggest that, for some people, relationships may in fact influence sexual orientation, meaning that emotionally intimate relationships may lead to sexual attractions toward a gender to which one had not previously been attracted" (p. 168). Change-allowing talk therapy may address exactly such influences, assisting clients with their relationships in ways that for some may facilitate genuine shifting in sexual attractions and behaviors.

62. At this point in time there are only political as opposed to theoretical obstacles to acknowledging some people can be their own agents of change in a process assisted by change-allowing talk therapy, including minors. Therapists who engage in this work report such experiences with some regularity, though certainly not for all clients. Research in this arena is of course very desirable, but hard to come by, for many reasons. Demands for such research seem to ignore the fact that (1) it is quite difficult to study a therapy process that is being made illegal, (2) funding sources for such research typically have vested interests in the outcomes as do the researchers, (3) obtaining findings favorable in any way to change-allowing talk therapies will likely result in the marginalization and professional ostracization of the researcher (Wood, 2013). It appears there will need to be a change, or at least a significant shifting, in the ideologically unbalanced professional culture of psychology before we can undo the current politically required foreclosure on the science of talk therapy-assisted fluidity in same-sex attractions and behaviors. 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).

D. Professional SOCE Bans Target Speech, Not Aversive Practices.

63. There is now clear evidence from state legislative proceedings that the intent of bans such as Ordinance 2017-47 is to stifle therapist speech and not certain aversive practices. Across the country where ban legislation for minors has been debated, politicians are hearing testimonials that directly or by implication associate SOCE provided by licensed therapists with painful aversive techniques such as shocking genitals, chemically induced vomiting, taking ice baths, and the like. This caricature of contemporary change-allowing talk therapies as promoting such child abuse is both disingenuous and slanderous, as was revealed in the legislative process surrounding proposed therapy bans in the states of Washington in 2015 and Utah in 2019. In both instances, amendments were made in committee that would have preserved a legal prohibition on the harmful aversive techniques but would have specially protected therapist speech. In the Utah example, the amendment would even have penalized guarantees of "a complete and permanent reversal in the patient or client's sexual orientation."

64. Nevertheless, despite the prospect of bipartisan support for these bills, proponents pulled the legislation, complaining they did not go far enough despite their targeting of the same aversive practices that were prominently mentioned as a basis for these bans (Backholm, 2015; "Watered down anti-conversion therapy bill," 2019). Particularly telling were the comments by

University of Utah College of Law professor Clifford Rosky, who developed the original ban bill in Utah, as reported in the local gay press:

> "Licensed therapists haven't been doing electric shock therapy and adversant [sic] practices in decades," Rosky continued. What they do these days, he said was talk therapy. "As we know, words are just as damaging to children."

Clearly then, proponents of change-allowing talk therapy bans have known all along that allowing abusive aversive practices to be associated with contemporary professional SOCE is a fundamentally dishonest political maneuver. Politicians and judges need to hear from ban proponents examples of what specific words change-allowing talk therapy practitioners say to minors that creates damage on a par with electroshocking their genitals.

E. State Regulatory Boards Already Are Equipped to Discipline Abusive Practitioners.

65. If any minors in the care of licensed therapists have been subjected to any of the aversive practices often declared by ban proponents, it is incomprehensible that some of these clinicians would not have been brought before their state licensing boards for such egregiously unethical child abuse. This raises a question for proponents of bans such as Ordinance 2017-47: Are these bans a solution to a problem that does not exist for minor clients of licensed therapists?

66. State regulatory boards exist and are funded for the purposes of addressing exactly the kinds of unacceptable aversive practices ban proponents claim is occurring with some licensed SOCE providers. It is imperative any concerns along these lines be addressed by a state regulatory body of other therapists who have the training and expertise to ensure ethical counseling practices. Such a body will understand the nuances of psychotherapeutic work and hence be in a position to accurately determine genuine malpractice. Given that mental health professionals who engage in change-allowing therapies have expended great amounts of time and money on their education and careers and have much to lose, genuine justice demands any questions about their therapy-related speech be adjudicated by their professional peers in state regulatory agencies. Untrained politicians and city officials are by no means qualified to police professional practice issues, including the goals and content of therapy offered by licensed mental health practitioners.

IV. Concluding Statements

67. As this declaration has documented, there is reasonable evidence to suggest that professional associations such as the APA do not approach the SOCE literature in an objective manner but rather with an eye to their advocacy interests. This is seen in the purposeful exclusion of conservative and SOCE sympathetic psychologists from the APA task force as well as the clearly uneven application of methodological standards in assessing evidence of SOCE efficacy and harm. As the task force noted, the prevalence of success and harm from SOCE cannot be determined at present, and recent SOCE research does not advance the field sufficiently to provide a scientific basis for ban legislation. Anecdotal accounts of harm, which are a focal point of attention by supporters of bans such as Ordinance 2017-47, cannot serve as a basis for the blanket prohibition of an entire form of psychological care, however meaningful they may be on a personal

level. It is negligent if not fraudulent that APA and other professional organizations accept such unverified claims that experiences of SOCE were "harmful" while dismissing much better documented claims that experiences of SOCE were "beneficial," and were not "harmful" (Phelan, Whitehead, & Sutton, 2009). Indeed, it is not difficult to find counterbalancing anecdotal accounts of benefit from change-allowing talk therapies (see http://voicesofchange.net; https://changedmovement.com/). Furthermore, as observed earlier, accounts of harm cannot tell us if the prevalence of reported harm from change-allowing therapies is any greater than that from psychotherapy in general.

68. The normative occurrence of spontaneous change in sexual orientation among youth and adults and the nontrivial degree of choice reported by some in the development of sexual orientation further bring into question the appropriateness of Ordinance 2017-47. Sexual orientation is not a stable and enduring trait among youth, and this lends plausibility to the potential for professionally conducted SOCE to assist in change in unwanted same-sex attraction and behaviors with some minors. Granted, high quality research is needed to confirm clinical reports of change. However, it should be mentioned in this regard that Ordinance 2017-47 would make further research on change-allowing talk therapies with minors impossible in Tampa, despite the APA task force's clear mandate that such research be conducted (APA, 2009).

69. Any purported concerns of harm anecdotally attributed to SOCE practice with minors can most appropriately be remedied by the application of ethical principles of practice, including informed consent, and addressed through the existing oversight functions of state regulatory boards and state mental health associations. Ordinance 2017-47 is a legislative overreach that takes an overly broad and absolute approach to SOCE harm and success despite evidence suggesting age, gender, and non-heterosexual sexual orientation differences in the experience and degree of change in sexual orientation. In particular, it is fair to ask whether bisexual and mostly heterosexual youth are well served by Ordinance 2017-47, a distinction this law does not make.

70. Proponents of Ordinance 2017-47 reason that because homosexuality is no longer considered to be a disorder, providing change-allowing talk therapies to minors with unwanted same-sex attractions and behaviors is at best unnecessary and at worst unethical. However, this reasoning betrays a profound misrepresentation of the scope of psychotherapeutic practice, as there are numerous examples of professionally sanctioned targets of treatment that are not considered to be disorders. These include relationship distress, normal grief reactions, and unplanned pregnancy. Clients often pursue psychological care for such difficulties due to deeply held religious and moral beliefs (i.e., that divorce or abortion are wrong) and may experience significant emotional distress in addressing these issues. In this context, the selective attention Ordinance 2017-47 gives to SOCE again hints at political advocacy rather than science as a primary inspiration for this law.

71. Clients will not be well served if change-allowing talk therapy with minors is judged *never* to be an appropriate modality for psychological care. Neither the courts nor the professional associations should be substituting their judgment for that of a 17-year old who is calculating a cost-benefit analysis in deciding whether to undergo change-allowing talk therapy, understanding through informed consent that fluidity in unwanted same-sex attractions may or may not occur. The APA is quite clear that it supports the competence of a 17-year old girl to give

consent to an abortion. Why does the 17-year old lose competence when it comes to change-allowing talk therapies?

72. Similarly, the APA is on record as supporting the availability of sexual reassignment surgery for adolescents (APA, 2008b) and Ordinance 2017-47 implicitly protects this option. Is it reasonable that 17-year olds who experience themselves to be the wrong biological sex be allowed to surgically remove breasts and alter genitalia while others with unwanted same-sex attractions and behavior be prohibited from even *talking* to a licensed therapist in a manner that could be construed as promoting the pursuit of change? This question is especially relevant in light of high quality longitudinal research that suggests sexual reassignment surgery does not remedy high rates of morbidity and mortality among transgendered individuals (Dhejne, et al., 2011).

73. The task force Report (APA, 2009), and the mental health associations that subsequently relied on it for their resolutions on SOCE, including those cited in the Ordinance, provide one viewpoint into research and reasoning which must be considered incomplete and therefore not definitive enough to justify a complete ban on change-allowing therapies with minors. Currently, there is a lack of sociopolitical diversity within mental health associations (Duarte et al., 2015; Redding, 2001), which has an inhibitory influence on the production of scholarship in controversial areas such as change-allowing talk therapies that might run counter to preferred worldviews and advocacy interests. An authentically scientific approach to a contentious subject must proceed in a different direction in order to give confidence that the relevant database is a sufficiently complete one on which to base public policy. As Haidt (2012) observed, genuine diversity of perspective is absolutely necessary:

> "In the same way, each individual reasoner is really good at one thing: finding evidence to support the position he or she already holds, usually for intuitive reasons...This is why it's so important to have intellectual and ideological diversity within any group or institution whose goal is to find truth (such as an intelligence agency or a community of scientists) or to produce good public policy (such as a legislature or advisor board)" (p. 90).

Such diversity is precisely what is lacking currently in professional mental health organizations and their associated scientific communities as regards the study of contested social issues related to sexual orientation, including SOCE (Duarte et al., 2015; Wright & Cummings, 2005). It would hard to understand, for example, how the leadership of the National Association of Social Workers could endorse a total of 542 candidates in federal elections between 2014 and 2018—all of whom were affiliated with the Democratic Party (NASW, 2018). These figures undoubtedly represent a "statistically impossible lack of diversity" (Tierney, 2011).

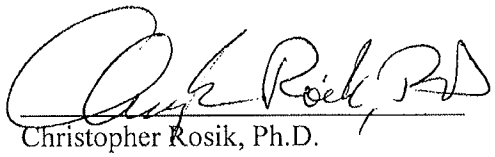
74. The APA lost 10% of its members between 2008 and 2013 and now represents less than 44% of psychologists in America (Robiner, Fossum, & Hong, 2015). The American Medical Association now represents less than 20% of physicians in the country. These downward trends have in part come about due to these associations' taking left-of-center positions on several social and policy issues, alienating conservative members and leading many of them to disaffiliate. It is evident from these kinds of statistics that, when it comes to socially contentious issues such as

change-allowing talk therapies, the mental health and medical associations likely do not speak for many of those professionals who practice in their respective fields.

75. To repeat a final time, a truly scientific response to the concerns of the sponsors of Ordinance 2017-47 would be to encourage bipartisan research into SOCE with minors that could provide sound data to answer questions of harm and efficacy that currently are only primitively understood. Change-allowing talk therapy practitioners take seriously their responsibility to do no harm and would assuredly embrace such an opportunity (Jones, et al., 2010). Were proponents of Ordinance 2017-47 not playing a winner-take-all approach to the issue of professional SOCE, there would undoubtedly be substantial ground both sides could agree upon that would address concerns regarding alleged harms and reported benefits from change-allowing talk therapies. Unfortunately, the approach taken by Ordinance 2017-47 sponsors represented only one (political and legislative) perspective on how to best address the challenges that come with the psychological care of unwanted same-sex attractions and behaviors. It is therefore a scientifically premature, and therefore unjust, violation of the rights of current and potential change-allowing talk therapy consumers, their parents, and their therapists and should not be allowed to stand.

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

Executed this May 6, 2019.



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Ph.D. Fuller Graduate School of Psychology, Pasadena, California, 1986 (clinical psychology - APA approved program).

II. Honors.

Phi Beta Kappa, Alpha of Oregon, 1980.
Exemplary Paper in Humility Theology Award, John Templeton Foundation, 1998.

III. Professional Experiences.

9/85 - 8/ 86	Clinical psychology intern, Camarillo State Hospital, Camarillo, California (APA approved internship).
11/86 - 5/88	Postdoctoral intern, Link Care Center, Fresno, California.
5/88 - Present	Licensed clinical psychologist, Link Care Center, Fresno, California.
11/94 - 6/96	Assistant Clinical Director, Link Care Center, Fresno, California.
7/96 - 12/99	Clinical Director, Link Care Center, Fresno, California.
1/01 – Present	Clinical Faculty, Fresno Pacific University
1/05 – Present	Director of Research, Link Care Center, Fresno, California

IV. Professional Affiliations.

1/84 - Present	Member, American Psychological Association.
1/86 - Present	Member, Christian Association for Psychological Studies (CAPS).
6/90 - 6/93	Member, board of directors, CAPS-Western region.
6/01 – 5/05	President-Elect, President, and Past-President, CAPS-Western Region
1/92 - Present	Member, International Society for the Study of Dissociation.
7/99 – Present	Member, Alliance for Therapeutic Choice and Scientific Integrity (Alliance)
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1/11 - Present	Member, National Association of Social Workers.

V. Selected Publications.

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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:

TABLE OF CONTENTS

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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EXHIBIT

3-B

(Deposition of Christopher Rosik, Ph.D.)

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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Zubenko, G. S., George, A. W., Soloff, P. H., & Schulz, P. (1987). Sexual practices among patients with borderline personality disorder. *American Journal of Psychiatry,* 144, 748–752. http://dx.doi.org/10.1176/ajp.144.6.748

Zucker, K. J., & Bradley, S. J. (1995). *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*. New York: Guilford.

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.

STATE OF FLORIDA)
) CITY OF TAMPA
COUNTY OF HILLSBOROUGH)

CLERK'S CERTIFICATE

I, Shirley Foxx-Knowles, the duly appointed and qualified City Clerk of the City of Tampa, Florida, do hereby certify to the best of my knowledge, that the attached document is a true and correct copy of Ordinance No. 2017-47 adopted by the City Council of the City of Tampa, on April 6, 2017 and approved by the Mayor on April 10, 2017 relating to conversion therapy on patients who are minor, making revisions to City of Tampa Code of Ordinances, Chapter 14 (Offenses); creating Article X, Sections 14-310 – 14-313; amending Chapter 19 (Property Maintenance and Structural Standards); amending Section 19-4(a)(2), Department of Code Enforcement; duties and scope of authority of the Director; on file in the Office of the City Clerk.

WITNESS, My hand and the Official Seal of the City of Tampa, Florida on this the 15th day of December, 2017.

Shirley Foxx-Knowles
City Clerk

(SEAL OF THE CITY OF TAMPA)

EXHIBIT 5
Deponent: Rosik
Depo Date: 7/29/19
Reporter: E. Hernandez
Anthem Reporting, LLC

Code Change

ORDINANCE NO. 2017- 47

AN ORDINANCE OF THE CITY OF TAMPA, FLORIDA, **RELATING TO CONVERSION THERAPY ON PATIENTS WHO ARE MINORS,** MAKING REVISIONS TO CITY OF TAMPA CODE OF ORDINANCES, CHAPTER 14 (OFFENSES); CREATING ARTICLE X, SECTIONS 14-310 – 14-313; AMENDING CHAPTER 19 (PROPERTY MAINTENANCE AND STRUCTURAL STANDARDS); AMENDING SECTION 19-4(a)(2), DEPARTMENT OF CODE ENFORCEMENT; DUTIES AND SCOPE OF AUTHORITY OF THE DIRECTOR; REPEALING ALL ORDINANCES OR PARTS OF ORDINANCES IN CONFLICT THEREWITH; PROVIDING FOR SEVERABILITY; PROVIDING AN EFFECTIVE DATE.

WHEREAS, as recognized by major professional associations of mental health practitioners and researchers in the United States and elsewhere for nearly 40 years, being lesbian, gay, bisexual, transgender or gender nonconforming, or questioning (LGBT or LGBTQ) is not a mental disease, disorder or illness, deficiency or shortcoming; and

WHEREAS, the American Academy of Pediatrics in 1993 published an article in its Journal, stating: "Therapy directed at specifically changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation;"[1] and

WHEREAS, the American Psychiatric Association in December 1998 published its opposition to any psychiatric treatment, including reparative or conversion therapy, which therapy regime is based upon the assumption that homosexuality is a mental disorder *per se* or that a patient should change his or her homosexual orientation;[2] and

WHEREAS, the American Psychological Association's Task Force on Appropriate Therapeutic Responses to Sexual Orientation ("APA Task Force") conducted a systematic review of peer-reviewed journal literature on Sexual Orientation Change Efforts ("SOCE"), and issued its report in 2009, citing research that sexual orientation change efforts can pose critical health risks to lesbian, gay, and bisexual people, including confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, suicidality, substance abuse, stress, disappointment, self-blame, decreased self-esteem and authenticity to others, increased self-hatred, hostility and blame toward parents, feelings of anger and betrayal, loss of friends and potential romantic partners, problems in sexual and emotional intimacy, sexual

[1] http://pediatrics.aappublications.org/content/pediatrics/92/4/631.full.pdf
[2] https://www.camft.org/ias/images/PDFs/SOCE/APA_Position_Statement.pdf

E2017-48
E2017-8 CH 14
E2017-8 CH 19

dysfunction, high-risk sexual behaviors, a feeling of being dehumanized and untrue to self, a loss of faith, and a sense of having wasted time and resources;[3] and

WHEREAS, following the report issued by the APA Task Force, the American Psychological Association in 2009 issued a resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts, advising parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support, and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth;[4] and

WHEREAS, the American Psychoanalytic Association in June 2012 issued a position statement on conversion therapy efforts, articulating that "As with any societal prejudice, bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice" and that psychoanalytic technique "does not encompass purposeful attempts to 'convert,' 'repair,' change or shift an individual's sexual orientation, gender identity or gender expression," such efforts being inapposite to "fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes;"[5] and

WHEREAS, the American Academy of Child & Adolescent Psychiatry in 2012 published an article in its Journal stating that 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;" that there is "no medically valid basis for attempting to prevent homosexuality, which is not an illness;" and that such efforts may encourage family rejection and undermine self-esteem, connectedness and caring, important protective factors against suicidal ideation and attempts; and that, for similar reasons cumulatively stated above, carrying the risk of significant harm, SOCE is contraindicated[6]; and

WHEREAS, the Pan American Health Organization, a regional office of the World Health Organization, issued a statement in 2012 stating: "'These supposed conversion therapies constitute a violation of the ethical principles of health care and violate human rights that are protected by international and regional agreements.'" The organization also noted that conversion therapies "lack medical justification and represent a serious threat to the health and well-being of affected people;"[7] and

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[3] https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf
[4] http://www.apa.org/about/policy/sexual-orientation.pdf
[5] http://www.apsa.org/content/2012-position-statement-attempts-change-sexual-orientation-gender-identity-or-gender
[6] http://www.jaacap.com/article/S0890-8567(12)00500-X/pdf
[7] http://www.paho.org/hq/index.php?option=com_content&view=article&id=6803%3A2012-therapies-changesexual-orientation-lack-medical-justification-threaten health&catid=740%3Apress-releases&Itemid=1926&lang=en

WHEREAS, in 2014 the American School Counselor Association issued a position statement that states: "It is not the role of the professional school counselor to attempt to change a student's sexual orientation or gender identity. Professional school counselors do not support efforts by licensed mental health professionals to change a student's sexual orientation or gender as these practices have been proven ineffective and harmful;"[8] and

WHEREAS, a 2015 report of the Substance Abuse and Mental Health Services Administration, a division of the U.S. Department of Health and Human Services, "Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth" further reiterates based on scientific literature that conversion therapy efforts to change an individual's sexual orientation, gender identity, or gender expression is a practice not supported by credible evidence and has been disavowed by behavioral health experts and associations, perpetuates outdated views of gender roles and identities, negative stereotypes, stating, importantly, that such therapy may put young people at risk of serious harm, and recognizing that, same-gender sexual orientation (including identity, behavior, and attraction) is part of the normal spectrum of human diversity and does not constitute a mental disorder;[9] and

WHEREAS, the American College of Physicians wrote a position paper in 2015 opposing the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons, stating that "[a]vailable research does not support the use of reparative therapy as an effective method in the treatment of LGBT persons. Evidence shows that the practice may actually cause emotional or physical harm to LGBT individuals, particularly adolescents or young persons;"[10] and

WHEREAS, In 2016, the American Medical Association issued policy statement H-160.991, which expressly opposed the use of "reparative" or "conversion" therapy for sexual orientation or gender identity; [11] and

WHEREAS, The World Psychiatric Association issued a policy statement in March, 2016 on Gender Identity and Same-Sex Orientation, which stated, "There is no sound scientific evidence that innate sexual orientation can be changed. Furthermore, so-called treatments of homosexuality can create a setting in which prejudice and discrimination flourish, and they can be potentially harmful. The provision of any intervention purporting to 'treat' something that is not a disorder is wholly unethical;"[12] and

WHEREAS, The National Association of Social Workers ("NASW") issued a policy statement stating that "No data demonstrates that reparative or conversion therapies are effective, and in fact they may be harmful." The NASW went further and stated that "conversion and reparative therapies are an infringement to the guiding principles inherent to social worker ethics and values;"[13] and

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[8] https://www.schoolcounselor.org/asca/media/asca/PositionStatements/PS_LGBTQ.pdf
[9] http://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf
[10] http://annals.org/article.aspx?articleid=2292051
[11] https://www.ama-assn.org/delivering-care/policies-lesbian-gay-bisexual-transgender-queer-lgbtq-issues
[12] http://www.wpanet.org/WPA_in_News.php
[13] http://www.naswdc.org/diversity/lgb/reparative.asp

WHEREAS, The Agency for Healthcare Research and Quality issued a clinician's guideline for practitioners who work with children and adolescents based on research provided by the American Academy of Child and Adolescent Psychiatry. It stated that "There is no empirical evidence that adult homosexuality can be prevented if gender nonconforming children are influenced to be more gender conforming. Indeed, there is no medically valid basis for attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may encourage family rejection and undermine self-esteem, connectedness, and caring, which are important protective factors against suicidal ideation and attempts;"[14] and

WHEREAS, At least two federal circuit courts of appeal have upheld bans on conversion therapy. [15] Both courts found that bans on conversion therapy did not violate free speech rights; nor did such bans run afoul of the Free Exercise Clause; nor were such bans vague or impermissibly overbroad. Further the courts found that counseling is professional speech, subject to a lower level of judicial scrutiny because the government has a substantial interest in protecting citizens from ineffective or harmful professional practices; and

WHEREAS, the City does not intend to prevent mental health providers from speaking to the public about SOCE; expressing their views to patients; recommending SOCE to patients; administering SOCE to any person who is 18 years of age or older; or referring minors to unlicensed counselors, such as religious leaders. This ordinance does not prevent unlicensed providers, such as religious leaders, from administering SOCE to children or adults; nor does it prevent minors from seeking SOCE from mental health providers in other political subdivisions or states outside of the City of Tampa, Florida; and

WHEREAS, City of Tampa has a compelling interest in protecting the physical and psychological well-being of minors, including but not limited to lesbian, gay, bisexual, transgender and questioning youth, and in protecting its minors against exposure to serious harms caused by sexual orientation and gender identity change efforts; and

WHEREAS, the City Council hereby finds the overwhelming research demonstrating that sexual orientation and gender identity change efforts can pose critical health risks to lesbian, gay, bisexual, transgender or questioning persons, and that being lesbian, gay, bisexual, transgender or questioning is not a mental disease, mental disorder, mental illness, deficiency, or shortcoming; and

WHEREAS, the City Council finds minors receiving treatment from licensed therapists in the City of Tampa, Florida who may be subject to conversion or reparative therapy are not effectively protected by other means, including, but not limited to, other state statutes, local ordinances, or federal legislation; and

[14] https://www.guideline.gov/summaries/summary/38417
[15] King v. Governor of the State of New Jersey, 767 F.3d 216 (3rd Cir. 2014) and Pickup v. Brown, 740 F.3d 1208 (9th Cir. 2013)

WHEREAS, the City Council desires to prohibit, within the geographic boundaries of the City, the practice of sexual orientation or gender identity change efforts on minors by licensed therapists only, including reparative and/or conversion therapy, which have been demonstrated to be harmful to the physical and psychological well-being of lesbian, gay, bisexual, transgender and questioning persons.

NOW, THEREFORE,

BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF TAMPA, FLORIDA,

Section 1. That the Whereas Clauses are adopted as if set forth fully herein.

Section 2. That **"Chapter 14, Article X"** is created as follows:

"CHAPTER 14, ARTICLE X, CONVERSION THERAPY"

Section 3. That **"Sec. 14.310. – Intent."** is hereby created by adding the underlined language as follows:

"Sec. 14-310. – Intent.

The Intent of this Ordinance is to protect the physical and psychological well-being of minors, including but not limited to lesbian, gay, bisexual, transgender and/or questioning youth, from exposure to the serious harms and risks caused by conversion therapy or reparative therapy by licensed providers, including but not limited to licensed therapists. These provisions are exercises of police power of the City for the public safety, health, and welfare; and its provisions shall be liberally construed to accomplish that purpose."

Section 4. That **"Sec. 14-311. – Definitions."** is hereby created by adding the underlined language as follows:

"Sec. 14-311. – Definitions.

(a) *Conversion therapy* or *reparative therapy* means, interchangeably, any counseling, practice or treatment performed with the goal of changing an individual's sexual orientation or gender identity, including, but not limited to, efforts to change behaviors, gender identity, or gender expression, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender or sex. Conversion therapy does not include counseling that provides support and assistance to a person undergoing gender transition or counseling that provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as such counseling does not seek to change sexual orientation or gender identity.

(b) *Minor* means any person less than 18 years of age.
(c) *Provider* means any person who is licensed by the State of Florida to provide professional counseling, or who performs counseling as part of his or her professional training under chapters 456, 458, 459, 490 or 491 of the Florida Statutes, as such chapters may be amended, including but not limited to, medical practitioners, osteopathic practitioners, psychologists, psychotherapists, social workers, marriage and family therapists, and licensed counselors. A Provider does not include members of the clergy who are acting in their roles as clergy or pastoral counselors and providing religious counseling to congregants, as long as they do not hold themselves out as operating pursuant to any of the aforementioned Florida Statutes licenses."

Section 5. That **"Sec. 14-312. – Conversion Therapy Prohibited."** is hereby created by adding the underlined language as follows:

"Sec. 14-312. – Conversion Therapy Prohibited.

It shall be unlawful for any Provider to practice conversion therapy efforts on any individual who is a minor regardless of whether the Provider receives monetary compensation in exchange for such services."

Section 6. That **"Sec. 14-313. – Enforcement and Civil Penalties."** is hereby created by adding the underlined language as follows:

"Sec. 14-313. – Enforcement and Civil Penalties.

(a) This article may be enforced pursuant to Chapter 9, Article II of this Code.
(b) The violation of Sec. 14-312 of this Division is deemed an irreparable or irreversible violation.
(c) Each separate incident of a violation of Sec. 14-312 shall constitute a separate violation for enforcement purposes.
(d) The fine for a first violation of Sec. 14-312 is $1000.00. The fine for a second and subsequent violation(s) of Sec. 14-312 is $5000.00
(e) These penalties shall not preclude any other remedies available at law or in equity, including, injunctive relief in the circuit court."

Section 7. That **"Sec. 19-4(a)(2). – Department of Code Enforcement; duties and scope of authority of the director"** is hereby amended by adding the underline language as follows:

"Sec. 19-4(a)(2). – Department of Code Enforcement; duties and scope of authority of the director

(a)The director shall have all powers, duties and responsibilities to administer and enforce the following City Code chapters or sections: The director shall be deemed to be an officer for the purpose of enforcing the provisions of this chapter under authority provided in section 1-14 of this Code.

(1)Section 5-105;

(2)Chapter 14, articles III, IV, and X;
(3)Chapter 19;
(4)Chapter 21, articles I, II, III and V;
(5)Chapter 22, articles I and III;
(6)Chapter 25, article I;
(7)Chapter 27."

Section 8. All ordinances or parts of ordinances in conflict herewith are hereby repealed.

Section 9. Should any section or provision of this Ordinance or any portion, paragraph, sentence, or word be declared invalid by a court of competent jurisdiction, such decision shall not affect the validity of the remainder of this Ordinance.

Section 10. Authority is hereby granted to codify the text amendment set forth in Section 1 of this Ordinance.

Section 11. That this Ordinance shall take effect immediately upon its adoption.

PASSED AND ORDAINED BY THE CITY COUNCIL OF THE CITY OF TAMPA, FLORIDA, ON APR 0 6 2017.

CHAIRMAN/~~CHAIRMAN PRO-TEM~~,
CITY COUNCIL

ATTEST:

SHIRLEY FOXX-KNOWLES, CITY CLERK

APPROVED BY ME ON APR 1 0 2017

BOB BUCKHORN, MAYOR

Approved As to Legal Sufficiency:

E/S
Ernest Mueller, Senior Assistant City Attorney

FOOTNOTE 1

American Psychological Association

Report of the American Psychological Association Task Force on

Appropriate Therapeutic Responses to Sexual Orientation

Report of the American Psychological Association Task Force on

Appropriate Therapeutic Responses to Sexual Orientation

Task Force Members

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Jack Drescher, MD
Beverly Greene, PhD
Robin Lin Miller, PhD
Roger L. Worthington, PhD

Clinton W. Anderson, PhD, Staff Liaison

Report of the American Psychological Association Task Force on

Appropriate Therapeutic Responses to Sexual Orientation

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

Printed copies available from:
Lesbian, Gay, Bisexual, and Transgender Concerns Office
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APA reports synthesize current psychological knowledge in a given area and may offer recommendations for future action. They do not constitute APA policy or commit APA to the activities described therein. This particular report originated with the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation.

August 2009
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ABSTRACT

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

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

Summary of the Systematic Review of the Literature

Efficacy and Safety

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

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

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

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

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

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

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

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

Individuals Who Seek SOCE and Their Experiences

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

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

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

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

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

Literature on Children and Adolescents

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

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

Recommendations and Future Directions

Practice

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

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

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

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

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

We were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or the behavioral expression of their sexual orientation, or both, or whose parent or guardian expresses a desire for the minor to change. The framework proposed for adults (i.e., acceptance and support, a comprehensive assessment, active coping, social support, and identity exploration and development) is also pertinent—with unique relevant features—to children and adolescents. For instance, the clinical literature stresses interventions that accept and support the development of healthy self-esteem, facilitate the achievement of appropriate developmental milestones—including the development of a positive identity—and reduce internalized sexual stigma.

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

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

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

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

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

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

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

Education and Training

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

- Sexuality, sexual orientation, and sexual identity development.
- Various perspectives on religion and spirituality, including models of faith development, religious coping, and the positive psychology of religion.
- Identity development, including integration of multiple identities and the resolution of identity conflicts.
- The intersections of age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status.
- Sexual stigma and minority stress.

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

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

Research

The task force was asked to provide recommendations for future research. We recommend that researchers and practitioners investigate multiculturally competent and affirmative evidence-based treatments for sexual

minorities that do not aim to alter sexual orientation. For such individuals, the focus would be on frameworks that include acceptance and support, a comprehensive assessment, active coping, social support, and identity exploration and development without prioritizing one outcome over another.

The research on SOCE has not adequately assessed efficacy and safety. Any future research should conform to best-practice standards for the design of efficacy research. Research on SOCE would (a) use methods that are prospective and longitudinal; (b) employ sampling methods that allow proper generalization; (c) use appropriate, objective, and high-quality measures of sexual orientation and sexual orientation identity; (d) address preexisting and co-occurring conditions, mental health problems, other interventions, and life histories to test competing explanations for any changes; (e) address participants' biases and potential need for monitoring self-impression and life histories; and (f) include measures capable of assessing harm.

Policy

The task force was asked to inform (a) the association's response to groups that promote treatments to change sexual orientation or its behavioral expression and (b) public policy that furthers affirmative therapeutic interventions. We encourage APA to continue its advocacy for LGBT individuals and families and to oppose stigma, prejudice, discrimination, and violence directed at sexual minorities. We recommend that APA take a leadership role in opposing the distortion and selective use of scientific data about homosexuality by individuals and organizations and in supporting the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias. We encourage APA to engage in collaborative activities with religious communities in pursuit of shared prosocial goals when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles.

The 1997 Resolution on Appropriate Responses to Sexual Orientation (APA, 1998) focuses on ethical issues for practitioners and still serves this purpose. However, on the basis of (a) our systematic review of efficacy and safety issues, (b) the presence of SOCE directed at children and adolescents, (c) the importance of religion for those who currently seek SOCE, and (d) the ideological and political disputes that affect this area, the task force recommended that the APA Council of Representatives adopt a new resolution, the **Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts**, to address these issues. [The Council adopted the resolution in August 2009.] (See Appendix A.)

PREFACE

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

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

Nominations of task force members were solicited through an open process that was widely publicized through professional publications, electronic media, and organizations. The qualifications sought were (a) advanced knowledge of current theory and research on the development of sexual orientation; (b) advanced knowledge of current theory and research on therapies that aim to change sexual orientation; and (c) extensive expertise in affirmative mental health treatment for one or more of the following populations: children and adolescents who present with distress regarding their sexual orientation, religious individuals in distress regarding their sexual orientation, and adults who present with desires to their change sexual orientation or have undergone therapy to do so. An additional position was added for an expert in research design and methodology.

Nominations were open to psychologists, qualified counselors, psychiatrists, or social workers, including members and nonmembers of APA. Nominations of

ethnic minority psychologists, bisexual psychologists, psychologists with disabilities, transgender psychologists, and other psychologists who are members of underrepresented groups were welcomed. In April 2007, then-APA President Sharon Stephens Brehm, PhD, appointed the following people to serve on the task force: Judith M. Glassgold, PsyD (chair); Lee Beckstead, PhD; Jack Drescher, MD; Beverly Greene, PhD; Robin Lin Miller, PhD; and Roger L. Worthington, PhD.

The task force met face-to-face twice in 2007 and supplemented these meetings with consultation and collaboration via teleconference and the Internet. Initially, we reviewed our charge and defined necessary bodies of scientific and professional literature to review to meet that charge. In light of our charge to review the 1997 resolution, we concluded that the most important task was to review the existing scientific literature on treatment outcomes of sexual orientation change efforts (SOCE).

We also concluded that a review of research before 1997 as well as since 1997 was necessary to provide a complete and thorough evaluation of the scientific literature. Thus, we conducted a review of the available empirical research on treatment efficacy and results published in English from 1960 on and also used common databases such as PsycINFO and Medline, as well as other databases such as the ATLA Religion Database, LexisNexis, Social Work Abstracts, and Sociological Abstracts, to review evidence regarding harm and benefit from SOCE. The literature review for other areas of the report was also drawn from these databases and included lay sources such as GoogleScholar and material found through Internet searches. Due to our charge, we limited our review to sexual orientation and did not address gender identity, because the final report of another task force, the APA Task Force on Gender Identity and Gender Variance, was forthcoming (see APA, 2009).

The task force received comments from the public, professionals, and other organizations and read all comments received. We also welcomed submission of material from the interested public, mental health professionals, organizations, and scholarly communities. All nominated individuals who were not selected for the task force were invited to submit suggestions for articles and other material for us to review. We reviewed all material received. Finally, APA staff met with interested parties to understand their concerns.

The writing of the report was completed in 2008, with editing and revisions occurring in 2009. After a draft report was generated in 2008, we asked for professional review by noted scholars in the area who were also APA members. Additionally, APA boards and committees were asked to select reviewers to provide feedback. After these reviews were received, the report was revised in line with these comments. In 2009, a second draft was sent to a second group of reviewers, including those who had previously reviewed the report, scholars in the field (including some who were not members of APA), representatives of APA boards and committees, and APA staff. The task force consulted with Nathalie Gilfoyle, JD, of the APA Office of General Counsel, as well as with Stephen Behnke, PhD, JD, of the APA Ethics Office. Other staff members of APA were consulted as needed.

We would like to thank the following two individuals who were essential to the accomplishment of our charge: Clinton W. Anderson, PhD, and Charlene DeLong, Dr. Anderson's knowledge of the field of LGBT psychology as well as his sage counsel, organizational experience, and editorial advice and skills were indispensable. Ms. DeLong was fundamental in providing technological support and aid in coordinating the activities of the task force.

We appreciate the assistance of Maria T. Valenti, MA, in conducting the research review and in organizing the tables. Mary Campbell also provided editorial advice on the report, and Stephanie Liotta provided assistance in preparing the final manuscript. We are grateful to David Spears for designing the report.

We would also like to acknowledge 2007 APA President Sharon Stephens Brehm, PhD, who was supportive of our goals and provided invaluable perspective at our first meeting, and to thank Alan E. Kazdin, PhD, past president, James H. Bray, PhD, president, and Carol D. Goodheart, EdD, president-elect, for their support. Douglas C. Haldeman, PhD, served as the Board of Director's liaison to the task force in 2007–2008 and provided counsel and expertise. Melba J.T. Vasquez, PhD, Michael Wertheimer, PhD, and Armand R. Cerbone, PhD, members of the APA Board of Directors, also reviewed this report and provided feedback.

We would very much like to thank Gwendolyn Puryear Keita, PhD, the executive director of the APA Public Interest Directorate, for her advice, support, and expertise. In addition, we acknowledge Rhea Farberman, executive director, and Kim Mills, associate executive director, of the APA Public and Member Communications office, for their expertise and support. Stephen H. Behnke, PhD, director of the APA Ethics

Office, and Nathalie Gilfoyle, APA Office of the General Counsel, provided valuable feedback on the report.

We acknowledge the following individuals, who served as scholarly reviewers of the first and second drafts of the report; their feedback on the content was invaluable (in alphabetical order): Eleonora Bartoli, PhD; Rosie Phillips Bingham, PhD; Elizabeth D. Cardoso, PhD; June W. J. Ching, PhD; David Michael Corey, PhD; Isiaah Crawford, PhD; Anthony D'Augelli, PhD; Sari H. Dworkin, PhD; Randall D. Ehrbar, PsyD; Angela Rose Gillem, PhD; Terry Sai-Wah Gock, PhD; Marvin R. Goldfried, PhD; John C. Gonsiorek, PhD; Perry N. Halkitis, PhD; Kristin A. Hancock, PhD; J. Judd Harbin, PhD; William L. Hathaway, PhD; Gregory M. Herek, PhD; W. Brad Johnson, PhD; Jon S. Lasser, PhD; Alicia A. Lucksted, PhD; Connie R. Matthews, PhD; Kathleen M. Ritter, PhD; Darryl S. Salvador, PsyD; Jane M. Simoni, PhD; Lori C. Thomas, JD, PhD; Warren Throckmorton, PhD; Bianca D. M. Wilson, PhD; Mark A. Yarhouse, PsyD; and Hirokazu Yoshikawa, PhD.

1. INTRODUCTION

In the mid-1970s, on the basis of emerging scientific evidence and encouraged by the social movement for ending sexual orientation discrimination, the American Psychological Association (APA) and other professional organizations affirmed that homosexuality per se is not a mental disorder and rejected the stigma of mental illness that the medical and mental health professions had previously placed on sexual minorities.[1] This action, along with the earlier action of the American Psychiatric Association that removed *homosexuality* from the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association, 1973), helped counter the social stigma that the mental illness concept had helped to create and maintain. Through the 1970s and 1980s, APA and its peer organizations not only adopted a range of position statements supporting nondiscrimination on the basis of sexual orientation (APA, 1975, 2005a; American Psychiatric Association, 1973; American Psychoanalytic Association, 1991, 1992; National Association of Social Workers [NASW], 2000) but also acted on the basis of those positions to advocate for legal and policy changes (APA, 2003, 2005a, 2008b; NASW, 2000). On the basis of growing scientific evidence (Gonsiorek, 1991), licensed mental health providers (LMHP)[2] of all professions increasingly took the perspective throughout this period that homosexuality per se is a normal variant[3] of human sexuality and that lesbian, gay, and bisexual (LGB) people deserve to be affirmed and supported in their sexual orientation,[4] relationships, and social opportunities. This approach to psychotherapy is generally termed *affirmative*, *gay affirmative*, or *lesbian, gay, and bisexual (LGB) affirmative.*

Consequently, the published literature on psychotherapeutic efforts to change sexual orientation that had been relatively common during the 1950s and 1960s began to decline, and approaches to psychotherapy that were not LGB affirmative came under increased scrutiny (cf. Mitchell, 1978; G.T. Wilson & Davison, 1974). The mainstream organizations for psychoanalysis and behavior therapy—the two types of therapeutic orientation most associated with the published literature on sexual orientation change therapies—publicly rejected these practices (American Psychoanalytic Association, 1991, 1992; Davison, 1976, 1978; Davison & Wilson, 1973; D. J. Martin, 2003).

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

[2] We use the term *licensed mental health providers* (LMHP) to refer to professional providers of mental health services with a variety of educational credentials and training backgrounds, because state licensure is the basic credential for independent practice.

[3] We use the adjective *normal* to denote both the absence of a mental disorder and the presence of a positive and healthy outcome of human development.

[4] We define sexual orientation as an individual's patterns of erotic, sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics (see pp. 29–32 for a more detailed discussion).

In the early 1990s, some APA members began to express concerns about the resurgence of individuals and organizations that actively promoted the idea of homosexuality as a developmental defect or a spiritual and moral failing and that advocated psychotherapy and religious ministry to alter homosexual feelings and behaviors, because these practices seemed to be an attempt to repathologize sexual minorities (Drescher & Zucker, 2006; Haldeman, 1994; S. L. Morrow & Beckstead, 2004). Many of the individuals and organizations appeared to be embedded within conservative political and religious movements that supported the stigmatization of homosexuality (Drescher, 2003; Drescher & Zucker, 2006; Southern Poverty Law Center [SPLC], 2005).

The concerns led to APA's adoption in 1997 of the Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998). In the resolution, APA reaffirmed the conclusion shared by all mainstream health and mental health professions that homosexuality is not a mental disorder and rejected any form of discrimination based on sexual orientation. In addition, APA highlighted the ethical issues that are raised for psychologists when clients present with a request to change their sexual orientation—issues such as bias, deception, competence, and informed consent (APA, 1998; Schneider, Brown, & Glassgold, 2002). APA reaffirmed in this resolution its opposition to "portrayals of lesbian, gay, and bisexual youths and adults as mentally ill due to their sexual orientation" and defined appropriate interventions as those that "counteract bias that is based in ignorance or unfounded beliefs about sexual orientation" (APA, 1998, p. 934).

In the years since APA's adoption of the 1997 resolution, there have been several developments that have led some APA members to believe that the resolution needed to be reevaluated. First, several professional mental health and medical associations adopted resolutions that opposed sexual orientation change efforts (SOCE)[5] on the basis that such efforts were ineffective and potentially harmful (e.g., American Counseling Association, 1998; American Psychiatric Association, 2000; American Psychoanalytic Association, 2000; NASW, 1997). In most cases, these statements were substantially different from APA's position, which did not address questions of efficacy or safety of SOCE.

Second, several highly publicized research reports on samples of individuals who had attempted sexual orientation change (e.g., Nicolosi, Byrd, & Potts, 2000; Shidlo & Schroeder, 2002; Spitzer, 2003) and other empirical and theoretical advances in the understanding of sexual orientation were published (e.g., Blanchard, 2008; Chivers, Seto, & Blanchard, 2007; Cochran & Mays, 2006; Diamond, 2008; Diaz, Ayala, & Bein, 2004; DiPlacido, 1998; Harper, Jernewall, & Zea, 2004; Herek, 2009; Herek & Garnets, 2007; Mays & Cochran, 2001; Meyer, 2003; Mustanski, Chivers, & Bailey, 2002; Rahman & Wilson, 2005; Savic & Lindstrom 2008; Szymanski, Kashubeck-West, & Meyer, 2008).

Third, advocates who promote SOCE as well as those who oppose SOCE have asked that APA take action on the issue. On the one hand, professional organizations and advocacy groups that believe that sexual orientation change is unlikely, that homosexuality is a normal variant of human sexuality, and that efforts to change sexual orientation are potentially harmful[6] wanted APA to take a clearer stand and to clarify the conflicting media reports about the likelihood of sexual orientation change (cf. Drescher, 2003; Stålström & Nissinen, 2003). On the other hand, the proponents of SOCE that consist of organizations that adopt a disorder model of homosexuality and/or advocate a religious view of homosexuality as sinful or immoral wanted APA to clearly declare that consumers have the right to choose SOCE (Nicolosi, 2003; Nicolosi & Nicolosi, 2002; Rosik, 2001).

For these reasons, in 2007, APA established the Task Force on Appropriate Therapeutic Responses to Sexual Orientation, with the following charge:

1. Revise and update the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998);
2. Generate a report that includes discussion of the following:
   - The appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or

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

[6] Two advocacy organizations (Truth Wins Out and Lambda Legal) are encouraging those who feel they were harmed by SOCE to seek legal action against their providers.

whose guardian expresses a desire for the minor to change.

- The appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both.
- The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.
- Education, training, and research issues as they pertain to such therapeutic interventions.
- Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

3. Inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.

The task force addressed its charge by completing a review and analysis of the broad psychological literature in the field. After reviewing the existing 1997 resolution in light of this literature review, we concluded that a new resolution was necessary. The basis for this conclusion, including a review and analysis of the extant research, is presented in the body of this report, and a new resolution, adopted in August 2009 by the APA Council of Representatives, is presented in Appendix A.

The report starts with a brief review of the task force charge and the psychological issues that form the foundation of the report. The second chapter is a brief history of the evolution of psychotherapy, from treatments based on the idea that homosexuality is a disorder to those that focus on affirmative approaches to sexual orientation diversity. Chapters 3 and 4 are a review of the peer-reviewed research on SOCE: Chapter 3 provides a methodological evaluation of this research, and Chapter 4 reports on the outcomes of this research. Chapter 5 reviews a broader base of literature regarding the experience of individuals who seek SOCE in order to elucidate the nature of clients' distress and identity conflicts. Chapter 6 then examines affirmative approaches for psychotherapy practice with adults and presents a specific framework for interventions. Chapter 7 returns to the 1997 APA resolution and its focus on ethics to provide an updated discussion of the ethical issues surrounding SOCE. Chapter 8 considers the more limited body of research on SOCE and reports of affirmative psychotherapy with children, adolescents, and their families. Chapter 9 summarizes the report and presents recommendations for research, practice, education, and policy. The policy resolution that the task force recommended and that was adopted by the APA Council of Representatives on August, 5, 2009, is in Appendix A.

Laying the Foundation of the Report

Understanding Affirmative Therapeutic Interventions

The task force was asked to report on appropriate application of affirmative psychotherapeutic interventions for those who seek to change their sexual orientation. As some debates in the field frame SOCE and conservative religious values as competing viewpoints to affirmative approaches (cf. Throckmorton, 1998; Yarhouse, 1998a) and imply that there is an alternative "neutral" stance, we considered it necessary to explain the term *affirmative therapeutic interventions*, its history, its relationship to our charge and to current psychotherapy literature, and our application and definition of the term.

The concept of gay-affirmative therapeutic interventions emerged in the early literature on the psychological concerns of sexual minorities (Malyon, 1982; Paul, Weinrich, Gonsiorek, & Hotvedt, 1982), and its meaning has evolved over the last 25 years to include more diversity and complexity (APA, 2000; Bieschke, Perez, & DeBord, 2007; Firestein, 2007; Herek & Garnets, 2007; Perez, DeBord, & Bieschke, 2000; Ritter & Terndrup, 2002). The affirmative approach grew out of a perception that sexual minorities benefit from psychotherapeutic interventions that address the sexual stigma[7] they experience and the impacts of stigma on their lives (APA, 2000; Brown, 2006; Browning, Reynolds, & Dworkin, 1991; Davison, 1978; Malyon, 1982; Pachankis & Goldfried, 2004; Ritter & Terndrup, 2002; Shannon & Woods, 1991; Sophie, 1987). For example, Garnets, Hancock, Cochran, Goodchilds, and Peplau (1991) proposed that LHMP use an understanding of societal prejudice and

[7] See p. 15 for the definition of *sexual stigma*.

discrimination to guide treatment for sexual minority clients and help these clients overcome negative attitudes about themselves.

The most recent literature in the field (e.g., APA, 2000, 2002c, 2004, 2005b, 2007b; Bartoli & Gillem, 2008; Brown, 2006; Herek & Garnets, 2007) places affirmative therapeutic interventions within the larger domain of cultural competence, consistent with general multicultural approaches. Multicultural approaches recognize that individuals, families, and communities exist in social, political, historical, and economic contexts (cf. APA, 2002b) and that human diversity is multifaceted and includes age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. Understanding and incorporating these aspects of diversity are important to any intervention (APA, 2000, 2002c, 2004, 2005b, 2007b).

The task force takes the perspective that a multicultural competent and affirmative approach with sexual minorities is based on the scientific knowledge in key areas: (a) homosexuality and bisexuality are stigmatized, and this stigma can have a variety of negative consequences throughout the life span (D'Augelli & Patterson, 1995, 2001); (b) same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality and are not indicators of either mental or developmental disorders (American Psychiatric Association, 1973; APA, 2000; Gonsiorek, 1991); (c) same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientation identities (Diamond, 2006, 2008; Klein, Sepekoff, & Wolf, 1985; McConaghy, 1999); and (d) lesbians, gay men, and bisexual people can live satisfying lives and form stable, committed relationships and families that are equivalent to heterosexuals' relationships and families in essential respects (APA, 2005c; Kurdek, 2001, 2003, 2004; Peplau & Fingerhut, 2007).

Although affirmative approaches have historically been conceptualized around helping sexual minorities accept and adopt a gay or lesbian identity (e.g., Browning et al., 1991; Shannon & Woods, 1991), the recent research on sexual orientation identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways, some of which are fluid (e.g., Diamond, 2006, 2008; Firestein, 2007; Fox, 2004; Patterson, 2008; Savin-Williams, 2005; R. L. Worthington & Reynolds, 2009). We define an affirmative approach as supportive of clients' identity development without a priori treatment goals for how clients identify or express their sexual orientations. Thus, a multiculturally competent affirmative approach aspires to understand the diverse personal and cultural influences on clients and enables clients to determine (a) the ultimate goals for their identity process; (b) the behavioral expression of their sexual orientation; (c) their public and private social roles; (d) their gender roles, identities, and expression[8]; (e) the sex[9] and gender of their partner; and (f) the forms of their relationships.

We define an affirmative approach as supportive of clients' identity development without a priori treatment goals for how clients identify or express their sexual orientations.

EVIDENCE-BASED PRACTICE AND EMPIRICALLY SUPPORTED TREATMENTS

Interest in the efficacy,[10] effectiveness, and empirical basis of psychotherapeutic interventions has grown in the last decade. Levant and Hasan (2009) distinguished between two types of treatments: empirically supported treatments (EST) and evidence-based approaches to psychotherapy (EBPP). EST are interventions for individuals with specific disorders; these interventions have been demonstrated to be effective through rigorously controlled trials (Levant & Hasan, 2009). EBPP is, as defined by APA's Policy Statement on Evidence-Based Practice in Psychology[11] (2005a), "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 1; see also, Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996).

We were not able to identify affirmative EST for this population (cf. Martell, Safran, & Prince, 2004).

[8] *Gender* refers to the cultural roles, behaviors, activities, and psychological attributes that a particular society considers appropriate for men and women. *Gender identity* is a person's own psychological sense of identification as male or female, another gender, or identifying with no gender. *Gender expression* is the activities and behaviors that purposely or inadvertently communicate one's gender identity to others, such as clothing, hairstyles, mannerisms, way of speaking, and social roles.

[9] We define *sex* as biological maleness and femaleness in contrast to gender, defined above.

[10] *Efficacy* is the measurable effect of an intervention, and *effectiveness* aims to determine whether interventions have measurable effects in real-world settings across populations (Nathan, Stuart, & Dolan, 2000).

[11] Discussion of the overall implications for practice can be found in Goodheart, Kazdin, and Sternberg (2006) and the *Report of the 2005 Presidential Task Force on Evidence-Based Practice* (APA, 2005b).

The lack of EST is a common dilemma when working with diverse populations for whom EST have not been developed or when minority populations have not been included in trials (Brown, 2006; Martell et al., 2004; Sue & Zane, 2006; Whaley & Davis, 2007). Thus, we provide an affirmative model in Chapter 6 that is consistent with APA's definition of EBPP in that it applies the most current and best evidence available to guide decisions about the care of this population (APA, 2005a; Sackett et al., 1996). We considered the APA EBPP resolution as utilizing a flexible concept of evidence, because it incorporates research based on well-designed studies with client values and clinical expertise. Given that the distress surrounding sexual orientation is not included in psychotherapy research (because it is not a clearly defined syndrome) and most treatment studies in psychology are for specific mental health disorders, not for problems of adjustment or identity relevant to sexual orientation concerns, we saw this flexibility as necessary (Brown, 2006). However, EST for specific disorders can be incorporated into this affirmative approach (cf. Martell et al., 2004). We acknowledge that the model presented in this report would benefit from rigorous evaluation.

Affirmative approaches, as understood by this task force, are evidence-based in three significant ways:

- They are based on the evidence that homosexuality is not a mental illness or disorder, which has a significant empirical foundation (APA, 2000; Gonsiorek, 1991).
- They are based on studies of the role of stigma in creating distress and health disparities in sexual minorities (Balsam & Mohr, 2007; Cochran & Mays, 2006; Omoto & Kurtzman, 2006; Pachankis, 2007; Pachankis, Goldfried, & Ramrattan, 2008; Safren & Heimberg, 1999; Syzmanski & Kashubeck-West, 2008).
- They are based on the literature that has shown the importance of the therapeutic alliance and relationship on outcomes in therapy and that these outcomes are linked to empathy, positive regard, honesty, and other factors encompassed in the affirmative perspective on therapeutic interventions (Ackerman & Hilsenroth, 2003; Brown, 2006; Farber & Lane, 2002; Horvath & Bedi, 2002; Norcross, 2002; Norcross & Hill, 2004).

The affirmative approach was the subject of a recent literature review that found that clients describe the safety, affirmation, empathy, and nonjudgmental acceptance inherent in the affirmative approach as helpful in their therapeutic process (M. King, Semlyen, Killaspy, Nazareth, & Osborn, 2007; see also, M. A. Jones & Gabriel, 1999). M. King et al. concluded that a knowledge base about sexual minorities' lives and social context is important for effective practice.

Sexual Stigma

To understand the mental health concerns of sexual minorities, one must understand the social psychological concept of stigma (Herek & Garnets, 2007). Goffman (1963) defined stigma as an undesirable difference that discredits the individual. Link and Phelan (2001) characterized stigma as occurring when (a) individual differences are labeled; (b) these differences are linked to undesirable traits or negative stereotypes; (c) labeled individuals are placed in distinct categories that separate them from the mainstream; and (d) labeled persons experience discrimination and loss of status that lead to unequal access to social, economic, and political power. This inequality is a consequence of stigma and discrimination rather than of the differences themselves (Herek, 2009). Stigma is a fact of the interpersonal, cultural, legal, political, and social climate in which sexual minorities live.

The stigma that defines sexual minorities has been termed *sexual stigma*[12]: "the stigma attached to any non-heterosexual behavior, identity, relationship or community" (Herek, 2009, p. 3). This stigma operates both at the societal level and the individual level. The impact of this stigma as a stressor may be the unique factor that characterizes sexual minorities as a group (Herek, 2009; Herek & Garnets, 2007; Katz, 1995).

Further, stigma has shaped the attitudes of mental health professions and related institutions toward this population (Drescher, 1998b; Haldeman, 1994; LeVay, 1996; Murphy, 1997; Silverstein, 1991). Moral and religious values in North America and Europe provided the initial rationale for criminalization, discrimination, and prejudice against same-

In the late modern period, the medical and mental health professions added a new type of stigmatization and discrimination by conceptualizing and treating homosexuality as a mental illness or disorder.

[12] Herek (2009) coined this term, and we use it because of the comprehensive analysis in which it is embedded. There are other terms for the same construct, such as Balsam and Mohr's (2007) *sexual orientation stigma*.

sex behaviors (Katz, 1995). In the late modern period, the medical and mental health professions added a new type of stigmatization and discrimination by conceptualizing and treating homosexuality as a mental illness or disorder (Brown, 1996; Katz, 1995).

Sexual minorities may face additional stigmas, as well, such as those related to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. At the societal level, sexual stigma is embedded in social structures through civil and criminal law, social policy, psychology, psychiatry, medicine, religion, and other social institutions. Sexual stigma is reflected in disparate legal and social treatment by institutions and is apparent in, for example, (a) the long history of criminalization of same-sex sexual behaviors; (b) the lack of legal protection for LGB individuals from discrimination in employment, health care, and housing; and (c) the lack of benefits for LGB relationships and families that would support their family formation, in contrast to the extensive benefits that accrue to heterosexual married couples and even sometimes to unmarried heterosexual couples.[13] The structural sexual stigma, called *heterosexism* in the scholarly literature, legitimizes and perpetuates stigma against sexual minorities and perpetuates the power differential between sexual minorities and others (Herek, 2007; see also Szymanski et al., 2008).

Expressions of stigma, such as violence, discrimination, rejection, and other negative interpersonal interactions, are *enacted stigma* (Herek, 2009). Individuals' expectations about the probability that stigma will be enacted in various situations is *felt stigma*. Individuals' efforts to avoid enacted and felt stigma may include withdrawing from self (e.g., self-denial or compartmentalization) and withdrawing from others (e.g., self-concealment or avoidance) (e.g., see Beckstead & Morrow, 2004; Drescher, 1998b; Malyon, 1982; Pachankis, 2007; Pachankis et al., 2008; Troiden, 1993).

In Herek's (2009) model, *internalized stigma*[14] is the adoption of the social stigma applied to sexual minorities. Members of the stigmatized groups as well as nonmembers of the group can internalize these values. *Self-stigma* is internalized stigma in those individuals who experience same-sex sexual attractions and whose self-concept matches the stigmatizing interpretations of society. Examples of this self-stigma are (a) accepting society's negative evaluation and (b) harboring negative attitudes toward oneself and one's own same-sex sexual attractions. *Sexual prejudice* is the internalized sexual stigma held by the non-stigmatized majority.

The Impact of Stigma on Members of Stigmatized Groups

One of the assumptions of the stigma model is that social stigma influences the individual through its impact on the different settings, contexts, and relationships in which each human being takes part (D'Augelli, 1994). This assumption is supported by a body of literature comparing sexual minority populations to the general population that has found health disparities between the two (Cochran & Mays, 2006; Mays & Cochran, 2001). The concept of minority stress (e.g., DiPlacido, 1998; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Meyer, 1995, 2003) has been increasingly used to explain these health disparities in much the same way that concepts of racism-derived stress and minority stress have been used to explain health disparities and mental health concerns in ethnic minority groups (Carter, 2007; Harrell, 2000; Mays, Cochran, & Barnes, 2007; Saldaina, 1994; Wei, Ku, Russell, Mallinckrodt, & Liao, 2008). Theoretically any minority group facing social stigma and prejudice, including stigma due to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, could develop minority stress.

In theory, minority stress—chronic stress experienced by members of minority groups—causes distress in

[13] Same-sex sexual behaviors were only recent universally decriminalized in the United States by Supreme Court action in *Lawrence v. Texas* (2003). There is no federal protection from employment and housing discrimination for LGB individuals, and only 20 states offer this protection. Only 6 states permit same-sex couples to marry; 6 states have broad recognition laws; 4 states have limited recognition laws; and 2 states recognize other states' marriages. For more examples, see National Gay and Lesbian Task Force, Reports & Research: http:// www.thetaskforce.org/reports_and_research/reports).

[14] Herek (2009) defined *internalization* as "the process whereby individuals adopt a social value, belief, regulation, or prescription for conduct as their own and experience it as part of themselves" (p. 7). The internalization of negative attitudes and assumptions concerning homosexuality has often been termed *internalized homophobia* (Malyon, 1982; Sophie, 1987; Weinberg, 1972). However, this term has been criticized because holding negative attitudes does not necessarily involve a phobia, in other words, "an exaggerated usually inexplicable and illogical fear of a particular object, class of objects, situation (*Merriam-Webster's Online Dictionary*).

certain sexual minority individuals (DiPlacido, 1998; Meyer, 1995, 2003). Meyer (2003) described these stress processes as due to (a) external objective events and conditions, such as discrimination and violence; (b) expectations of such events, and the vigilance that such expectations bring; and (c) internalization of negative social and cultural attitudes. For instance, mental health outcomes among gay men have been found to be influenced by negative appraisals of stigma-related stressors (Meyer, 1995).

The task force sees stigma and minority stress as playing a manifest role in the lives of individuals who seek to change their sexual orientation (Davison, 1978, 1982, 1991; Herek, Cogan, Gillis, & Glunt, 1998; Green, 2003; Silverstein, 1991; Tozer & Hayes, 2004). Davison, in particular, has argued that individuals who seek psychotherapy to change their sexual orientation do so because of the distress arising from the impact of stigma and discrimination. A survey of a small sample of former SOCE clients in Britain supports this hypothesis, as many of the former participants reported that hostile social and family attitudes and the criminalization of homosexual conduct were the reasons they sought treatment (G. Smith, Bartlett, & King, 2004).

One of the advantages of the minority stress model is that it provides a framework for considering the social context of stress, distress, coping, resilience (Allen, 2001; David & Knight, 2008; Herek, Gillis, & Cogan, 2009; Selvidge, Matthews, & Bridges, 2008; Levitt et al., 2009; Pachankis, 2007), and acceptance and goals of treatment (Beckstead & Israel, 2007; Bieschke, 2008; Frost & Meyer, 2009; Glassgold, 2007; Rostosky, Riggle, Horne, & Miller, 2009; Martell et al., 2004; Russell & Bohan, 2007). Some authors have proposed that LGB men and women improve their mental health and functioning through a process of positive coping, termed *stigma competence* (David & Knight, 2008). In this model, it is proposed that through actions such as personal acceptance of one's LGB identity and reduction of internalized stigma, an individual develops a greater ability to cope with stigma (cf. Crawford, Allison, Zamboni, & Soto, 2002; D'Augelli, 1994). For instance, Herek and Garnets (2007) proposed that collective identity (often termed *social identity*)[15] mitigates the impact of minority stress above and beyond the effects of individual factors such as coping skills, optimism, and resiliency. Individuals with a strong sense of positive collective identity integrate their group affiliation into their core self-concept and have community resources for responding to stigma (Balsam & Mohr, 2007; Crawford et al., 2002; Levitt et al., 2009). In support of this hypothesis, Balsam and Mohr (2007) found that collective identity, community participation, and identity confusion predicted coping with sexual stigma.

[15] A collective or social identity refers to an individual's sense of belonging to a group (the collective), and the collective or social identity forms a part of his or her personal identity.

Psychology, Religion, and Homosexuality

Most of the recent studies on SOCE focus on populations with strong religious beliefs (e.g., Beckstead & Morrow, 2004; Nicolosi et al., 2000; Ponticelli, 1999; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Spitzer, 2003; Tozer & Hayes, 2004; Wolkomir, 2001). Beliefs about sexual behavior and sexual orientation rooted in interpretations of traditional religious doctrine also guide some efforts to change others' sexual orientation as well as political opposition to the expansion of civil rights for LGB individuals and their relationships (Burack & Josephson, 2005; S. L. Morrow & Beckstead, 2004; Olyam & Nussbaum, 1998; Pew Forum on Religion and Public Life, 2003; Southern Poverty Law Center, 2005). Some authors have documented an increase in the provision of reliously-based SOCE (Burack & Josephson, 2005; Cianciotto & Cahill, 2006). Religious beliefs, motivations, and struggles play a role in the motivations of individuals who currently engage in SOCE (Beckstead & Morrow, 2004; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001; Yarhouse, Tan, & Pawlowski, 2005). Thus, we considered an examination of issues in the psychology of religion to be an important part of fulfilling our charge.

Intersections of Psychology, Religion, and Sexual Orientation

World religions regard homosexuality from a spectrum of viewpoints. It is important to note that some religious denominations' beliefs and practices have changed over time, reflecting evolving scientific and civil rights perspectives on homosexuality and sexual orientation (see, e.g., Dorff, Nevins, & Reisner, 2006; Olyam & Nussbaum, 1998; see also Hebrew Union College, Institute for Judaism & Sexual Orientation [http://www.huc.edu/ijso], and Ontario Consultants on Religious Tolerance [http://www.religioustolerance.org]). A number of religious denominations in the United States welcome LGB laity, and a smaller

number ordain LGB clergy (e.g., Reconstructionist Judaism, Reform Judaism, Conservative Judaism, Buddhist Peace Fellowship, Buddhist Churches of America, Episcopal Church of America, Friends General Conference, Unitarian Society, United Church of Christ Congregational) (Greenberg, 2004; Olyam & Nussbaum, 1998; see also Hebrew Union College, Institute for Judaism & Sexual Orientation [http://www.huc.edu/ijso], and Ontario Consultants on Religious Tolerance [http://www.religioustolerance.org]). However, others view homosexuality as immoral and sinful (e.g., Christian Reformed Church of North America, Church of Jesus Christ of Latter-Day Saints, Eastern Orthodox Christianity, Orthodox Judaism, Presbyterian Church in American, Roman Catholicism, Southern Baptist Convention, United Methodist Church) (see Ontario Consultants on Religious Tolerance: http://www.religioustolerance.org). These issues are being discussed within numerous denominations (e.g., Van Voorst, 2005), and some views are in flux (e.g., the Presbyterian Church [USA]) (see Ontario Consultants on Religious Tolerance: http://www.religioustolerance.org).

Several professional publications (e.g., *Journal of Gay and Lesbian Psychotherapy*, 2001, *5*[3/4]; *Professional Psychology*, 2002, *33*[3]; *Archives of Sexual Behavior*, 2003, *32*[5]; *The Counseling Psychologist*, 2004, *32*[5]; *Journal of Psychology and Christianity*, 2005, *24*[4]) have specifically considered the interactions among scientific views of sexual orientation, religious beliefs, psychotherapy, and professional ethics. Some difficulties arise because the professional psychological community considers same-sex sexual attractions and behaviors to be a positive variant of human sexuality, while some traditional faiths continue to consider it a sin, a moral failing, or a disorder that needs to be changed.

Some difficulties arise because the professional psychological community considers same-sex sexual attractions and behaviors to be a positive variant of human sexuality, while some traditional faiths continue to consider it a sin, a moral failing, or a disorder that needs to be changed.

The conflict between psychology and traditional faiths may have its roots in different philosophical viewpoints. Some religions give priority to *telic congruence* (i.e., living consistently within one's valuative goals[16]) (W. Hathaway, personal communication, June 30, 2008; cf. Richards & Bergin, 2005). Some authors propose that for adherents of these religions, religious perspectives and values should be integrated into the goals of psychotherapy (Richards & Bergin, 2005; Throckmorton & Yarhouse, 2006). Affirmative and multicultural models of LGB psychology give priority to *organismic congruence* (i.e., living with a sense of wholeness in one's experiential self[17]) (W. Hathaway, personal communication, June 30, 2008; cf. Gonsiorek, 2004; Malyon, 1982). This perspective gives priority to the unfolding of developmental processes, including self-awareness and personal identity.

This difference in worldviews can impact psychotherapy. For instance, individuals who have strong religious beliefs can experience tensions and conflicts between their ideal self and beliefs and their sexual and affectional needs and desires (Beckstead & Morrow, 2004; D. F. Morrow, 2003). The different worldviews would approach psychotherapy for these individuals from dissimilar perspectives: The telic strategy would prioritize values (Rosik, 2003; Yarhouse & Burkett, 2002), whereas the organismic approach would give priority to the development of self-awareness and identity (Beckstead & Israel, 2007; Gonsiorek, 2004; Haldeman, 2004).

It is important to note that the organismic worldview can be congruent with and respectful of religion (Beckstead & Israel, 2007; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Mark, 2008; Ritter & O'Neil, 1995), and the telic worldview can be aware of sexual stigma and respectful of sexual orientation (Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). Understanding this philosophical difference may improve the dialogue between these two perspectives represented in the literature, as it refocuses the debate not on one group's perceived rejection of homosexuals or the other group's perceived minimization of religious viewpoints but on philosophical differences that extend beyond this particular subject matter. However, some of the differences between these philosophical assumptions may be difficult to bridge.

Contrasting views exist within psychology regarding religious views about homosexuality. One way in which psychology has traditionally examined the

[16] These conflicts are not unique to religious individuals but are applicable to individuals making commitments and decisions about how to live according to specific ethics and ideals (cf. Baumeister & Exline, 2000; Diener, 2000; Richards & Bergin, 2005; B. Schwartz, 2000).

[17] Such naturalistic and empirically based models stress the organization, unity, and integration of human beings expressed through each individual's inherent growth or developmental tendency (see, e.g., Rogers, 1961; R. M. Ryan, 1995).

intersections between religion and homosexuality is by studying the impact of religious beliefs and motivations on attitudes and framing the discussion in terms of tolerance and prejudice (Fulton, Gorsuch, & Maynard, 1999; Herek, 1987; Hunsberger & Jackson, 2005; Plugge-Foust & Strickland, 2000; J. P. Schwartz & Lindley, 2005). For instance, one finding is that religious fundamentalism is correlated with negative views of homosexuality, whereas a quest orientation is associated with decreased discriminatory or prejudicial attitudes (Batson, Flink, Schoenrade, Fultz, & Pych, 1986; Batson, Naifeh, & Pate, 1978; Fulton et al., 1999; Plugge-Foust & Strickland, 2000). However, some authors have argued, in contrast to this approach, that conservative religious moral beliefs and evaluations about same-sex sexual behaviors and LGB individuals and relationships should be treated as religious diversity rather than as sexual prejudice (e.g., Rosik, 2007; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002).

APA Policies on the Intersection of Religion and Psychology

APA has addressed the interactions of religion and psychology in two recent resolutions: the Resolution Rejecting Intelligent Design as Scientific and Reaffirming Support for Evolutionary Theory (APA, 2008a) and the Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice (2008c). The first resolution articulates psychology's epistemological commitment: Hypothesis testing through rigorous scientific methods is the best means to gain new knowledge and to evaluate current practices, and psychologists base their theories on such research:

> While we are respectful of religion and individuals' right to their own religious beliefs, we also recognize that science and religion are separate and distinct. For a theory to be taught as science it must be testable, supported by empirical evidence and subject to disconfirmation. (APA, 2007a)

This is in contrast to viewpoints based on faith, as faith does not need confirmation through scientific evidence. Further, science assumes that some ideas can be rejected when proven false; faith and religious beliefs cannot be falsified in the eyes of adherents.

The APA Council of Representatives also passed a Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice (2008c). This resolution acknowledges the existence of two forms of prejudice related to religion: one derived from religious beliefs and another directed at religions and their adherents. The APA strongly condemns both forms of prejudice. The resolution affirms APA's position that prejudices directed at individuals because of their religious beliefs and prejudices derived from or justified by religion are harmful to individuals, society, and international relations.

In areas of conflicts between psychology and religion, as the APA Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice (2008c) states, psychology has no legitimate function in "arbitrating matters of faith and theology" or to "adjudicate religious or spiritual tenets" (p. 432) and psychologists are urged to limit themselves to speak to "psychological implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist" (p. 433). Further, the resolution states that faith traditions "have no legitimate place arbitrating behavioral or other sciences" or to "adjudicate empirical scientific issues in psychology" (p. 432).

The resolution affirms APA's position that prejudices directed at individuals because of their religious beliefs and prejudices derived from or justified by religion are harmful to individuals, society, and international relations.

The APA (2002b, 2008c) recommends that psychologists acknowledge the importance of religion and spirituality as forms of meaning-making, tradition, culture, identity, community, and diversity. Psychologists do not discriminate against individuals based on those factors. Further, when devising interventions and conducting research, psychologists consider the importance of religious beliefs and cultural values and, where appropriate, consider religiously and culturally sensitive techniques and approaches (APA, 2008c).

Psychology of Religion

Historically, some in psychology and psychiatry have held negative views of religion (Wulff, 1997). Yet, with the development of more sophisticated methodologies and conceptualizations, the field of the psychology of religion has flourished in the last 30 years (Emmons & Paloutzian, 2003), culminating in new interest in a diverse field (e.g., Koenig & Larson, 2001; Paloutzian & Park, 2005; Pargament, 2002; Pargament & Mahoney,

2005; Richards & Bergin, 2005; Sperry & Shafranske, 2004; Spilka, Hood, Hunsberger, & Gorsuch, 2003).

Many scholars have attempted to elucidate what is significant and unique about religious and spiritual faith, beliefs, and experiences (e.g., George, Larson, Koenig, & McCullough, 2000; McClennon, 1994). Pargament, Maygar-Russell, and Murray-Swank (2005) summarized religion's impact on people's lives as a unique form of motivation regarding how to live one's life and how to respond to self, others, and life events; a source of significance regarding what aspects of life one imbues with meaning and power; a contributor to mortality and health; a form of positive and negative coping; and a source of fulfillment and distress. Others, such as Fowler (1981, 1991) and colleagues (Oser, 1991; Streib, 2001, 2005) have posited developmental models of religious identity that are helpful in understanding personal faith.

Additionally, there is a growing literature on integrating spirituality into psychotherapy practice (Richards & Bergin, 2000, 2004, 2005; Shafranske, 2000; Sperry & Shafranske, 2004; E. L. Worthington, Kurusu, McCullough, & Sandage, 1996). These approaches include delineating how LMHP can work effectively with individuals from diverse religious traditions (Richards & Bergin, 2000, 2004; Sperry & Shafranske, 2004). Many of these techniques can be effective (McCullough, 1999) and improve outcomes in clinical treatment with religious clients (Probst, Ostrom, Watkins, Dean, & Mashburn, 1992; Richards, Berrett, Hardman, & Eggett, 2006; E. L. Worthington et al., 1996), even for clients in treatment with secular LMHP (Mayers, Leavey, Vallianatou, & Barker, 2007). These innovations point to ways that psychology can explore and understand religious beliefs and faith in an evidence-based and respectful manner.

There have been claims that some LMHP do not address the issues of conservative religious individuals who are distressed by their same-sex sexual attractions (e.g., Yarhouse, 1998a; Throckmorton, 2002; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002). One of the problems in the field has been an either/or perspective in which sexual orientation and religion are seen as incompatible (Phillips, 2004). Certainly, some individuals may perceive their religion and their sexual orientation as incompatible, because in some faiths homosexuality is perceived as sinful and immoral. However, there is a growing body of evidence illustrating that many individuals do integrate their religious and sexual orientation identities (Coyle & Rafalin, 2000; Kerr, 1997; Mahaffy, 1996; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Thumma, 1991; Yip, 2002, 2003, 2005). Thus, this dichotomy may be enabling a discourse that does not fully reflect the evidence and may be hindering progress to find a variety of viable solutions for clients.

Recently, some authors have suggested alternative frameworks, many of which are drawn from a variety of models of psychotherapy, such as multicultural views of psychology and the psychology of religion, that provide frames for appropriate psychotherapeutic interventions seeking to bridge this divide (Bartoli & Gillem, 2008; Beckstead & Israel, 2007; Buchanon, Dzelme, Harris, & Hecker, 2001; Glassgold, 2008; Gonsiorek; 2004; Haldeman, 2004; Lasser & Gottlieb, 2004; S. L. Morrow & Beckstead, 2004; Ritter & O'Neill, 1989; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). For instance, a growing number of authors address the religious and spiritual needs of LGBT individuals from integrative and affirmative perspectives that provide resources for LMHP working with this population (Astramovich, 2003; Beckstead & Israel, 2007; Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 1996, 2004; Horne & Noffsinger-Frazier, 2003; Mark, 2008; D. F. Morrow, 2003; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). On the basis of these scholarly contributions, we take the perspective that religious faith and psychology do not have to be seen as being opposed to each other. Further, psychotherapy that respects faith can also explore the psychological implications and impacts of such beliefs.

We take the perspective that religious faith and psychology do not have to be seen as being opposed to each other. Further, psychotherapy that respects faith can also explore the psychological implications and impacts of such beliefs.

We support affirmative and multiculturally competent approaches that integrate concepts from the psychology of religion and the modern psychology of sexual orientation. These perspectives are elaborated later in this report. In the next chapter we review the history of SOCE in order to provide a perspective on the foundation and evolution of these approaches.

2. A BRIEF HISTORY OF SEXUAL ORIENTATION CHANGE EFFORTS

Sexual orientation change efforts (SOCE)[18] within mental health fields originally developed from the science of sexuality in the middle of the 19th century (Katz, 1995). At that time, same-sex eroticism and gender-nonconforming behaviors came under increased medical and scientific scrutiny. New terms such as *urnings*, *inversion*, *homosexual*, and *homosexuality* emerged as scientists, social critics, and physicians sought to make sense of what was previously defined as sin or crime (Katz, 1995). This shift to a scientific approach did not challenge the underlying social values, however, and thus continued to reflect the existing sexual stigma, discrimination, criminalization, and heterosexism. Much of the medical and scientific work at that time conceptualized homosexual attractions and behaviors as abnormal or as an illness (Katz, 1995).

In that era, homosexuality was predominantly viewed as either a criminal act or a medical problem, or both (Krafft-Ebing, 1886/1965). Homosexuality was seen as caused by psychological immaturity (i.e., as a passing phase to be outgrown on the road to adult heterosexuality) or pathology (e.g., genetic defects, gender-based confusions, intrauterine hormonal exposure, too much parental control, insufficient parenting, hostile parenting, seduction, molestation, or decadent lifestyles) (Drescher, 1998b, 2002). The first treatments attempted to correct or repair the damage done by pathogenic factors or to facilitate maturity (Drescher, 1998b, 2002; LeVay, 1996; Murphy, 1992, 1997). These perspectives on homosexuality lasted into the first half of the 20th century, shaping the views of psychoanalysis, the dominant psychiatric paradigm of that time (Drescher, 1998b).

Homosexuality and Psychoanalysis

Initial psychotherapeutic approaches to homosexuality in the first half of the 20th century reflected psychoanalytic theory. Freud's own views on sexual orientation and homosexuality were complex. Freud viewed homosexuality as a developmental arrest and heterosexuality as the adult norm (Freud, 1905/1960). However, in a now-famous letter, Freud (1935/1960) reassured a mother writing to him about her son that homosexuality was "nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness, but a variation of sexual function" (p. 423). He further went on to say that psychoanalysts could not promise to "abolish homosexuality and make normal heterosexuality take its place" (p. 423), as the results of treatment could not be determined. Freud's only report (1920/1960) about his deliberate attempt to change someone's sexual orientation described his unsuccessful efforts at changing the sexual orientation of a young woman brought for involuntary treatment by her

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

parents. At the end of this case, Freud concluded that attempts to change homosexual sexual orientation were likely to be unsuccessful.[19]

In the psychoanalysis that dominated the mental health fields after Freud, especially in the United States, homosexuality was viewed negatively, considered to be abnormal, and believed to be caused by family dynamics (Bieber et al., 1962; Rado, 1940; Socarides, 1968). Other approaches based loosely on psychoanalytic ideas advocated altering gender-role behaviors to increase conformity with traditional gender roles (Moberly, 1983; Nicolosi, 1991). Significantly impacting psychiatric thought in the mid-20th century, these theories were part of the rationale for including homosexuality as a mental illness in both the first (1952) and second (1968) editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), thus reinforcing and exacerbating sexual stigma and sexual prejudice. It was during this period that the first attempts to study the efficacy of SOCE were conducted (e.g., Bieber et al., 1962).

Sexual Orientation Change Efforts

The pathologizing psychiatric and psychological conception of homosexuality and concomitant efforts to alter sexual orientation through psychoanalytic and behavior therapy were prevalent through the 1960s and into the early 1970s. Although behavior therapy emerged in the 1960s, adding a different set of techniques to psychotherapy, the goals of SOCE did not change. For example, Ovesey (1969) based his behavioral interventions on the belief that homosexuality developed from a phobia of taking on the normal qualities of one's gender and that sexual intercourse with the other[20] sex would cure the so-called phobia.

Behavior therapists tried a variety of aversion treatments, such as inducing nausea, vomiting, or paralysis; providing electric shocks; or having the individual snap an elastic band around the wrist when the individual became aroused to same-sex erotic images or thoughts. Other examples of aversive behavioral treatments included covert sensitization, shame aversion, systematic desensitization, orgasmic reconditioning, and satiation therapy (Beckstead & Morrow, 2004; S. James, 1978; Katz, 1995; Langevin, 1983; LeVay, 1996; Murphy, 1992, 1997). Some nonaversive treatments used an educational process of dating skills, assertiveness, and affection training with physical and social reinforcement to increase other-sex sexual behaviors (Binder, 1977; Greenspoon & Lamal, 1987; Stevenson & Wolpe, 1960). Cognitive therapists attempted to change gay men's and lesbians' thought patterns by reframing desires, redirecting thoughts, or using hypnosis, with the goal of changing sexual arousal, behavior, and orientation (e.g., Ellis, 1956, 1959, 1965).

Affirmative Approaches: Kinsey; Ford and Beach; and Hooker

At the same time that the pathologizing views of homosexuality in American psychiatry and psychology were being codified, countervailing evidence was accumulating that this stigmatizing view was ill founded. The publication of *Sexual Behavior in the Human Male* (Kinsey, Pomeroy, & Martin, 1948) and *Sexual Behavior in the Human Female* (Kinsey, Pomeroy, Martin, & Gebhard, 1953) demonstrated that homosexuality was more common than previously assumed, thus suggesting that such behaviors were part of a continuum of sexual behaviors and orientations. C. S. Ford and Beach (1951) revealed that same-sex behaviors and homosexuality were present in a wide range of animal species and human cultures. This finding suggested that there was nothing unnatural about same-sex behaviors or homosexual sexual orientation.

Psychologist Evelyn Hooker's (1957) research put the idea of homosexuality as mental disorder to a scientific test. She studied a nonclinical sample of homosexual men and compared them with a matched sample of heterosexual men. Hooker found, among other things, that based on three projective measures (the Thematic Apperception Test, the Make-a-Picture Story test, and the Rorschach), the homosexual men were comparable to their matched heterosexual peers on ratings of adjustment. Strikingly, the experts who examined the Rorschach protocols could not

[19] Analyses of this case have focused on Freud's intense negative reactions to this young woman and his attempts to enforce social conformity—especially with regard to traditional female gender roles and sexuality (e.g., Lesser & Schoenberg, 1999; O'Connor & Ryan, 1993).

[20] We use *other sex* instead of *opposite sex*, as the latter term makes assumptions regarding the binary nature of male and female that are unsupported. We acknowledge that this term also has limitations, as there are fluid and diverse representations of sex and gender in many cultures.

distinguish the protocols of the homosexual cohort from the heterosexual cohort, a glaring inconsistency with the then-dominant understanding of homosexuality and projective assessment techniques. Armon (1960) performed research on homosexual women and found similar results.

In the years following Hooker's (1957) and Armon's (1960) research, inquiry into sexuality and sexual orientation proliferated. Two major developments marked an important change in the study of homosexuality. First, following Hooker's lead, more researchers conducted studies of nonclinical samples of homosexual men and women. Prior studies primarily included participants who were in distress or incarcerated. Second, quantitative methods to assess human personality (e.g., Eysenck Personality Inventory, Cattell's Sixteen Personality Factor Questionnaire [16PF]) and mental disorders (Minnesota Multiphasic Personality Inventory [MMPI]) were developed and were a vast psychometric improvement over prior measures, such as the Rorschach, Thematic Apperception Test, and House-Tree-Person Test. Research conducted with these newly developed measures indicated that homosexual men and women were essentially similar to heterosexual men and women in adaptation and functioning (Siegelman, 1979; M. Wilson & Green, 1971; see also the review by Gonsiorek, 1991). Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation (e.g., Bell, Weinberg, & Hammersmith, 1981; Bene, 1965; Freund & Blanchard, 1983; Freund & Pinkava, 1961; Hooker, 1969; McCord, McCord, & Thurber, 1962; D. K. Peters & Cantrell, 1991; Siegelman, 1974, 1981; Townes, Ferguson, & Gillem, 1976). This research was a significant challenge to the model of homosexuality as psychopathology.

Research conducted with these newly developed measures indicated that homosexual men and women were essentially similar to heterosexual men and women in adaptation and functioning.

Homosexuality Removed From the Diagnostic and Statistical Manual

In recognition of the legal nexus between psychiatric diagnosis and civil rights discrimination, especially for government employees, activists within the homophile[21] rights movement, including Frank Kameny and the Mattachine Society of Washington, DC, launched a campaign in late 1962 and early 1963 to remove homosexuality as a mental disorder from the American Psychiatric Association's *DSM* (D'Emilio, 1983; Kameny, 2009). This campaign grew stronger in the aftermath of the Stonewall riots in 1969. Those riots were a watershed, as the movement for gay and lesbian civil rights was embraced openly by thousands rather than limited to small activist groups (D'Emilio, 1983; Katz, 1995). In the area of mental health, given the results of research, activists within and outside of the professions led a large and vocal advocacy effort directed at mental health professional associations, such as the American Psychiatric Association, the American Psychological Association, and the American Association for Behavior Therapy, and called for the evaluation of prejudice and stigma within mental health associations and practices (D'Emilio, 1983; Kameny, 2009). At the same time, some LGB professionals and their allies encouraged the field of psychotherapy to assist sexual minority clients to accept their sexual orientation (Silverstein, 2007).

As a result of the research and the advocacy outside of and within the American Psychiatric Association, that association embarked upon an internal process of evaluating the literature to address the issue of homosexuality as a psychiatric disorder (Bayer, 1981; Drescher 2003; Drescher & Merlino, 2007; Sbordone, 2003; Silverstein, 2007). On the recommendation of its committee evaluating the research, the American Psychiatric Association Board of Trustees and general membership voted to remove homosexuality per se[22] from the *DSM* in December 1973 (Bayer, 1981). The American Psychiatric Association (1973) then issued a position statement supporting civil rights protection for gay people in employment, housing, public accommodation, and licensing, and the repeal of all sodomy laws.

In December 1974, the American Psychological Association (APA) passed a resolution affirming the resolution of the American Psychiatric Association. APA concluded:

[21] *Homophile* is an early term for what would become the gay rights or gay and lesbian rights movement.

[22] The diagnoses of sexual orientation disturbance and ego-dystonic homosexuality sequentially replaced homosexuality. These diagnoses, however, were ultimately removed, due to conceptual problems and psychiatry's evolving evidence-based approach to delineating a mental disorder (Drescher, Stein, & Byne, 2005).

> Homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities. Further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations. (APA, 1975, p. 633)

Since that time, the APA has passed numerous resolutions supporting LGB civil rights and psychological well-being (see APA, 2005a).

Other mental health associations, including the National Association of Social Workers and the American Counseling Association, and medical associations, including the American Medical Association and the American Academy of Pediatrics, have passed similar resolutions. Gradual shifts began to take place in the international mental health community as well. In 1992, the World Health Organization removed homosexuality per se from the *International Classification of Diseases* (Nakajima, 2003).

Decline of Sexual Orientation Change Efforts

Following the removal of homosexuality from the *DSM*, the publication of studies of SOCE decreased dramatically, and nonaffirming approaches to psychotherapy came under increased scrutiny. Behavior therapists became increasingly concerned that aversive therapies designed as SOCE for homosexuality were inappropriate, unethical, and inhumane (Bancroft, 2003; Davison, 1976, 1978; Davison & Wilson, 1973; M. King, Smith, & Bartlett, 2004; D. J. Martin, 2003; Silverstein, 1991, 2007). The Association for Behavioral and Cognitive Therapies (formerly the Association for Advancement of Behavior Therapy) as well as other associations affiliated with cognitive and behavior therapies currently reject the use of SOCE (D. J. Martin, 2003). Behavior therapy for LGB individuals now focuses on issues of increasing adjustment, as well as on addressing a variety of their mental health concerns (Campos & Goldfried, 2001; Hart & Heimberg, 2001; Martell et al., 2004; Pachankis & Goldfried, 2004; Safren & Rogers, 2001).

Prominent psychoanalytic practitioners (see, e.g., Mitchell, 1978, 1981) began questioning SOCE within their own profession and challenged therapies that started with assumptions of pathology. However, such a movement did not take hold until the late 1980s and early 1990s (Drescher, 1998a, 1998b; Glassgold & Iasenza, 1995). In 1991, the American Psychoanalytic Association (ApsaA) effectively ended stigmatization of homosexuality by mainstream psychoanalysis when it adopted a sexual orientation nondiscrimination policy regarding the selection of candidates for psychoanalytic training. This policy was revised in 1992 to include selection of faculty and training analysts as well (ApsaA, 1991, 1992). In 2000, ApsaA adopted a policy against SOCE, attempting to end that practice within the field:

> As in all psychoanalytic treatments, the goal of analysis with homosexual patients is understanding. Psychoanalytic technique does not encompass purposeful efforts to "convert" or "repair" an individual's sexual orientation. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized homophobic attitudes. (¶ 1)

Numerous publications document the theoretical limitations and problems with SOCE within psychoanalysis (Drescher, 1998a, 1998b; O'Connor & Ryan, 1993). In the last decade, many psychoanalytic publications have described an affirmative approach to sexual orientation variation and diversity.[23]

Currently, mainstream mental health professional associations support affirmative approaches that focus on helping sexual minorities cope with the impact of minority stress and stigma (American Counseling Association Governing Council, 1998; American Psychiatric Association, 2000; APA, 1997, 2000; NASW, 1997). The literature on affirmative psychotherapy has grown enormously during this time (e.g., Bieschke et al., 2007; Eubanks-Carter, Burckell, & Goldfried, 2005; Ritter & Terndrup, 2002). Included in this literature are publications that aim to support individuals with strong religious beliefs and same-sex sexual orientation in exploring ways to integrate the two (e.g., Astramovich, 2003; Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 1996, 2004; Horne & Noffsinger-Frazier, 2003; Mark, 2008; D. F. Morrow, 2003; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Ritter & Terndrup, 2002; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). These changes within the mental health fields are reflected in the larger society, where there have been increasing shifts in acceptance of LGB

[23] ApsaA and Divisions 39 (Psychoanalysis) and 44 (Society for the Psychological Study of Lesbian, Gay, & Bisexual Concerns) have collaborated on a bibliography of affirmative resources in psychoanalysis.

individuals (see National Gay and Lesbian Task Force: http://www.thetaskforce.org). For instance, in 2003, the U.S. Supreme Court made a landmark ruling in *Lawrence v. Texas* that declared as unconstitutional the sodomy laws of the 13 states that still criminalized homosexuality. However, issues such as same-sex marriage are still controversial (Phy-Olsen, 2006).

However, SOCE is still provided by LMHP. Some LMHP (Nicolosi, 2003, Nicolosi & Nicolosi, 2002; Rosik, 2001) advocate for SOCE to be provided to distressed individuals, and an organization was founded to advocate for these types of treatments (National Association for Research and Treatment of Homosexuality). Additionally, a survey of randomly selected British LMHP (psychologists, counselors, and psychiatrists) completed in 2003 found that 17% of the total sample of 1,328 had provided SOCE in the past and that 4% would consider providing such therapy upon client request in the future (Bartlett, King, & Phillips, 2001; cf. Liszcz & Yarhouse, 2005). Among those who provided such services, the number of clients provided SOCE had remained constant over time (Bartlett et al., 2001; cf. M. King et al., 2004).

Sexual Orientation Change Efforts Provided to Religious Individuals

The visibility of SOCE has increased in the last decade (Drescher, 2003; Drescher & Zucker, 2006; Herek, 2003). From our survey of recent publications and research, most SOCE currently seem directed to those holding conservative religious and political beliefs, and recent research on SOCE includes almost exclusively individuals who have strong religious beliefs (e.g., Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Shidlo & Schroeder, 2002; Spitzer, 2003). In an evolution for some religious communities, sexual minorities are not automatically expelled or shunned (Drescher & Zucker, 2006; Sanchez, 2007; SPLC, 2005). Instead, individuals with a same-sex sexual orientation are embraced for renouncing their homosexuality and seeking "healing" or change (Burack & Josephson, 2005; Erzen, 2006; Ponticelli, 1999). This development has led to a movement of religiously based self-help groups for distressed individuals who often refer to themselves as ex-gay (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006). Individuals and organizations that promote religion-based efforts to change sexual orientation often target messages to adults, adolescents, and their families that portray homosexuality as negative (Burack & Josephson, 2005; Cianciotto & Cahill, 2006; Wolkomir, 2006). These efforts include religious outreach, support groups, and psychotherapy (Erzen, 2006, Ponticelli, 1999; Wolkomir, 2001, 2006).

Debates between those who advocate SOCE and those who oppose it have at times become polemical, with charges that professional psychology has not reflected the concerns of religious individuals,[24] and both supporters and opponents of SOCE have presented themselves as advocates for consumers (cf. Brooke, 2005). Despite the polarization, there have been recent attempts to envision alternate frameworks to address these issues (e.g., Bartoli & Gillem, 2008; Beckstead & Israel, 2007; Benoit, 2005; Haldeman, 2004; McMinn, 2005; Phillips, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006).

We concluded that these debates can only be resolved through an evidence-based appraisal of the potential benefits and harm of SOCE. In the next two chapters, we consider the research evidence on SOCE. In Chapter 3 we discuss methodological concerns, and in Chapter 4, the results that can be drawn from this literature.

[24] APA has received correspondence from individuals and organizations asserting this point.

3. A SYSTEMATIC REVIEW OF RESEARCH ON THE EFFICACY OF SEXUAL ORIENTATION CHANGE EFFORTS: OVERVIEW AND METHODOLOGICAL LIMITATIONS

Although the charge given to the task force did not explicitly call for a systematic review of research on the efficacy and safety of sexual orientation change efforts (SOCE),[25] we decided in our initial deliberations that such a review was important to the fulfillment of our charge. First, the debate over SOCE has centered on the issues of efficacy, benefit, and harm. Thus, we believe it was incumbent on us to address those issues in our report. We attempted to answer the following questions in this review:

- Do SOCE alter sexual orientation?
- Are SOCE harmful?
- Do SOCE result in any outcomes other than changing sexual orientation?

Second, systematic literature reviews are frequently used to answer questions about the effectiveness of interventions in health care to provide the basis for informed treatment decisions (D. J. Cook, Mulrow, & Haynes, 1998; Petticrew, 2001). Current criteria for effective treatments and interventions are specific in stating that to be considered effective, an intervention has consistent positive effects without serious harmful side effects (Beutler, 2000; Flay et al., 2005). Based on Lilienfeld's (2007) comprehensive review of the issue of harm in psychotherapy, our systematic review examines harm in the following ways:

- Negative side effects of treatment (iatrogenic effects)
- Client reports of perceptions of harm from treatment
- High drop-out rates
- Indirect harm such as the costs (time, energy, money) of ineffective interventions

Finally, we were given the charge to "inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions." We decided that a systematic review[26] would likely be the only effective basis for APA's response to advocacy groups for SOCE.

In our review, we considered only peer-reviewed research, in keeping with current standards for conducting scientific reviews (see Khan, Kunz, Kleijnen, & Antes, 2003), which exclude the grey literature[27] and lay material. In this chapter, we provide an overview of the review and a detailed report on the methodological concerns that affect the validity[28] of the conclusions

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

[26] A systematic review starts with a clear question to be answered, strives to locate all relevant research, has clear inclusion and exclusion criteria, carefully assesses study quality, and synthesizes study results (Petticrew, 2001).

[27] Grey literature refers to any publication in any format published outside of peer-reviewed scientific journals.

[28] *Validity* is defined as the extent to which a study or group of studies produce information that is useful for a specific purpose. It also includes an overall evaluation of the plausibility of the intended

derived from the research. In the next chapter, we present our review of the outcomes of the research.

Overview of the Systematic Review

Our review included peer-reviewed empirical research on treatment outcomes published from 1960 to 2007. Studies were identified through systematic searches of scholarly databases, including PsycINFO and Medline, using such search terms as *reparative therapy*, *sexual orientation*, *homosexuality*, and *ex-gays* cross-referenced with treatment and therapy. Reference lists from all identified articles were searched for additional nonindexed, peer-reviewed material. We also obtained review articles and commentaries and searched the reference lists of these articles to identify refereed publications of original research investigations on SOCE that had not been identified via the aforementioned procedures. As noted earlier, in keeping with standards for systematic reviews, only empirically based, peer-reviewed articles addressing the key questions of this review regarding SOCE efficacy, safety, and harm were included in this section. Other research studies of children, adolescents, and adults, including the grey literature and clinical accounts, are included in other sections of this report, most notably Chapter 5 (Research on Adults Who Undergo Sexual Orientation Change Efforts) and Chapter 8 (Issues for Children, Adolescents, and Their Families). The studies that met our criteria and are mentioned in this chapter on the systematic review are listed in Appendix B.[29]

The vast majority of research on SOCE was conducted prior to 1981. This early research predominantly focused on evaluating behavioral interventions, including those using aversive methods. Following the declassification of homosexuality as a mental disorder in 1973 (American Psychiatric Association, 1973) and subsequent statements of other mental health professional associations, including APA (Conger, 1975), research on SOCE declined dramatically. Indeed, we found that the peer-reviewed empirical literature after 1981 contains no rigorous intervention trials on changing same-sex sexual attractions.

There is a small, more recent group of studies conducted since 1999 that assess perceived effects of SOCE among individuals who have participated in psychotherapy as well as efforts based in religious beliefs or practices, including support groups, faith healing, and prayer. There are distinct types of research within this recent literature. One type focused on evaluating individuals' positive accounts of sexual orientation change (Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003). Another type examined potential harm of SOCE and experiences of those who seek sexual orientation change (Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002). A third type is high-quality[30] qualitative research investigations that provide insight into people's experiences of efforts aimed at altering their same-sex sexual attractions (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkimir, 2001).[31]

In all areas of intervention evaluation, the quality of the methods used in the research affects the validity and credibility of any claims the researcher can make about whether the intervention works, for whom it works, and under what circumstances it works. Many have described methodological concerns regarding the research literature on sexual orientation change efforts (e.g., Cramer, Golom, LoPresto, & Kirkley, 2008; Haldeman, 1994; S. L. Morrow & Beckstead, 2004; Murphy, 1992; Sandfort, 2003). Overall, we found that the low quality of the research on SOCE is such that claims regarding its effectiveness and widespread applicability must be viewed skeptically.

Overall, we found that the low quality of the research on SOCE is such that claims regarding its effectiveness and widespread applicability must be viewed skeptically.

As shown in Appendix B, few studies on SOCE produced over the past 50 years of research rise to current scientific standards for demonstrating the efficacy of psychological interventions (cf. Chambless & Hollon, 1998; Chambless & Ollendick, 2001;

interpretations—in this case, does SOCE produce a change in sexual orientation (see American Educational Research Association, APA, & National Council on Measurement in Education, 1999).

[29] A meta-analytic review of 14 research articles (Byrd & Nicolosi, 2002) is not discussed in this report. The review suffers from significant methodological shortcomings and deviations from recommended meta-analytic practice (see, e.g., Durlak, Meerson, & Ewell Foster, 2003; Lipsey & Wilson, 2001) that preclude reliable conclusions being drawn from it. However, studies that were included in the meta-analysis and were published in refereed journals between 1960 and the present are included and described in the current review. Additionally, a recent study (Byrd, Nicolosi, & Potts, 2008) is not included, as it was published after the review period and appears to be a reworking of an earlier study by Nicolosi, Byrd, and Potts (2000).

[30] These studies meet the standards of research rigor that are used for the qualitative research paradigms that informed each of the studies (e.g., grounded theory, ethnomethodology, phenomenology).

[31] These studies are discussed more thoroughly in later sections of the report.

Flay et al., 2005; Shadish, Cook, & Campbell, 2002; Society for Prevention Research, 2005) or provide for unambiguous causal evidence regarding intervention outcomes. Indeed, only six studies, all conducted in the early period of research, used rigorous experimental[32] procedures. Only one of these experiments (Tanner, 1974) assessed treatment outcomes in comparison to an untreated control group. Only three additional studies used strong quasi-experimental procedures such as a nonequivalent comparison group (see Appendix B). All of these studies were also from the early period. The rest of the studies that we reviewed are nonexperimental (see Appendix B). We thus concluded that there is little in the way of credible evidence that could clarify whether SOCE does or does not work in changing same-sex sexual attractions.

The studies in this area also include a highly select group of people who are unique among those who experience same-sex sexual attractions. Thus, psychologists should be extremely cautious in attributing success to SOCE and assuming that the findings of the studies of it can be applied to all sexual minorities. An overview of the methodological problems in determining the effects of SOCE and making treatment decisions based on findings from these studies follows.

Methodological Problems in the Research Literature on Sexual Orientation Change Efforts

Problems in Making Causal Claims

A principal goal of the available research on SOCE was to demonstrate that SOCE consistently and reliably produce changes in aspects of sexual orientation. Overall, due to weaknesses in the scientific validity of research on SOCE, the empirical research does not provide a sound basis for making compelling causal claims. A detailed analysis of these issues follows.

INTERNAL VALIDITY CONCERNS

Internally valid research convincingly demonstrates that a cause (such as SOCE) is the only plausible explanation for an observed outcome such as change in same-sex sexual attractions. Lack of internal validity limits certainty that observed changes in people's attitudes, beliefs, and behaviors are a function of the particular interventions to which they were exposed. A major limitation to research on SOCE, both the early and the recent research, stems from the use of weak research designs that are prone to threats to internal validity. Research on SOCE has rarely used designs that allow for confident conclusions regarding cause-and-effect relationships between exposure to SOCE and outcomes.

Research on SOCE has rarely used designs that allow for confident conclusions regarding cause-and-effect relationships between exposure to SOCE and outcomes.

As noted previously, true experiments and rigorous quasi-experiments are rare in the SOCE research. There are only a few studies in the early period that are experiments or quasi-experiments, and no true experiments or quasi-experiments exist within the recent research. Thus, none of these recent studies meet current best practice standards for experimental design and cannot establish whether SOCE is efficacious.

In early studies, comparison and no-treatment control groups were uncommon procedures, and early studies rarely employed multiple baseline assessments, randomization to condition, multiple long-term follow-up assessments, or other procedures to aid in making causal inferences. These procedures are widely accepted as providing the most compelling basis for ruling out the possibility that an alternative source is responsible for causing an observed or reported treatment effect.

Common threats to internal validity in early studies include history (i.e., other events occurring over the same time period as the treatment that could produce the results in the absence of the intervention), regression (i.e., extreme scores are typically less extreme on retest in the absence of intervention), and testing (i.e., taking a test once influences future scores on the test in the absence of intervention). Within-subject and patient case studies are the most common designs in the early SOCE research (see Appendix

[32] True experiments have more methodological rigor because study participants are randomly assigned to treatment groups such that individual differences are more equally distributed and are not confounded with any change resulting from the treatment. Experiments are also rigorous because they include a way for the researcher to determine what would have happened in the absence of any treatment (e.g., a counterfactual) through the use of a no-treatment control group. Quasi-experimental designs do not have random assignment but do incorporate a comparison of some kind. Although they are less rigorous than experiments, quasi-experiments, if appropriately designed and conducted, can still provide for reasonable causal conclusions to be made.

B). In these designs, an individual's scores or clinical status prior to treatment is compared with his or her scores or status following treatment. These designs are particularly vulnerable to internal validity threats.

Sample attrition

Early research is especially vulnerable to threats to internal validity related to sample attrition. The proportions of participants in these studies who dropped out of the intervention and were lost to follow-up are unacceptably high; drop-out rates go as high as 74% of the initial study sample. Authors also reported high rates of refusal to undergo treatment after participants were initially enrolled in the studies. For instance, 6 men in Bancroft's (1969) study refused to undergo treatment, leaving only 10 men in the study. Callahan and Leitenberg (1973) reported that of 23 men enrolled, 7 refused and 2 dropped out of treatment; 8 also showed inconsistent baseline responses in penile arousal to the experimental stimuli so could not be included in the analysis, leaving only 6 subjects on whom treatment analyses could be performed. Of 37 studies reviewed by H. E. Adams and Sturgis (1977), 31 studies lost from 36% to 58% of the sample. In many studies, therefore, what appear to be intervention effects may actually reflect systematic changes in the composition of the study sample; in the handful of available comparison group studies, differences between the groups in the studies in the rate of dropout and in the characteristics of those who drop out may be the true cause of any observed differences between the groups. Put simply, dropout may undermine the comparability of groups in ways that can bias study outcomes.

Retrospective pretest

With the exception of prospective ethnographic studies (e.g., Ponticelli, 1999; Wolkomir, 2001), the recent research (e.g., Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003) relies exclusively on uncontrolled retrospective pretest designs. In these studies, people who have been exposed to SOCE are asked to recall and report on their feelings, beliefs, and behaviors at an earlier age or time and are then asked to report on these same issues at present. Change is assessed by comparing contemporary scores with scores provided for the earlier time period based on retrospective recall. In a few studies, LMHP who perform SOCE reported their view of how their clients had changed. The design is problematic because all of the pretest measures are not true pretests but retrospective accounts of pretest status. Thus, the recent research studies on SOCE have even weaker designs than do nonexperimental studies from the early period of research on SOCE. Again, none of these recent studies can establish whether SOCE is efficacious.

An extensive body of research demonstrates the unreliability of retrospective pretests. For example, retrospective pretests are extremely vulnerable to response-shift biases resulting from recall distortion and degradation (C. E. Schwartz & Rapkin, 2004; Schwarz & Clore, 1985). People find it difficult to recall and report accurately on feelings, behaviors, and occurrences from long ago and, with the passage of time, will often distort the frequency, intensity, and salience of things they are asked to recall.

Retrospective pretests are also vulnerable to biases deriving from impression management (Fisher & Katz, 2000; Schwarz, Hippler, Deutsch, & Strack, 1985; A. E. Wilson & Ross, 2001), change expectancy (Hill & Betz, 2005; Lam & Bengo, 2003; Norman, 2003; M. A. Ross, 1989; Sprangers, 1989), and effort justification (Aronson & Mills, 1959; Beauvois & Joule, 1996; Festinger, 1957). Individuals tend to want to present themselves in a favorable light. As a result, people have a natural tendency to report on their current selves as improved over their prior selves (impression management). People will also report change under circumstances in which they have been led to expect that change will occur, even if no change actually does occur (change expectancy). In addition, people will seek to justify the time and effort that they have made in treatment to reduce any dissonance they may feel at experiencing no change or less than they had expected by overestimating the effectiveness of the treatment (effort justification). Effort justification has been demonstrated to become stronger as intervention experiences become more unpleasant. In combination, these factors lead to inaccurate self-reports and inflated estimates of treatment effects, distortions that are magnified in the context of retrospective pretest designs.

CONSTRUCT VALIDITY CONCERNS

Construct validity is also a significant concern in research on SOCE. Construct validity refers to the degree to which the abstract concepts that are investigated in the study are validly defined, how well these concepts are translated into the study's treatments and measures, and, in light of these definitional and operational decisions, whether the study findings are appropriately interpreted. For

instance, do the researchers adequately define and measure sexual orientation? Are their interpretations of the study results regarding change in sexual orientation appropriate, given how the constructs were defined and translated into measures? On the whole, research on SOCE presents serious concerns regarding construct validity.

Definition of sexual orientation

Sexual orientation is a complex human characteristic involving attractions, behaviors, emotions, and identity. Research on sexual orientation is usually seen as beginning with the Kinsey studies (Kinsey et al., 1948, 1953). Kinsey used a unidimensional, 7-category taxonomic continuum, from 0 (*exclusively heterosexual*) to 6 (*exclusively homosexual*), to classify his participants. As the research has developed since the Kinsey studies, the assessment of sexual orientation has focused largely on measuring three variables—identity, behavior, and attraction. Many studies measure only one or two, but very seldom all three, of these variables.

A key finding in the last 2 decades of research on sexual orientation is that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways (Carrillo, 2002; Diamond, 2003, 2006; Dunne, Bailey, Kirk, & Martin, 2000; Laumann, Gagnon, Michael, & Michals, 1994; Savin-Williams, 2005). For instance, individuals with sexual attractions may not act on them or may understand, define, and label their experiences differently than those with similar desires, because of the unique cultural and historical constructs regarding ethnicity, gender, and sexuality (Harper et al., 2004; Mays & Cochran, 1998; Walters, Simoni, & Horwath, 2001; Weinrich & Williams, 1991).

Further, a subset of individuals who engage in same-sex sexual behaviors or have same-sex sexual attractions do not self-identify as LGB or may remain unlabeled, and some self-identified lesbian and gay individuals may engage in other-sex sexual behaviors without self-identifying as bisexual or heterosexual (Beckstead, 2003; Carrillo, 2002; Diamond, 2003, 2008; Diamond & Savin-Williams, 2000; Dunne et al., 2000; Fox, 2004; Gonsiorek, Sell, & Weinrich, 1995; Hoburg, Konik, Williams, & Crawford, 2004; Kinsey et al., 1948, 1953; Klein et al., 1985; Masters & Johnson, 1979; McConaghy, 1987, 1999; McConaghy, Buhrich, & Silove, 1994; Storms, 1980; Thompson & Morgan, 2008). Thus, for some individuals, personal and social identities differ from sexual attraction, and sexual orientation identities may vary due to personal concerns, culture, contexts, ethnicity, nationality, and relationships.

As a result, a number of scholars have argued that the construct of sexual orientation would be more easily and reliably assessed and defined if it were disentangled from sexual orientation identity (e.g., Chang & Katayama, 1996; Drescher, 1998a, 1998b; Drescher, Stein, & Byne, 2005; Rust, 2003; Stein, 1999; R. L. Worthington, Savoy, Dillon, & Vernaglia, 2002). Recent research has found that distinguishing the constructs of sexual orientation and sexual orientation identity adds clarity to an understanding of the variability inherent in reports of these two variables (R. L. Worthington et al., 2002; R. L. Worthington & Reynolds, 2009).

We adopted this current understanding of sexuality to clarify issues in the research literature. For instance, *sexual orientation* refers to an individual's patterns of sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics. Sexual orientation is tied to physiological drives and biological systems that are beyond conscious choice and involve profound emotional feelings, such as "falling in love." Other dimensions commonly attributed to sexual orientation (e.g., sexual behavior with men and/or women, social affiliations with LGB or heterosexual individuals and communities, emotional attachment preferences for men or women, gender role and identity, lifestyle choices) are potential correlates of sexual orientation rather than principal dimensions of the construct.

Sexual orientation identity refers to acknowledgment and internalization of sexual orientation and reflects self-exploration, self-awareness, self-recognition, group membership and affiliation, culture, and self-stigma. Sexual orientation identity involves private and public ways of self-identifying and is a key element in determining relational and interpersonal decisions, as it creates a foundation for the formation of community, social support, role models, friendship, and partnering (APA, 2003; Jordan & Deluty, 1998; McCarn & Fassinger, 1996; Morris, 1997; Ponticelli, 1999; Wolkomir, 2001).

Given this new understanding of sexual orientation and sexual orientation identity, a great deal of debate surrounds the question of how best to assess sexual orientation in research (Gonsiorek et al., 1995; Kinsey et al., 1948, 1953; Masters & Johnson, 1979; Sell, 1997). For example, some authors have criticized the Kinsey scale for dichotomizing sexual orientation—with heterosexuality and homosexuality as opposites along a single dimension and bisexuality in between—

thus implying that in increasing desire for one sex represents reduced desire for the other sex (Gonsiorek et al., 1995; Sell, 1997; R. L. Worthington, 2003; R. L. Worthington & Reynolds, 2009). An alternative that has been proposed suggests that same-sex and other-sex attractions and desires may coexist relatively independently and may not be mutually exclusive (Diamond, 2003, 2006; 2008; Fox, 2004; Klein et al., 1985,[33] Sell, 1997; Shively & DeCecco, 1977; Storms, 1980; R. L. Worthington, 2003; R. L. Worthington & Reynolds, 2009). Models with multiple dimensions that permit the rating of the intensity of an individual's sexual desire or arousal for other-sex individuals separately from the intensity of that individual's sexual desire or arousal for same-sex individuals allow individuals to have simultaneous levels of attractions. Some commentators believe such models allow for greater understanding of sexual diversity and its interactions with other aspects of identity and culture (Mays & Cochran, 1998; R. L. Worthington et al. 2002).

Considered in the context of the conceptual complexities of and debates over the assessment of sexual orientation, much of the SOCE research does not adequately define the construct of sexual orientation, does not differentiate it from sexual orientation identity, or has misleading definitions that do not accurately assess or acknowledge bisexual individuals. Early research that focuses on sexual arousal may be more precise than that which relies on self-report of behavior. Overall, recent research may actually measure sexual orientation identity (i.e., beliefs about sexual orientation, self-report of identity or group affiliation, self-report of behavior, and self-labeling) rather than sexual orientation.

Much of the SOCE research does not adequately define the construct of sexual orientation, does not differentiate it from sexual orientation identity, or has misleading definitions that do not accurately assess or acknowledge bisexual individuals.

Study treatments

In general, what constitutes SOCE in empirical research is quite varied. As we show in Appendix B, early studies tested a variety of interventions that include aversive conditioning techniques (e.g., electric shock, deprivation of food and liquids, smelling salts, chemically induced nausea), biofeedback, hypnosis, masturbation reconditioning, psychotherapy, systematic desensitization, and combinations of these approaches. A small number of early studies compare approaches alone or in combination. The more recent research includes an even wider variety of interventions (e.g., gender role reconditioning, support groups, prayer, psychotherapy) and providers (e.g., licensed and unlicensed LMHP in varied disciplines, pastoral counselors, laypersons). The recent studies were conducted in such a way that it is not possible to attribute results to any particular intervention component, approach, or provider. For instance, these interventions were provided simultaneously or sequentially, without specific separate evaluations of each intervention. The recent research and much of the early research cannot provide clarity regarding which specific efforts are associated with which specific outcomes.

Outcome measures

Regarding assessment mode, outcomes in early studies were assessed by one or more of the following: gauging an individual's physiological responses when presented with sexual stimuli, obtaining the person's self-report of recent sexual behavior and attractions, and using clinical opinion regarding improvement. In men especially, physiological measures are considered more dependable than self-report of sexual arousal or attraction (Freund, 1976; McConaghy, 1999). However, these measures have important limitations when studying sexual orientation. Some men are incapable of sexual arousal to any stimuli in the laboratory and must be excluded from research investigations in which the measure is the sole outcome measure. More recent research indicates that some penile circumference gauges are less consistent than penile volume gauges (Kuban, Barbaree, & Blanchard, 1999; McConaghy, 1999; Quinsey & Lalumiere, 2001; Seto, 2004) and that some men can intentionally produce false readings on the penile circumference gauges by suppressing their standard sexual arousal responses (Castonguay, Proulx, Aubut, McKibben, & Campbell, 1993; Lalumiere & Harris, 1998) or consciously making themselves aroused when presented with female erotic stimuli (Freund, 1971, 1976; Freund, Watson, & Rienzo, 1988; Lalumiere & Earls, 1992; McConaghy, 1999, 2003). The physiological measure used in all the SOCE experiements was the penile circumference gauge.

[33] Although Klein advanced the notion of sexual orientation as a multidimensional variable, his Sexual Orientation Grid confounds constructs of sexual orientation and sexual orientation identity, as it includes attraction; behavior; identification; and emotional, political, and social preferences.

McConaghy (1999) has questioned the validity of the results of SOCE research using this gauge and believes that data illustrating a reduction in same-sex sexual attraction should be viewed skeptically.

In recent research on SOCE, overreliance on self-report measures and/or on measures of unknown validity and reliability is common. Reliance on self-reports is especially vulnerable to a variety of reactivity biases such that shifts in an individual's score will reflect factors other than true change. Some of these biases are related to individual motivations, which have already been discussed, and others are due to features of the experimental situation. Knowing that one is being studied and what the experimenter hopes to find can heighten people's tendency to self-report in socially desirable ways and in ways that please the experimenter.

Measures used in early studies vary tremendously in their psychometric acceptability, particularly for attitudinal and mental health measures, with a limited number of studies using well-validated measures. Recent research has not advanced significantly in using psychometrically sound measures of important study variables such as depression, despite the widespread use of measures that permit accurate assessment of these variables in other studies. Measures in these studies are also sources of bias due to problems such as item wording and response anchors from which participants may have inferred that other-sex attraction is a normative standard, as well as from the exclusion of items related to healthy homosexual functioning to parallel items that ask for reports on healthy heterosexual functioning.

Study operations

Regarding the adequacy of study operations, few of the early studies attempted to overcome the demand characteristics associated with the interventionists' obtaining measures of change themselves. In other words, few studies sought to minimize the possibility that people receiving treatment would be motivated to please their treatment providers by providing them with reports that were consistent with what the providers were perceived to desire and expect. Issues in recruitment of participants may also contribute to this effect; subjects were aware of the goals of the study, were recruited by individuals with that knowledge, or were participating in treatment to avoid legal and/or religious sanction. Novelty effects associated with exposure to an experimental laboratory situation may also have influenced study results. People may become excited and energized by participating in a research investigation, and these reactions to being in the research environment may contribute to change in scores. Recent research is also vulnerable to demand characteristics as a function of how individuals are recruited into samples, which is discussed in more detail in the section on sampling concerns.

CONCLUSION VALIDITY CONCERNS

Conclusion validity concerns the validity of the inferences about the presence or absence of a relationship among variables that are drawn from statistical tests. Small sample sizes, sample heterogeneity, weak measures, and violations to the assumptions of statistical tests (e.g., non-normally distributed data) are central threats to drawing valid conclusions. In this body of research, conclusion validity is often severely compromised. Many of the studies from the early period are characterized by samples that are very small, containing on the average about 9 subjects (see Appendix B; see also H. E. Adams & Sturgis, 1977). Combined with high rates of attrition, skewed distributions, unreliable measures, and infrequent use of statistical tests designed for small and skewed samples, confidence in the statistical results of many of these studies may be misplaced. The recent research involved unreliable measures and inappropriate selection and performance of statistical tests, which are threats to their statistical conclusion validity,[34] even though these studies involved larger samples than the early research.

[34] For instance, to assess whether sexual orientation had changed, Nicolosi et al. (2000) performed a chi-square test of association on individuals' prior and current self-rated sexual orientation. Several features of the analysis are problematic. Specifically, the nature of the data and research question are inappropriate to a chi-square test of association, and it does not appear that the tests were properly performed. Chi-square tests of association assume that data are independent, yet these data are not independent because the row and column scores represent an individual's rating of his or her past and present self. Chi-square tests ought not to be performed if a cell in the contingency table includes fewer than five cases. Other tests, such as the nonparametric McNemar's test for dichotomous variables (McNemar, 1969) or the sign (Conover, 1980) or Wilcoxon signed-rank tests (Wilcoxon, 1945) for nominal and ordinal data, respectively, are used to assess whether there are significant differences between an individual's before and after score and are appropriate when data fail to meet the assumptions of independence and normality, as these data do and would have been more appropriate choices. Paired *t* tests for mean differences could also have been performed on these data. There are procedural problems in how Nicolosi et al. conducted the chi-square test, such as missing data, and the analyses were conducted without adjustment for chance, with different numbers of subjects responding to each item, and without corrections to the gain scores to address regression artifacts. Taken together, the problems associated with running so many tests without adjusting for chance associations

Problems in Generalizing Findings

A significant challenge to interpreting the research on SOCE is establishing external validity—that is, judging to whom and to what circumstances the results of any particular study might reasonably be generalized.

SAMPLE COMPOSITION

Concerns regarding the sample composition in these studies are common in critiques (e.g., Cramer et al., 2008). The studies from the early period are characterized by samples that are narrow in their demographic characteristics, composed almost exclusively of Caucasian males over the age of 18. No investigations are of children and adolescents exclusively, although adolescents are included in a very few study samples. Few SOCE studies in the early period include women. Although more recent research includes women and respondents of diverse ethnic and racial backgrounds (e.g., Moran, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Schaeffer et al., 2000; Spitzer, 2003; Wolkomir, 2001), White men continue to dominate recent study samples. Thus, the research findings from early and recent studies may have limited applicability to non-Whites, youth, or women. The samples in the recent research have been narrowly defined in other respects, focusing on well-educated, middle-class individuals to whom religion is extremely important (e.g., Beckstead & Morrow, 2004; Nicolosi et al., 2000; Pattison & Pattison, 1980; Schaeffer et al., 2000; Spitzer, 2003; Wolkomir, 2001). Same-sex sexual attraction and treatments are confounded with these particular demographic characteristics across the recent literature. These research findings may be most applicable to educated White men who consider themselves highly religious.

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

The early research sometimes included men who were receiving intervention involuntarily (e.g., Barlow, Agras, Abel, Blanchard, & Young, 1975; Callahan & Leitenberg, 1973; S. James, 1978; MacCulloch & Feldman, 1967; MacCulloch et al., 1965; McConaghy, 1969, 1976; McConaghy et al., 1972), usually men who were court referred as a result of convictions on charges related to criminalized acts of homosexual sex.[35] The samples also include men who were not receiving intervention because of same-sex sexual attractions; rather, some of the men receiving intervention are described as pedophiles, exhibitionists, transvestites, and fetishists (Callahan & Leitenberg, 1973; Conrad & Wincze, 1976; Fookes, 1960; Hallam & Rachman, 1972; Marquis, 1970; Thorpe, Schmidt, Brown, & Castell, 1964; Thorpe, Schmidt, & Castell, 1963). Thus, the early samples are notable for including men who may not be same-sex attracted at all or have been distressed by their attractions but who had to undergo intervention by court order or out of fear of being caught by law enforcement in the future.

Moreover, in the early research—to the extent that it was assessed—the samples contained individuals who varied widely along the spectrum of same-sex sexual orientation prior to intervention, so that the studies included men who were other-sex sexually attracted to varying degrees alongside men who were primarily or exclusively same-sex sexually attracted (Bancroft, 1969; Barlow et al., 1975; Birk, 1974; Conrad & Wincze, 1976; Fookes, 1960; Hallman & Rachman, 1972; Kendrick & MacCulloch, 1972; LoPiccolo, Stewart, & Watkins, 1972; Marquis, 1970; McCrady, 1973). Additionally, study samples included men with and without histories of current and prior sexual contact with men and women (Bancroft, 1969; Colson, 1972; Curtis & Presly, 1972; Fookes, 1960; Freeman & Meyer, 1975; Gray, 1970; Hallman & Rachman, 1972; Herman, Barlow, & Agras, 1974; Larson, 1970; Levin, Hirsch, Shugar, & Kapche, 1968; LoPiccolo et al., 1972; MacCulloch & Feldman, 1967; McConaghy, 1969; McConaghy, Armstrong, & Blaszcynski, 1981; McConaghy & Barr, 1973; McConaghy et al., 1972; Segal & Sims, 1972; Thorpe et al., 1964), so that men who were or had been sexually active with women and men, only women, only men, or neither were combined. Some recent studies of SOCE have similar problems (e.g., Spitzer, 2003). Including participants with attractions, sexual arousal, and behaviors to both sexes in the research on SOCE makes evaluating change more difficult (Diamond, 2003; Rust, 2003; Vasey & Rendell, 2003; R. L. Worthington, 2003).

Data analyses rarely adjust for preintervention factors such as voluntary pursuit of intervention, initial degree of other-sex attraction, or past and current other-sex and same-sex behaviors; in very few studies did investigators perform and report subgroup analyses to clarify how

or correcting for regression artifacts and having different respondents in nearly every test make it difficult to assess what changes in scores across these items actually reflect.

[35] Shidlo and Schroeder (2002) found that roughly 24% of their respondents perceived that SOCE was imposed on them rather than pursued voluntarily.

subpopulations fared as a result of intervention. The absence of these analyses obscures results for men who are primarily same-sex attracted and seeking intervention regarding these attractions versus any other group of men in these studies, such as men who could be characterized as bisexual in their attractions and behaviors or those on whom treatment was imposed. For these reasons, the external validity (generalizability) of the early studies is unclear, with selection–treatment interactions of particular concern. It is uncertain which effects observed in these studies would hold for which groups of same-sex attracted people.

SAMPLING AND RECRUITMENT PROCEDURES

Early and recent study samples are typically of convenience, so it is unclear precisely what populations these samples represent. Respondents in the recent studies were typically recruited through ex-gay ministries and advocates of SOCE rather than through population-based probability sampling strategies designed to obtain a representative sample of same-sex attracted people or the subset who experience their attractions as distressing and have sought and been exposed to SOCE. Additionally, study respondents are often invited to participate in these studies by LMHP who are proponents of SOCE, introducing unknown selection biases into the recruitment process (cf. Beckstead, 2003; Shidlo & Schroeder, 2002).

Qualitative studies have been more successful in applying a variety of purposive stratified sampling strategies (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001) and developing appropriate comparison samples. However, the qualitative studies were not undertaken with the purpose of determining if SOCE interventions are effective in changing sexual orientation. These studies focused on understanding aspects of the experience of participating in SOCE from the perspective of same-sex attracted people in distress.

As noted previously, recent research has used designs that are incapable of making attributions of intervention effects. In many of the recent studies, the nature of the procedures for recruiting samples is likely to have accentuated response-shift biases rather than to have minimized them, because study recruiters were open proponents of the techniques under scrutiny; it cannot be assumed that the recruiters sought to encourage the participation of those individuals whose experiences ran counter to their own view of the value of these approaches. Proponents of these efforts may also have limited access to the research for former clients who were perceived to have failed the intervention or who experienced it as harmful. Some of the recent research to assess harm resulting from these interventions (Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002) suffers from sampling weaknesses and biases of a similar nature.

Treatment Environments

Clinically trained professionals using reasonably well-described change efforts generally conducted early research in clinical laboratory settings. By contrast, the recent research included a wide variety of change efforts, providers, and settings in which these efforts may take place. The recent research has not been performed in a manner that permits examination of the interactions among characteristics of change efforts, providers, settings, and individuals seeking to change, nor does the research associate these patterns with outcomes.

Summary

Our analysis of the methodology of SOCE reveals substantial deficiencies. These deficiencies include limitations in making causal claims due to threats to internal validity (such as sample attrition, use of retrospective pretests); lack of construct validity, including definition and assessment of sexual orientation; and variability of study treatments and outcome measures. Additional limitations with recent research include problems with conclusion validity (the ability to make inferences from the data) due to small or skewed samples, unreliable measures, and inappropriate selection and performance of statistical tests. Due to these limitations, the recent empirical literature provides little basis for concluding whether SOCE has any effect on sexual orientation. Any reading of the literature on SOCE outcomes must take into account the limited generalizability of the study samples to the population of people who experience same-sex sexual attraction and are distressed by it. Taking into account the weaknesses and limitations of the evidence base, we next summarize the results from research in which same-sex sexual attraction and behavior have been treated.

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

4. A SYSTEMATIC REVIEW OF RESEARCH ON THE EFFICACY OF SEXUAL ORIENTATION CHANGE EFFORTS: OUTCOMES

In Chapter 3, we provided an overview of our systematic review of research on sexual orientation change efforts (SOCE)[36] and the results of the review for methodological concerns. In this chapter, we describe the evidence on outcomes associated with SOCE, whether beneficial or harmful. No studies reported effect size estimates or confidence intervals, and many studies did not report all of the information that would be required to compute effect sizes. As a result, statistical significance and methodology are considered in interpreting the importance of the findings. As the report will show, the peer-refereed empirical research on the outcomes of efforts to alter sexual orientation provides little evidence of efficacy and some evidence of harm. We first summarize the evidence of efficacy and then the evidence of unintended harmful effects.

Reports of Benefit

Sexual orientation change efforts have aimed to address distress in individuals with same-sex sexual attractions by achieving a variety of outcomes:

- Decreased interest in, sexual attraction to, and sexual behavior with same-sex sexual partners.
- Increased interest in, sexual attraction to, and sexual behavior with other-sex sexual partners.
- Increased healthy relationships and marriages with other-sex partners.
- Improved quality of life and mental health.

Although not all of these aims are equally well studied, these are the outcomes that have been studied frequently enough to be reported in this systematic review. One general point that we wish to emphasize as we begin the discussion of the outcomes that have been reported in this literature is that nonexperimental studies often find positive effects that do not hold up under the rigor of experimentation. The literature on SOCE is generally consistent with this point. In other words, the least rigorous studies in this body of research generally provide a more positive assessment of efficacy than do studies that meet even the most minimal standards of scientific rigor.

Decreasing Same-Sex Sexual Attraction

EARLY STUDIES

A number of investigators have assessed aversion therapy interventions to reduce physiological and self-reported sexual arousal in response to same-sex stimuli and self-reports of same-sex sexual attraction (see Appendix B).

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

Experimental studies

Results from the experimental studies of aversive techniques provide some evidence that these treatments can reduce self-reported and physiological sexual arousal for some men. The experimental studies that we reviewed showed lower rates of change in sexual arousal toward the same sex than did the quasi-experimental and nonexperimental studies. This finding was consistent with H. E. Adams and Sturgis's (1977) review of studies published through 1976.

In their review, H. E. Adams and Sturgis (1977) found that across the seven studies that they classified as controlled studies, 34% of the 179 subjects that were retained in these studies decreased their same-sex sexual arousal. McConaghy (1976) found that roughly half of the men who received one of four treatment regimens reported less intense sexual interest in men at 6 months. McConaghy et al. (1972) found reductions in penile response in the laboratory following treatment. Penile response to female nudes also declined for those men who initially responded to female stimuli. McConaghy (1969) similarly reported a decline in sexual arousal to all stimuli as a result of treatment for some men and that treatment also increased same-sex sexual arousal for some men. Overall, however, a majority of participants showed decreases in same-sex sexual arousal immediately following treatment. McConaghy and Barr (1973) found that about half of men reported that their same-sex sexual attractions were reduced. Tanner (1975) found that aversive shock could lessen erectile response to male stimuli.

An important caveat in considering the results of these experiments is that none compared treatment outcomes to an untreated control group. That is, these studies compared treatments to one another. The fact that four of these studies also involved men who were being treated by court referral should also be considered in interpreting the findings. These experiments cannot address whether men would have changed their sexual arousal pattern in the absence of treatment. Only one of the experiments that we identified compared treatment outcomes against the outcomes for an untreated control group. Tanner (1974) examined change in sexual arousal among 8 men receiving electric shock therapy. Tanner found that physiological arousal to male stimuli in the laboratory had declined at the 8-week follow-up, when scores among the 8 men in the treatment were compared with those of the 8 men in a control group. Changes were not achieved for all of the men, and there were no differences between the experimental and control groups in the frequency of same-sex sexual behavior.

The results of the experimental studies suggest that some men who participate in clinical treatment studies may be conditioned to control their sexual arousal response to sexual stimuli, although McConaghy's (cf. McConaghy, 1999) studies suggest that aversive treatments may affect sexual arousal indiscriminately. These studies found that not all men reduce their sexual arousal to these treatments and that changes in sexual arousal in the lab are not necessarily associated with changes in sexual behavior.

Quasi-experimental studies

The three quasi-experiments listed in Appendix B all compare treatment alternatives for nonequivalent groups of men. Birk et al. (1971) found that 5 (62%) of the 8 men in the aversive treatment condition reported decreased sexual feelings following treatment; one man out of the 8 (12%) demonstrated reduced sexual arousal at long-term follow-up. In comparing groups, the researchers found that reports of same-sex "cruising," same-sex sexual "petting," and orgasm declined significantly for men receiving shocks when compared with men receiving associative conditioning. McConaghy and colleagues (1981) found that 50% of respondents reported decreased sexual feelings at 1 year. S. James (1978) reported that anticipatory avoidance learning was relatively ineffective when compared with desensitization. In their review, H. E. Adams and Sturgis (1977) found that 50% of the 124 participants in what they termed uncontrolled studies reported reduced sexual arousal.

Nonexperimental studies

Nonexperimental studies, which lack sufficient rigor to assess efficacy but which may be useful in identifying potential treatment approaches, offer a similar view of the impact of aversive treatment on reductions in sexual arousal. For instance, Bancroft (1969), in a within-subject study without a comparison group, delivered electric shocks based on males' penile volume responses to photographs of nude men as they were fantasizing about homosexual sexual encounters. Research subjects underwent a minimum of 30 treatment sessions. Bancroft reported that of the men who were initially sexually attracted to both sexes, 30% ($n = 3$) of these men lessened their same-sex sexual interest over the long-term. Among those with no initial other-sex sexual attraction, no lasting changes were observed in sexual

arousal and attraction. Several other uncontrolled studies found reductions in participants' self-reported sexual attraction and physiological response under laboratory conditions (range = 7%–100%; average = 58%) (Callahan & Leitenberg, 1973; Feldman & MacCulloch, 1965; Fookes, 1960; Hallam & Rachman, 1972; MacCulloch & Feldman, 1967; Sandford, Tustin, & Priest, 1975).

As is typically found in intervention research, the average proportion of men who are reported to change in uncontrolled studies is roughly double the average proportion of men who are reported to change in controlled studies. For instance, as noted previously, results from controlled studies show that far less change can be produced in same-sex sexual arousal by aversion techniques. H.E. Adams and Sturgis (1977) reported that in the nonexperimental studies in their review, 68% of 47 participants reduced their same-sex sexual arousal, compared with 34% of participants in experimental studies.

The studies of nonaversive techniques as the primary treatment, such as biofeedback and hypnosis, were only assessed in the nonexperimental within-subject and patient case studies. For example, Blitch and Haynes (1972) treated a single female who was heterosexually experienced and whom they described as strongly committed to reducing her same-sex sexual attractions. Using relaxation, rehearsal, and masturbation reconditioning, she was reported to be able to masturbate without female fantasies 2 months after intervention. Curtis and Presly (1972) used covert sensitization to treat a married man who experienced guilt about his attraction to and extramarital engagement with men. After intervention, he showed reduced other-sex and same-sex sexual interest, as measured by questionnaire items. Huff (1970) treated a single male who was interested in becoming sexually attracted to women. Following desensitization, his journal entries showed that his same-sex sexual fantasies continued, though the ratio of other-sex to same-sex sexual fantasies changed by the 6-month follow-up to favor other-sex sexual fantasies. His MMPI scores showed improvement in his self-concept and reductions in his distress.

By contrast, among the 4 men exposed to orgasmic reconditioning by Conrad and Wincze (1976), all reported decreased same-sex sexual attractions immediately following intervention, but only one demonstrated a short-term measurable alteration in physiological responses to male stimuli. Indeed, one subject's sexual arousal to same-sex sexual stimuli increased rather than decreased, a result that was obtained for some men in the experimental studies. In a study by Barlow and colleagues (1975), among 3 men who were each exposed to unique biofeedback treatment regimens, all maintained same-sex sexual arousal patterns at follow-up, as measured by penile circumference change in response to photos of male stimuli.

Mintz (1966) found that 8 years after initiating group and individual therapy, 5 of his 10 research participants (50%) had dropped out of therapy. Mintz perceived that among those who remained, 20% (n = 1) were distressed, 40% (n = 2) accepted their same-sex sexual attractions, and 40% (n = 2) were free from conflict regarding same-sex sexual attractions. Birk (1974) assessed the impact of behavioral therapy on 66 men, of whom 60% (n = 40) had dropped out of intervention by 7 months. Among those who remained in the study, a majority shifted toward heterosexual scores on the Kinsey scale by 18 months.

Overall, the low degree of scientific rigor in these studies is likely to lead to overestimates of the benefits of these treatments on reductions in same-sex sexual arousal and attraction and may also explain the contradictory results obtained in nonexperimental studies.

Overall, the low degree of scientific rigor in these studies is likely to lead to overestimates of the benefits of these treatments on reductions in same-sex sexual arousal and attraction and may also explain the contradictory results obtained in nonexperimental studies.

RECENT STUDIES

Recent studies have investigated whether people who have participated in efforts to change their sexual orientation report decreased same-sex sexual attractions (Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003) or how people evaluate their overall experiences of SOCE (Beckstead & Morrow 2004; Pattison & Pattison, 1980; Ponticelli, 1999; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Wolkomir, 2001). These studies all use designs that do not permit cause-and-effect attributions to be made. We conclude that although these studies may be useful in describing people who pursue SOCE and their experiences of SOCE, none of the recent studies can address the efficacy of SOCE or its promise as an intervention. These studies are therefore described elsewhere in the

report in places where they contribute to understanding respondents' motivations for and experiences of SOCE.

SUMMARY

Overall, early studies suggest that modest short-term effects on reducing same-sex sexual arousal in the laboratory may be obtained for a minority of study participants through some forms of SOCE, principally interventions involving aversion procedures such as electric shock. Short-term reductions in sexual arousal to other-sex stimuli were also reported for some treatments. When outcomes were described for individual participants or subgroups of participants, short-term reductions in same-sex sexual arousal patterns were more commonly reported for people described as having other-sex sexual attractions prior to intervention and high levels of motivation to change. Initial and sustained reductions in sexual arousal were reported less commonly for people who were described as having no other-sex sexual attraction prior to intervention. The results from the uncontrolled studies are more positive than those from the controlled studies, as would be expected. Yet these studies also found that reduction in sexual arousal may not occur for study participants. Recent studies provide no sound scientific basis for determining the impact of SOCE on decreasing same-sex sexual attraction.

Decreasing Same-Sex Sexual Behavior

EARLY STUDIES

Early studies show that SOCE have limited impact on same-sex sexual behavior, even in cases in which lab results show some reduction in same-sex sexual arousal.[37]

Experimental studies

In their review, H. E. Adams and Sturgis (1977) found that across the seven controlled studies published between 1960 and 1976, 18% of 179 subjects in these studies were reported to have decreased same-sex sexual behavior; the percentage reporting reductions in sexual arousal was nearly double that percentage, at 34%. In our review, we found that the results of the experimental studies that we reviewed provided a picture of the effects of aversive forms of SOCE similar to that painted by H. E. Adams & Sturgis.

For instance, in his study comparing aversion and aversion relief therapies,[38] McConaghy (1969) reported that about 20% of men had engaged in same-sex sexual behavior within 2 weeks following treatment. No longer-term follow-up data were reported. McConaghy (1976) found that 50% of men had reduced the frequency of their same-sex behavior, 25% had not changed their same-sex behavior, and 25% reported no same-sex behavior at 1 year. McConaghy and Barr (1973) reported that 25% of men had reduced their same-sex sexual behavior at 1-year. Tanner (1975) reported a significant decline in same-sex behavior across treatments. In the only untreated control group study that we identified, Tanner (1974) found that intervention had no effect on rates of same-sex behavior, even though the intervention did reduce changes in penile circumference in response to male stimuli in the lab.

Quasi-experimental studies

Birk and colleagues (1971) found that 2 of 18 men (11%) had avoided same-sex behavior at 36 months. McConaghy et al. (1981) reported that among the 11 men who were sexually active with same-sex partners, about 25% reduced their same-sex behavior. S. James (1978) did not report on behavior. In their review, H. E. Adams and Sturgis (1977) found that 50% of the 124 participants in what they called uncontrolled group studies reported reduced sexual arousal, and 42% reported less frequent same-sex sexual behavior. Among the quasi-experiments that we reviewed, the reported reductions in sexual behavior were lower (i.e., 11% and 25%) than what was reported by H. E. Adams and Sturgis. These differences may be due to our more rigorous criteria of what constitutes a quasi-experiment than the criteria employed by Adams and Sturgis.

Nonexperimental studies

Among the case and single-group within-subject studies, the results are mixed. Some studies found that people reported having abstained from same-sex behavior in the months immediately following intervention or having decreased its frequency. Bancroft (1969) found that 4 of the 10 men in his study had reduced their behavior at follow-up. Freeman and Meyer (1975) found that 7 of the 9 men in their study were abstinent at 18

[37] In considering the results of early studies on this outcome, readers are advised that data on this outcome are not always reported. In some cases, not all research participants in these studies had engaged in sexual activity with same-sex partners prior to treatment, though they may have fantasized about doing so. In other studies, reducing sexual arousal under lab conditions was examined and not behavior in daily life.

[38] Aversion therapy involves the application of a painful stimulus; aversion relief therapy involves the cessation of an aversive stimulus.

months. Other single-subject and case study subjects reported declines in or no same-sex behavior (Gray, 1970; Huff, 1970; B. James, 1962, 1963; Kendrick & McCullough, 1972; Larson, 1970; LoPiccolo, 1971; Segal & Sims, 1972).

Not all individuals, however, successfully abstained on every occasion of sexual opportunity (Colson, 1972; Rehm & Rozensky, 1974), and some relapse occurred within months following treatment (Bancroft, 1969; Freeman & Meyer, 1975; Hallam & Rachman, 1972; Levin et al., 1968; MacCulloch et al., 1965; Marquis, 1970). In other studies, the proportion reporting that they changed their sexual behavior was a minority. For instance, among Barlow et al.'s (1975) research participants, 2 of the 3 men demonstrated no change in their same-sex behavior. In the case studies, clients who were described as exclusively attracted to the same sex prior to treatment were most commonly reported to have failed to avoid same-sex sexual behavior following treatment.

RECENT STUDIES

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

SUMMARY

In the early studies with the greatest rigor, it appears that SOCE may have decreased short-term same-sex sexual behavior for a minority of men. However, in the only randomized control group trial, the intervention had no effect on same-sex sexual behavior. Quasi-experimental results found that a minority of men reported reductions in same-sex sexual behavior following SOCE. The nonexperimental studies found that study participants often reported reduced behavior but also found that reductions in same-sex sexual behavior, when reported, were not always sustained.

Increasing Other-Sex Sexual Attraction

Early studies provide limited evidence for reductions in sexual arousal to same-sex stimuli and for reductions in same-sex sexual behavior following aversive treatments. The impact of the use of aversive treatments for increasing other-sex sexual arousal is negligible.

EARLY STUDIES

Experimental studies

In many of the early experiments on aversive treatments, sexual arousal to female sexual stimuli was a desired outcome. McConaghy (1969) found that about 16% of 40 men increased their sexual arousal to female stimuli immediately following treatment and that 5% increased their sexual arousal to male stimuli. It is unclear how the 50% of men in this study who were aroused by females prior to the treatment were distributed among the men who increased their sexual arousal and among those who did not. In other words, it is possible that most of the men who changed were sexually aroused by women initially. In interviews following treatment, McConaghy (1976) reported that 25% of 157 men indicated that they felt more sexual arousal toward females than they did before treatment. McConaghy et al. (1972) found no change in rates of sexual arousal to female stimuli. McConaghy et al.'s (1972) research participants showed no change in penile volume in response to female stimuli after intervention.

In a randomized control trial, Tanner's (1974) 8 research participants reported increases in sexual fantasizing about other-sex partners after aversive conditioning. However, penile circumference data showed no increased sexual arousal to female stimuli. H. E. Adams and Sturgis (1977) found that 26% of 179 participants in the controlled studies that they reviewed increased their sexual arousal toward the other-sex.

Quasi-experimental studies

Birk and colleagues (1971) found no difference between their treatment groups in reported sexual arousal to women. Two men (11% of 18 participants) in the study reported sustained sexual interest in women following treatment. McConaghy and colleagues (1981) reported no significant improvement in attraction to females. S. James (1978) reported little impact of treatment on participants in anticipatory avoidance learning. He noted a general improvement among 80% of the 40 men undergoing desensitization to other-sex situations.

Nonexperimental studies

Among the nonexperimental studies, for men who were described as having some degree of other-sex sexual attraction and experience before the intervention, the balance of studies showed an increase in other-sex sexual attraction over time, although given the nonexperimental nature of these studies, this change

cannot be validly attributed to SOCE. For men with little or no preintervention other-sex sexual attraction, the research provides little evidence of increased other-sex sexual attraction.

As in some of the experimental studies, the results reported in the nonexperiments were not always in the desired direction. Studies occasionally showed that reductions in sexual arousal and interest may occur for same- and other-sex partners, suggesting the possibility that treatments may lower sexual arousal to sexual stimuli in general. For instance, Curtis and Presly's (1972) married male subject reported slightly lower rates of sexual arousal in response to women than before intervention, in addition to reduced same-sex sexual arousal.

Among early studies, many found little or no increases in other-sex sexual attraction among participants who showed limited or no other-sex sexual attraction to begin with. For instance, 2 of the 3 men in Barlow et al.'s (1975) within-subject biofeedback investigation reported little or no other-sex sexual interest prior to intervention. As measured by penile circumference, one of these men demonstrated negligible increases in other-sex sexual attraction; one other individual showed stable low other-sex sexual attraction, which contradicted his self-report.

In contrast, a handful of the early single-patient case studies found increases in other-sex attraction. For instance, Hanson and Adesso's (1972) research participant, who was reported to be primarily same-sex sexually attracted at the onset of intervention, increased his sexual arousal to women and ultimately reported that he enjoyed sex with women. Huff's (1970) male research participant also reported increased other-sex sexual attraction at 6 months following desensitization.

RECENT STUDIES

As we have noted, recent studies provide no sound basis for attributing individual reports of their current other-sex sexual attraction to SOCE. No results are reported for these studies.

SUMMARY

Taken together, the research provides little support for the ability of interventions to develop other-sex sexual attraction where it did not previously exist, though it may be possible to accentuate other-sex sexual attraction among those who already experience it.

Increasing Other-Sex Sexual Behavior

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

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

EARLY STUDIES

Experimental studies

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

Quasi-experimental studies

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

Nonexperimental studies

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

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

RECENT STUDIES

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

SUMMARY

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

Marriage

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

Improving Mental Health

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

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

Reports of Harm

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

EARLY STUDIES

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

EXPERIMENTAL STUDIES

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

QUASI-EXPERIMENTAL STUDIES

None reported on adverse events.

NONEXPERIMENTAL STUDIES

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

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

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

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

RECENT STUDIES

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

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

Summary

We conclude that there is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE. However, studies from both periods indicate that attempts to change sexual orientation may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts. The lack of rigorous research on the safety of SOCE represents a serious concern, as do studies that report perceptions of harm (cf. Lilienfeld, 2007).

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Conclusion

The limited number of rigorous early studies and complete lack of rigorous recent prospective research on SOCE limits claims for the efficacy and safety of SOCE. Within the early group of studies, there are a small number of rigorous studies of SOCE, and those focus on the use of aversive treatments. These studies show that

enduring change to an individual's sexual orientation is uncommon and that a very small minority of people in these studies showed any credible evidence of reduced same-sex sexual attraction, though some show lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and increased attraction to and engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. We found that nonaversive and recent approaches to SOCE have not been rigorously evaluated. Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective.

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

We found that there was some evidence to indicate that individuals experienced harm from SOCE. Early studies do document iatrogenic effects of aversive forms of SOCE. High dropout rates characterize early aversive treatment studies and may be an indicator that research participants experience these treatments as harmful. Recent research reports indicate that there are individuals who perceive they have been harmed and others who perceive they have benefited from nonaversive SOCE. Across studies, it is unclear what specific individual characteristics and diagnostic criteria would prospectively distinguish those individuals who will later perceive that they have succeeded and benefited from nonaversive SOCE from those who will later perceive that they have failed or been harmed. In the next chapter, we explore the literature on individuals who seek to change their sexual orientation to better understand their concerns.

5. RESEARCH ON ADULTS WHO UNDERGO SEXUAL ORIENTATION CHANGE EFFORTS

In the preceding three chapters, we have focused on sexual orientation change efforts (SOCE),[39] because such interventions have been the primary focus of attention and contention in recent decades. Now we turn from the problem of sexual orientation change, as it has been defined by "expert" narratives of sin, crime, disorder, and dysfunction in previous chapters, to the problem of sexual orientation distress, as it exists in the lives of individuals who seek and participate in sexual orientation change. We try to present what the research literature reveals—and clarify what it does not—about the natural history of the phenomenon of people who present to LMHP seeking SOCE.

We do this for two major reasons. The first is to provide a scholarly basis for responding to the core task force charge: "the appropriate application of affirmative therapeutic interventions" for the population of those individuals who seek sexual orientation change. The second is our hope to step out of the polemic that has defined approaches to sexual orientation distress. As discussed in the introduction, some professional articles (e.g., Rosik, 2001, 2003; Yarhouse & Burkett, 2002), organizations, and accounts of debates (cf. Drescher, 2003) have argued that APA and mainstream psychology are ignoring the needs of those for whom same-sex sexual attractions are unwanted, especially for religious populations. We hope that an empathic and comprehensive review of the scholarly literature of the population that seeks and participates in SOCE can facilitate an increased understanding of the needs of this population so that an affirmative therapeutic approach may be developed.

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We decided to expand our review beyond empirical literature to have a fuller view of the population in question. Because of the lack of empirical research in this area, the conclusions must be viewed as tentative. The studies that are included in this discussion are (a) surveys and studies of individuals who participated in SOCE and their perceptions of change, benefit, and harm (e.g., S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003; Throckmorton & Welton, 2005)[40]; (b) high-quality qualitative studies of the concerns of participants and the dynamics of SOCE (e.g., Beckstead & Morrow, 2004; Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006); (c) case reports, clinical articles, dissertations, and reviews in

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

[40] As previously noted, these studies, due to their significant methodological issues, cannot assess whether actual sexual orientation change occurred.

which sexual orientation or sexual orientation identity change were considered or attempted (e.g., Borowich, 2008; Drescher, 1998b; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Horlacher, 2006; Karten, 2006; Mark, 2008; Tan, 2008, Yarhouse et al., 2005; Yarhouse, 2008); and (d) scholarly articles, case reports, dissertations, and reviews on the concerns of religious individuals who are conflicted by their same-sex sexual attractions, some of whom accept their same-sex sexual orientation (e.g., Coyle & Rafalin, 2000, Horlacher, 2006; Kerr, 1997; Mahaffy, 1996; Mark, 2008, Moran, 2007; O'Neill & Ritter, 1992; Shallenberger, 1998; Tan, 2008; Thumma, 1991; Yarhouse, 2008; Yarhouse et al., 2005; Yip, 2000, 2002, 2003, 2005). We also reviewed a variety of additional scholarly articles on subtopics such as individuals in other-sex marriages and general literature on sexual orientation concerns.

Demographics

The majority of participants in research studies on SOCE have been Caucasian men. Early studies included some men who were court-referred and whose participation was not voluntary (S. James, 1978; McConaghy, 1969, 1976; McConaghy et al., 1972), but more recent research primarily included men who indicated that their religion is of central importance (Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Wolkomir, 2001). Some studies included small numbers of women (22%–29%; Nicolosi et al., 2000; S. L. Jones & Yarhouse, 2007; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003), and two studies focused exclusively on women (Moran, 2007; Ponticelli, 1999). However, these studies do not examine if there are potential differences between the concerns of men and women.

To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals who have sought SOCE.

Members of racial-ethnic groups are not included in some samples (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001) and are a small percentage (5%–14%) of the sample in other studies (S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003). In the recent studies, no comparisons were reported between the ethnic minorities in the sample and others. Thus, there is no evidence that can elucidate concerns of ethnic minority individuals who have sought SOCE. To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals who have sought SOCE.

Samples in recent SOCE studies have been composed predominantly of individuals from conservative Christian denominations (Beckstead & Morrow, 2004; Erzen, 2006; Nicolosi et al., 2000; Ponticelli, 1999; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003; Wolkomir, 2001). These studies included very few nonreligious individuals, and the concerns of religious individuals of faiths other than Christian are not described. Thus, the existing literature limits information to the concerns of a particular group of religious individuals. Finally, most individuals in studies of SOCE have tried multiple ways to change their sexual orientation, ranging from individual psychotherapy to religiously oriented groups, over long periods of time and with varying degrees of satisfaction and varying perceptions of success (Beckstead & Morrow, 2004; Comstock, 1996; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Mark, 2008; Nicolosi et al., 2000; Shidlo & Schroeder, 2002).

Why Individuals Undergo Sexual Orientation Change Efforts

Because no research provides prevalence estimates of those participating in SOCE, we cannot determine how prevalent the wish to change sexual orientation is among the conservative Christian men who have predominated in the recent research, or among any other population. Clients' motivations to seek out and participate in SOCE seem to be complex and varied and may include mental health and personality issues, cultural concerns, religious faith, internalized stigma, as well as sexual orientation concerns (Beckstead & Morrow, 2004; Drescher, 1998b; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Lasser & Gottlieb, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000). Some of the factors influencing a client's request for SOCE that have been identified in the literature include the following:

- Confusion or questions about one's sexuality and sexual orientation (Beckstead & Morrow, 2004; G. Smith et al., 2004)
- Religious beliefs that consider homosexuality sinful or unacceptable (Erzen, 2006; Haldeman, 2004; S. L. Jones & Yarhouse, 2007; Mark, 2008; Ponticelli, 1999; Tan, 2008; Tozer & Hayes, 2004; Wolkomir, 2001, 2006; Yarhouse, 2008)
- Fear, stress, and anxiety surrounding the implications of an LGB identity (especially the illegitimacy of such an identity within the client's religious faith or community) (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008; Shidlo & Schroeder, 2002)
- Family pressure to be heterosexual and community rejection of those who are LGB (Haldeman, 2004; Glassgold, 2008; Mark, 2008; Shidlo & Schroeder, 2002; G. Smith et al., 2004)

Some individuals who have pursued SOCE report having had only unsuccessful or unfulfilling same-sex sexual experiences in venues such as bars or sexual "cruising" areas (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). These experiences reflected and re-created restricted views that the "gay lifestyle" is nonspiritual, sexually desperate, or addicted, depressive, diseased, and lonely (Drescher, 1998b; Green, 2003; Rosik, 2003; Scasta, 1998). Many sexual minority individuals who do not seek SOCE are also affected by these factors. Thus, these findings do not explain why some people seek SOCE and others do not.

There are some initial findings that suggest differences between those who seek SOCE and those who resolve their sexual minority stress through other means. For example, Ponticelli (1999) and S. L. Jones and Yarhouse (2007) reported higher levels of self-reported family violence and sexual abuse in their samples than were reported by Laumann et al. (1994) in a population-based sample. Beckstead and Morrow (2004) and S. L. Jones and Yarhouse reported high levels of parental rejection or authoritarianism among their religious samples (see also G. Smith et al., 2004). Wolkomir (2001) found that distress surrounding nonconformity to traditional gender roles distinguished the men in her sample who did not accept their sexual orientation from those who did. Similarly, Beckstead and Morrow found that distress and questions about masculinity were an important appeal of SOCE; some men who sought SOCE described feeling distress about not acting more traditionally masculine. In reviewing the SOCE literature, Miville and Ferguson (2004) proposed that White, conservatively religious men might not feel adept at managing a minority status and thus seek out SOCE as a resolution.

The views of LMHP concerning SOCE and homosexuality appear to influence clients' decision making in choosing SOCE; some clients reported being urged by their provider to participate in SOCE (M. King et al. 2004; Schroeder & Shidlo, 2001; G. Smith et al., 2004). For example, G. Smith et al. (2004) found that some who had received SOCE had not requested it. These individuals stated they had presented with confusion and distress about their orientation due to cultural and relational conflicts and were offered SOCE as the solution.

Specific Concerns of Religious Individuals

In general, the participants in research on SOCE have come from faiths that believe heterosexuality and other-sex relationships are part of the natural order and are morally superior to homosexuality (Beckstead & Morrow, 2004; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001, 2006). The literature on SOCE suggests that individuals reject or fear their same-sex sexual attractions because of the internalization of the values and attitudes of their religion that characterize homosexuality negatively and as something to avoid (Beckstead & Morrow, 2004; Erzen, 2006; Glassgold, 2008; Mark, 2008; Nicolosi et al., 2000; Ponticelli, 1999; Wolkomir, 2001, 2006).

The experiences of some conservative religious individuals with same-sex sexual attractions who undergo SOCE appear to involve significant stress due to the struggle to live life congruently with their religious beliefs (S. L. Jones & Yarhouse, 2007; Yarhouse et al., 2005; Yarhouse & Tan, 2004). These individuals perceive homosexuality to be irreconcilable with their faith and do not wish to surrender or change their faith (Wolkomir, 2006). Some report fearing considerable shifts or losses in their core identity, role, purpose, and sense of order if they were to pursue an outward LGB identity (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Wolkomir, 2006). Some report difficulty coping with intense guilt over the failure to live a virtuous life and inability to stop committing unforgivable sins, as defined by their

religion (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008). Some struggled with their belief in God, perceiving that God was punishing or abandoning them—or would if they acted on their attractions; some expressed feelings of anger at the situation in which their God had placed them (Beckstead & Morrow, 2004; Glassgold, 2008; cf. Exline, 2002; Pargament, Smith, Koenig, & Perez, 1998; Pargament et al., 2005).

Some individuals' distress took the form of a crisis of faith in which their religious beliefs that a same-sex sexual orientation and religious goodness are diametrically opposed led them to question their faith and themselves (Glassgold, 2008; Moran, 2007; Tozer & Hayes, 2004). Spiritual struggles also occurred for religious sexual minorities due to struggling with conservatively religious family, friends, and communities who thought differently than they did. The distress experienced by religious individuals appeared intense, for not only did they face sexual stigma from society at large but also messages from their faith that they were deficient, sinful, deviant, and possibly unworthy of salvation unless they changed sexual orientation (Beckstead & Morrow, 2004).

The distress experienced by religious individuals appeared intense, for not only did they face sexual stigma from society at large but also messages from their faith that they were deficient, sinful, deviant, and possibly unworthy of salvation unless they changed sexual orientation.

These spiritual struggles had mental health consequences. Clinical publications and studies of religious clients (both male and female) (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008) have described individuals who felt culpable, unacceptable, unforgiven, disillusioned, and distressed due to the conflict between their same-sex sexual attractions and religion. The inability to integrate religion and sexual orientation into a religiously sanctioned life (i.e., one that provides an option for positive self-esteem and religiously sanctioned sexuality and family life) has been described as causing great emotional distress (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008; D. F. Morrow, 2003). These spiritual struggles were sometimes associated with anxiety, panic disorders, depression, and suicidality, regardless of the level of religiosity or the perception of religion as a source of comfort and coping (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Horalcher, 2006). The emotional reactions reported in the literature on SOCE among religious individuals are consistent with those reported in the psychology of religion literature that describes both the impact of an inability to live up to religious motivations and the effects of religion and positive and negative religious coping (Ano & Vasconcelles, 2005; Exline, 2002; Pargament & Mahoney, 2002; Pargament et al., 2005; Trenholm, Trent, & Compton, 1998).

Some individuals coped by trying to compartmentalize their sexual orientation and religious identities and behaviors or to suppress one identity in favor of another (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008). Relief came as some sought repentance from their "sins," but others continued to feel isolated and unacceptable in both religious and sexual minority communities (Shidlo & Schroeder, 2002; Yarhouse & Beckstead, 2007). As an alternative, some with strong religious motivations and purpose were willing to make sexual abstinence a goal and to limit sexual and romantic needs in order to achieve congruence with their religious beliefs (S. L. Jones & Yarhouse, 2007; Yarhouse et al., 2005; Yarhouse, 2008). These choices are consistent with the psychology of religion that emphasizes religious motivations and purpose (cf. Emmons, 1999; Emmons & Paloutzian, 2003; Hayduk, Stratkotter, & Rovers, 1997; Roccas, 2005). Success with this choice varied greatly and appeared successful in a minority of participants of studies, although not always in the long term, and both positive and negative mental heath effects have been reported (Beckstead & Morrow, 2004; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Shidlo & Schroeder, 2002).

Some conservatively religious individuals felt a need to change their sexual orientation because of the positive benefits that some individuals found from religion (e.g., community, mode of life, values, sense of purpose) (Beckstead & Morrow, 2004; Borowich, 2008; Glassgold, 2008; Haldeman, 2004; Mark, 2008; Nicolosi et al., 2000; Yarhouse, 2008). Others hoped that being heterosexual would permit them to avoid further negative emotions (e.g., self-hatred, unacceptability, isolation, confusion, rejection, and suicidality) and expulsion from their religious community (Beckstead & Morrow, 2004; Borowich, 2008; Glassgold, 2008; Haldeman, 2004; Mark, 2008).

The literature on non-Christian religious denominations is very limited, and no detailed literature was found on most faiths that differed from the descriptions cited previously. There is limited information on the specific concerns of observant

and Orthodox Jews[41] (e.g., Blechner, 2008; Borowich, 2008; Glassgold, 2008; Mark, 2008; Wolowelsky & Weinstein, 1995). This work stresses the conflicts that emerge within a communal and insular culture that values obedience to religious law and separates itself from mainstream society and other faiths, including mainstream LGB communities, thus isolating those in conflict and distress (Glassgold, 2008; Mark, 2008). As marriage, family, and community are the central units of life within such a religious context, LGB individuals do not have a place in Orthodox Judaism and traditional Jewish society and may fear losing contact with family and society or bringing shame and negative consequences to their family if their sexual orientation is disclosed.[42] Many of the responses and concerns of the conservative Christian population appear relevant to those who are Orthodox Jews, especially those that arise from the conflicts of faith and sexual orientation, such as feelings of guilt, doubt, crisis of faith, unworthiness, and despair (Glassgold, 2008; Mark, 2008).

We found no scholarly psychological literature on sexual minority Muslims who seek SOCE. There is some literature on debates about homosexuality within Islam and cultural conflicts for those Muslims who live in Western societies with more progressive attitudes toward homosexuality (Halstead & Lewicka, 1998; Hekma, 2002; de Jong & Jivraj, 2002; Massad, 2002; Nahas, 2004). Additionally, there is some literature on ways in which individuals integrate LGBT identities with their Muslim faith (Minwalla, Rosser, Feldman, & Varga, 2005; Yip, 2005). We did not find scholarly articles about individuals from other faiths who sought SOCE, except for one article (Nicolosi et al., 2000) that that did not report any separate results for individuals from non-Christian faiths.

It is important to note that not all sexual minorities with strong religious beliefs experience sexual orientation distress, and some resolve such distress in other ways than SOCE.

It is important to note that not all sexual minorities with strong religious beliefs experience sexual orientation distress, and some resolve such distress in other ways than SOCE (Coyle & Rafalin, 2000; Mahaffy, 1996; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Yip, 2000, 2002, 2003, 2005). For instance, some individuals are adherents of more accepting faiths and thus experience less distress. Some end their relationship with all religious institutions, although they may retain the religious and spiritual aspects of their original faiths that are essential to them. Others choose another form of religion or spirituality that is affirming of sexual minorities (Lease, Horne, & Noffsinger-Frazier, 2005; Ritter & O'Neill, 1989, 1995; Ritter & Terndrup, 2002; Rodriguez & Ouellette, 2000; Yip, 2000, 2002, 2003, 2004).

Conflicts of Individuals in Other-Sex Marriages or Relationships

There is indication that some individuals with same-sex sexual attractions in other-sex marriages or relationships may request SOCE. Many subjects in the early studies were married (H. E. Adams & Sturgis, 1977). In the more recent research, some individuals were married (e.g., Horlacher, 2006; Spitzer, 2003), and there are clinical reports of experiences of SOCE among other-sex married people (e.g., Glassgold, 2008; Isay, 1998). For some, the marriage to an other-sex person was described as based on socialization, religious views that deny same-sex sexual attractions, lack of awareness of alternatives, and hopes that marriage would change them (Gramick, 1984; Higgins, 2006; Isay, 1998; Malcolm, 2000; Ortiz & Scott, 1994; M. W. Ross, 1989). Others did not recognize or become aware of their sexuality, including same-sex sexual attractions, until after marriage, when they became sexually active (Bozett, 1982; Carlsson, 2007; Schneider et al., 2002). Others had attractions to both men and women (Brownfain, 1985; Coleman, 1989; Wyers, 1987).

For those who experienced distress with their other-sex relationship, some were at a loss as to how to decide what to do with their conflicting needs, roles, and responsibilities and experienced considerable guilt, shame, and confusion (Beckstead & Morrow, 2004; Bozett, 1982; Buxton, 1994, 2004, 2007; Gochros, 1989; Hays & Samuels, 1989; Isay, 1998; Shidlo & Schroeder, 2002; Yarhouse & Seymore, 2006). Love for their spouse conflicted with desires to explore or act on same-sex romantic and sexual feelings and relationships or to connect with similar others (Bridges & Croteau, 1994; Coleman, 1981/1982; Yarhouse & Seymore, 2006).

[41] Among Jewish traditions, Orthodox Judaism is the most conservative and does not have a role for same-sex relationships or sexual orientation identities within its faith (Mark, 2008). Individuals in other denominations (e.g., Conservative, Reform, Reconstructionist) may not face this type of conflict or this degree of conflict.

[42] These conflicts may also be relevant to those whose religion and community are similarly intertwined and separate from larger society; see Cates (2007), for instance, regarding an individual from an Old Amish community.

However, many individuals wished to maintain their marriage and work at making that relationship last (Buxton, 2007; Glassgold, 2008; Yarhouse, Pawlowski, & Tan, 2003; Yarhouse & Seymore, 2006). Thus, the sexual minority individual sometimes felt frustrated and hopeless in facing feelings of loss and guilt that result from trying to decide whether to separate from or remain in the marriage as he or she balanced hopes and ambiguities (e.g., the chances of finding a same-sex romantic or sexual partner or the possibilities of experiencing further intimacy with one's heterosexual spouse) (Hernandez & Wilson, 2007).

Reported Impacts of Sexual Orientation Change Efforts

Perceived Positives of SOCE

In this section we review the perceptions of individuals who underwent SOCE in order to examine what may be perceived as being helpful or detrimental by such individuals, distinct from a scientific evaluation of the efficacy or harm associated with sexual orientation change efforts, as reported in Chapter 4.

Individuals have reported that SOCE provided several benefits: (a) a place to discuss their conflicts (Beckstead & Morrow, 2004; Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001); (b) cognitive frameworks that permitted them to reevaluate their sexual orientation identity, attractions, and selves in ways that lessened shame and distress and increased self-esteem (Erzen, 2006; Karten, 2006; Nicolosi et al., 2000; Ponticelli, 1999; Robinson, 1998; Schaeffer et al., 2000; Spitzer, 2003; Throckmorton, 2002); (c) social support and role models (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006); and (d) strategies for living consistently with their religious faith and community (Beckstead & Morrow, 2004; Erzen, 2006; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Robinson, 1998; Throckmorton & Welton, 2005; Wolkomir, 2001, 2006).

For instance, participants reporting beneficial effects in some studies perceived changes to their sexuality, such as in their sexual orientation, gender identity, sexual behavior, sexual orientation identity (Beckstead, 2001; Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003; Throckmorton & Welton, 2005), or improving nonsexual relationships with men (Karten, 2006). These changes in sexual self-views were described in a variety of ways (e.g., ex-gay, heterosexual, heterosexual with same-sex sexual attractions, heterosexual with a homosexual past) and with varied and unpredictable outcomes, some of which were temporary (Beckstead, 2003; Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). McConaghy (1999) reported that some men felt they had more control in their sexual behavior and struggled less with their attractions after interventions, although same-sex sexual attractions still existed (cf. Beckstead & Morrow, 2004). Additionally, some SOCE consumers noted that trying and failing to change their same-sex sexual orientation actually allowed them to accept their same-sex attractions (Beckstead & Morrow, 2004; G. Smith et al., 2004).

Participants described the social support aspects of SOCE positively. Individuals reported as positive that their LMHP accepted their goals and objections and had similar values (i.e., believing that a gay or lesbian identity is bad, sick, or inferior and not supporting same-sex relationships) (Nicolosi et al., 2000; Throckmorton & Welton, 2005). Erzen (2006), Ponticelli (1999), and Wolkomir (2001) described these religiously oriented ex-gay groups as a refuge for those who were excluded from conservative churches and from their families because of their same-sex sexual attractions, as well as from gay organizations and social networks because of their conservative religious beliefs. In Erzen's experiences with these men, these organizations seemed to provide options for individuals to remain connected to others who shared their religious beliefs, despite ongoing same-sex sexual feelings and behaviors. Wolkomir (2006) found that ex-gay groups recast homosexuality as an ordinary sin, and thus salvation was still achievable. Erzen observed that such groups built hope, recovery, and relapse into an ex-gay identity, thus expecting same-sex sexual behaviors and conceiving them as opportunities for repentance and forgiveness.

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Some participants of SOCE reported what they perceived as other positive values and beliefs underlying SOCE treatments and theories, such as supporting celibacy, validating other-sex marriage, and encouraging and supporting other-sex sexual behaviors (Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Throckmorton & Welton, 2005). For instance, many SOCE theories

and communities focus on supporting clients' values and views, often linked to religious beliefs and values (Nicolosi et al., 2000; Schaeffer et al., 2000; Throckmorton & Welton, 2005). According to Ponticelli (1999), ex-gay support groups provide alternate ways of viewing same-sex attractions that permit individuals to see themselves as heterosexual, which provided individuals a sense of possibility.

Participants' interpretations of their SOCE experiences and the outcomes of their experiences appeared to be shaped by their religious beliefs and by their motivations to be heterosexual. In Schaeffer et al. (2000), people whose motivation to change was strongly influenced by their Christian beliefs and convictions were more likely to perceive themselves as having a heterosexual sexual orientation after their efforts. Schaeffer et al. also found that those who were less religious were more likely to perceive themselves as having an LGB sexual orientation after the intervention. Some of the respondents in Spitzer's (2003) study concluded that they had altered their sexual orientation, although they continued to have same-sex sexual attractions. These findings underscore the importance of the nature and strength of participants' motivations, as well as the importance of religious identity in shaping self-reports of perceived sexual orientation change.

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A number of authors (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001; Yarhouse et al., 2005; Yarhouse & Tan, 2004) have found that identity exploration and reinterpretation were important parts of SOCE. Beckstead and Morrow (2004) described the identity development of their research participants who were or had been members of the Church of Jesus Christ of Latter-Day Saints and had undergone therapy to change their sexual orientation to heterosexual. In this research, those who experienced the most satisfaction with their lives seemed to undergo a developmental process that included the following aspects: (a) becoming disillusioned, questioning authorities, and reevaluating outside norms; (b) wavering between ex-gay, "out" gay, heterosexual, or celibate identities that depended on cultural norms and fears rather than on internally self-informed choices; and (c) resolving their conflicts through developing self-acceptance, creating a positive self-concept, and making decisions about their relationships, religion, and community affiliations based on expanded information, self-evaluations, and priorities. The participants had multiple endpoints, including LGB identity, "ex-gay" identity, no sexual orientation identity, and a unique self-identity. Some individuals chose actively to *disidentify* with a sexual minority identity so the individual's sexual orientation identity and sexual orientation could be incongruent (Wolkomir, 2001, 2006; Yarhouse, 2001; Yarhouse & Tan, 2004; Yarhouse et al., 2005).

Further, the findings suggest that some participants may have reconceptualized their *sexual orientation identity* as heterosexual but *not* achieved sexual orientation change, as they still experienced same-sex sexual attractions and desires (for a discussion of the distinction between sexual orientation and sexual orientation identity, see Chapter 3; see also R. L. Worthington, 2003; R. L. Worthington et al., 2002). For these individuals, sexual orientation identity may not reflect underlying attractions and desires (Beckstead, 2003; Beckstead & Morrow, 2004; McConaghy, 1999; Rust, 2003; Shidlo & Schroeder, 2002).

Perceived Negatives of SOCE

Participants in the studies by Beckstead and Morrow (2004) and Shidlo and Schroeder (2002) described the harm they experienced as (a) decreased self-esteem and authenticity to others; (b) increased self-hatred and negative perceptions of homosexuality; (c) confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, and suicidality; (d) anger at and a sense of betrayal by SOCE providers; (e) an increase in substance abuse and high-risk sexual behaviors; (f) a feeling of being dehumanized and untrue to self; (g) a loss of faith; and (h) a sense of having wasted time and resources. Interpreting SOCE failures as individual failures was also reported in this research, in that individuals blamed themselves for the failure (i.e., weakness, and lack of effort, commitment, faith, or worthiness in God's eyes). Intrusive images and sexual dysfunction were also reported, particularly among those who had experienced aversion techniques.

Participants in these studies related that their relationships with others were also harmed in the following ways: (a) hostility toward and blame of parents, believing their parents "caused" their homosexuality; (b) anger at and a sense of betrayal by SOCE providers; (c) loss of LGB friends and potential romantic partners because of the belief that they should

avoid sexual minority people; (d) problems in sexual and emotional intimacy with other-sex partners; (e) stress due to the negative emotions of spouses and family members because of expectations that SOCE would work (e.g., disappointment, self-blame for failure of change, perception of betrayal by partner) (see also J. G. Ford, 2001); and (f) guilt and confusion when they were sexually intimate with other same-sex members of the ex-gay groups to which they had turned for help in avoiding their attractions.

LMHP working with former participants in SOCE noted that when clients who formerly engaged in SOCE consider adopting an LGB identity or experience same-sex romantic and sexual relationships later in life, they have more difficulty with identity development due to delayed developmental tasks and dealing with any harm associated with SOCE (Haldeman, 2001; Isay, 2001). Such treatments can harm some men's understanding of their masculine identity (Haldeman, 2001; Schwartzberg & Rosenberg, 1998) and obscure other psychological issues that contribute to distress (Drescher, 1998b).

Schroeder and Shidlo (2001) identified aspects of SOCE that their participants perceived as negative, which included (a) receiving pejorative or false information regarding sexual orientation and the lives of LGB individuals; (b) encountering overly directive treatment (told not to be LGB) or to repress sexuality; (c) encountering treatments based on unsubstantiated theories or methods; (d) being misinformed about the likelihood of treatment outcomes (i.e., sexual orientation change); (e) receiving inadequate information about alternative options; and (f) being blamed for lack of progress of therapy. Some participants in Schroeder and Shidlo's (2001) study reported feeling coerced by their psychotherapist or religious institution to remain in treatment and pressured to represent to others that they had achieved a "successful reorientation" to heterosexuality.

Religiously Oriented Mutual Support Groups

Much of the literature discusses the specific dynamics and processes of religiously oriented mutual self-help groups. A reduction of distress through sexual orientation identity reconstruction or development is described in the literature of self-help or religious groups, both for individuals who reject (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006) and for individuals who accept a minority sexual orientation identity (Kerr, 1997; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Thumma, 1991; Wolkomir, 2006).

Ponticelli (1999) and Wolkomir (2001, 2006) found several emotional and cognitive processes that seemed central to the sexual orientation "identity reconstruction" (i.e., recasting oneself as ex-gay, heterosexual, disidentifying as LGB) (Ponticelli, 1999, p. 157) that appeared to relieve the distress caused by conflicts between religious values and sexual orientation (Ponticelli, 1999). Ponticelli identified certain conditions necessary for resolving identity conflicts, including (a) adopting a new discourse or worldview, (b) engaging in a biographical reconstruction, (c) embracing a new explanatory model, and (d) forming strong interpersonal ties. For those rejecting a sexual minority identity, these changes occurred by participants taking on "ex-gay" cultural norms and language and finding a community that enabled and reinforced their primary religious beliefs, values, and concerns. For instance, participants were encouraged to rely on literal interpretations of the Bible, Christian psychoanalytic theories about the causes of homosexuality, and "ex-gay" social relationships to guide and redefine their lives.

Interesting counterpoints to the SOCE support groups are LGB-affirming religious support groups. These groups employ similar emotional and cognitive strategies to provide emotional support, affirming ideologies, and identity reconstruction. Further, they appear to facilitate integration of same-sex sexual attractions and religious identities into LGB-affirming identities (Kerr, 1997; Thumma, 1991; Wolkomir, 2001, 2006).

Both sexual-minority-affirming and ex-gay mutual help groups potentially appear to offer benefits to their participants that are similar to those claimed for self-help groups, such as social support, fellowship, role models, and new ways to view a problem through unique philosophies or ideologies (cf. Levine, Perkins, & Perkins, 2004).

The philosophy of mutual help groups often gives a normalizing meaning to the individual's situation and may act as an "antidote" to a sense of deficiency (Antze, 1976). New scripts can shape how a member views and shares her or his life story by replacing existing personal or cultural scripts with the group ideology (Humphreys, 2004; Mankowski, 1997, 2000; Maton, 2000). For instance, individuals who are involved in SOCE or LGB-affirming groups may adopt a new explanation for their homosexuality that permits reconceptualizing themselves as heterosexual or acceptable as LGB people (Ponticelli, 1999; Wolkomir, 2001, 2006).

Remaining Issues

Ponticelli (1999) ended her article with the following questions: "What leads a person to choose Exodus and a frame that defined them as sinful and in need of change?" (p. 170). Why do some individuals choose SOCE over sexual-minority-affirming groups, and why are some individuals attracted to and able to find relief in a particular ideology or group over other alternatives?

There are some indications that the nature and type of religious motivation and faith play a role. In comparing individuals with intrinsic[43] and quest religious motivations, Tozer and Hayes (2004) proposed that those with a greater intrinsic religiosity may be motivated to seek out SOCE more than those with the quest motivation. However, within both groups (intrinsic and quest motivation), internalized stigma influenced who sought SOCE; those who sought SOCE had higher levels of internalized stigma. Tozer and Hayes (2004) and Mahaffy (1996) found that individuals in earlier stages of sexual minority identity development (see, e.g., Cass, 1979; Troiden, 1993) were more likely to pursue SOCE.

Wolkomir (2001, 2006) found some evidence that biographical factors may be central to these choices. Wolkomir (2006) found that motivations for participation in faith distinguished individuals who joined ex-gay groups from sexual-minority-affirming groups. For instance, men who joined conservative Christian communities as a solution to lives that had been lonely and disconnected and those who turned to faith when they felt overwhelmed by circumstance were more likely to join ex-gay groups. Wolkomir hypothesized that these men perceived homosexuality as a threat to the refuge that conservative faith provided (cf. Glassgold, 2008).

The other common path to an ex-gay (as well as, to some degree, to a sexual-minority-affirming) group was remaining in the community of faith in which one was raised and meeting the expectations of that faith, such as heterosexuality. The loss of a personal relationship or a betrayal by a loved one might influence an individual's choice of a group, and the stress of loss and the self-blame that accompany such a loss may constitute factors that lead someone to seek SOCE (Wolkomir, 2001, 2006).

Additionally, Wolkomir found that a sense of gender inadequacy (see also "gender role strain"; Levant, 1992; Pleck, 1995) made groups that embraced traditional gender roles and gender-based models of homosexuality appealing to some men. Gender-based internalized stigma and self-stigma increased distress in these men.

Finally, "contractual promises" to God (Wolkomir, 2001, p. 332) regarding other concerns (e.g., drug/alcohol abuse) increased the likelihood that men would choose ex-gay groups. However, these issues are as yet underresearched and remain unresolved.

Very little is known about the concerns of other religious faiths and diverse ethnicities and cultures (Harper et al., 2004; Miville & Ferguson, 2004). There are some studies in the empirical and theoretical literature, clinical cases, and material from other fields (e.g., anthropology, sociology) on sexual orientation among ethnic minorities and in different cultures and countries. Sexual orientation identity may be constructed differently in ethnic minority communities and internationally (Boykin, 1996; Carillo, 2002; Crawford et al., 2002; Harper et al., 2004; Mays, Cochran, & Zamudio, 2004; Miville & Ferguson, 2004; Walters, Evans-Campbell, Simoni, Ronquillo, & Bhuyan, 2006; B. D.Wilson & Miller, 2002; Zea, Diaz, & Reisen, 2003). There is some information that such populations experience distress or conflicts due to legal discrimination, cultural stigma, and other factors (McCormick, 2006), and in some other countries, homosexuality is still seen as a mental disorder or is illegal (Forstein, 2001; see also the publications of the International Gay & Lesbian Human Rights Commission: http://www.iglhrc.org). We did not identify empirical research on members of these populations who had sought or participated in SOCE other than as part of the research already cited.

Summary and Conclusion

The recent literature on those who participate in SOCE identifies a population of predominantly White men who are strongly religious and participate in conservative faiths. This contrasts with the early research that included primarily nonreligious individuals. There is a lack of research on non-Christian individuals and limited information on ethnic minority populations, women, and nonreligious populations.

The religious individuals in the recent literature report experiencing serious distress, including depression, identity confusion, and fear due to the strong prohibitions of their faith regarding same-sex sexual orientation, behaviors, and relationships.

[43] Internal motivation refers to a motivation that focuses on belief and values as ends in themselves, and quest sees religion as a process of exploration.

These individuals struggle to combine their faiths and their sexualities in meaningful personal and social identities. These struggles cause them significant distress, including frequent feelings of isolation from both religious organizations and sexual minority communities. The ensuing struggles with faith, sexuality, and identity lead many individuals to attempt sexual orientation change through professional interventions and faith-based efforts.

These individuals report a range of effects from their efforts to change their sexual orientation, including both benefits and harm. The benefits include social and spiritual support, a lessening of isolation, an understanding of values and faith, and sexual orientation identity reconstruction. The perceived harms include negative mental health effects (depression and suicidality), decreased self-esteem and authenticity to others, increased self-hatred and negative perceptions of homosexuality, a loss of faith, and a sense of having wasted time and resources.

Mutual self-help groups (whether affirming or rejecting of sexual minorities) may provide a means to resolve the distress caused by conflicts between religious values and sexual orientation.

Mutual self-help groups (whether affirming or rejecting of sexual minorities) may provide a means of resolving the distress caused by conflicts between religious values and sexual orientation (Erzen, 2006; Kerr, 1997; Ponticelli, 1999; Thumma, 1991; Wolkomir, 2001, 2006). Sexual orientation identity reconstruction found in such groups (Ponticelli, 1999; Thumma, 1991) and identity work in general may provide reduction in individual distress (Beckstead & Morrow, 2004). Individuals may seek out sexual-minority-affirming religious groups or SOCE in the form of ex-gay religious support groups due to (a) a lack of other sources of social support; (b) a desire for active coping, including both cognitive and emotional coping (Folkman & Lazarus, 1980); and (c) access to methods of sexual orientation identity exploration and reconstruction (Ponticelli, 1999; Wolkomir, 2001).

The limited information provided by the literature on individuals who experience distress with their sexual attractions and seek SOCE provides some direction to LMHP in formulating affirmative interventions for this population. The following appear to be helpful to clients:

- Finding social support and interacting with others in similar circumstances
- Experiencing understanding and recognition of the importance of religious beliefs and concerns
- Receiving empathy for their very difficult dilemmas and conflicts
- Being provided with affective and cognitive tools for identity exploration and development

Reports of clients' perceptions of harm also provide information about aspects of interventions to avoid:

- Overly directive treatment that insists on a particular outcome
- Inaccurate, stereotypic, or unscientific information or lack of positive information about sexual minorities and sexual orientation
- The use of unsound or unproven interventions
- Misinformation on treatment outcomes

It is important to note that the factors that are identified as benefits are not unique to SOCE. An affirmative and multiculturally competent framework can mitigate the harmful aspects of SOCE by addressing sexual stigma while understanding the importance of religion and social needs. An approach that integrates the information identified in this chapter as helpful is described in an affirmative model of psychotherapy in Chapter 6.

6. THE APPROPRIATE APPLICATION OF AFFIRMATIVE THERAPEUTIC INTERVENTIONS FOR ADULTS WHO SEEK SEXUAL ORIENTATION CHANGE EFFORTS

Our charge was to "generate a report that includes discussion of "the appropriate application of affirmative therapeutic interventions for children, adolescents, and adults who present [themselves for treatment expressing] a desire to change either their sexual orientation or their behavioral expression of their sexual orientation." In this chapter, we report on affirmative interventions for adults. Affirmative interventions for children and adolescents are reported separately in Chapter 8.

The appropriate application of affirmative psychotherapy is based on the following scientific facts:

- Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality; in other words, they are not indicators of mental or developmental disorders.
- Homosexuality and bisexuality are stigmatized, and this stigma can have a variety of negative consequences (e.g., minority stress) throughout the life span (D'Augelli & Patterson, 1995; DiPlacido, 1998; Herek & Garnets, 2007; Meyer, 1995, 2003).
- Same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientations and sexual orientation identities (Diamond, 2006; Hoburg et al., 2004; Rust, 1996; Savin-Williams, 2005).
- Gay men, lesbians, and bisexual individuals can live satisfying lives as well as form stable, committed relationships and families that are equivalent to heterosexual relationships in essential respects (APA, 2005c; Kurdek, 2001, 2003, 2004; Peplau & Fingerhut, 2007).
- There are no empirical studies or peer-reviewed research that support theories attributing same-sex sexual orientation to family dysfunction or trauma (Bell et al., 1981; Bene, 1965; Freund & Blanchard, 1983; Freund & Pinkava, 1961; Hooker, 1969; McCord et al., 1962; D. K. Peters & Cantrell, 1991; Siegelman, 1974, 1981; Townes et al., 1976).

A Framework for the Appropriate Application of Affirmative Therapeutic Interventions

The task force findings that are relevant to the appropriate application of affirmative therapeutic interventions for adults are the following:

1. Our systematic review of the research on sexual orientation change efforts (SOCE)[44] found that enduring change to an individual's sexual orientation as a result of SOCE was unlikely. Further, some participants were harmed by the interventions.

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

2. What appears to shift and evolve in some individuals' lives is sexual orientation identity, not sexual orientation (Beckstead, 2003; Beckstead & Morrow, 2004; Buchanan, et al., 2001; Cass, 1983/1984; Diamond, 1998, 2006; McConaghy, 1999; Ponticelli, 1999; Rust, 2003; Tan, 2008; Throckmorton & Yarhouse, 2006; Troiden, 1988; Wolkomir, 2001, 2006; R. L. Worthington, 2003, 2004).
3. Some participants in SOCE reported benefits, but the benefits were not specific to SOCE. Rather, clients perceived a benefit when offered interventions that emphasized acceptance, social support, and recognition of important values and concerns.

On the basis of theaw three findings and our comprehensive review of the research and clinical literature, we developed a framework for the appropriate application of affirmative therapeutic interventions for adults that has the following central elements: (a) acceptance and support, (b) a comprehensive assessment, (c) active coping, (d) social support, and (e) identity exploration and development.

Acceptance and Support

In our review of the research and clinical literature, we found that the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation has been grounded in a client-centered approach[45] (e.g., Astramovich, 2003; Bartoli & Gillem, 2008; Beckstead & Israel, 2007, Buchanan et al., 2001; Drescher, 1998b; Glassgold; 2008; Gonsiorek; 2004; Haldeman, 2004, Lasser & Gottlieb, 2004; Mark, 2008; Ritter & O'Neill, 1989, 1995; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008; Yarhouse & Tan, 2005a). The client-centered approach (Rogers, 1957; cf. Brown, 2006) stresses (a) the LMHP's unconditional positive regard for and congruence and empathy with the client, (b) openness to the client's perspective as a means of understanding their concerns, and (c) encouragement of the client's positive self-concept. This approach incorporates aspects of the therapeutic relationship that have been shown in the research literature to have a positive benefit, such as empathy, positive regard, and honesty (APA, 2005a, 2005b; Lambert & Barley, 2001; Norcross, 2002; Norcross & Hill, 2004).

[45] We consider the client-centered approach not as the ultimate theoretical basis of our model but as a foundation that is consistent with a variety of theoretical approaches, as most psychotherapy focuses on acceptance and support as a foundation of interventions.

This approach consists of empathic attunement to concerns regarding sexual orientation identity that acknowledges the role of cultural context and diversity and allows the different aspects of the evolving self to be acknowledged, explored, respected, and potentially rewoven into a more coherent sense of self that feels authentic to the client (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; Brown, 2006; Buchanan et al., 2001; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Mark, 2008; Miville & Ferguson, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). The empathic therapeutic environment aspires to be a place of compassionate caring and respect that facilitates development (Bronfennbrenner, 1979; Winnicott, 1965) by exploring issues without criticism or condemnation (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; McMinn, 2005; Throckmorton & Welton, 2005) and by reducing distress caused by isolation, stigma, and shame (Drescher, 1998b; Glassgold, 2008; Haldeman, 2004; Isay, 2001).

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

This approach involves empathizing with the client's desire to change his or her sexual orientation while understanding that this outcome is unlikely (Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004). Haldeman (2004) cautioned that LMHP who turn down a client's request for SOCE at the onset of treatment without exploring and understanding the many reasons why the client may wish to change may instill hopelessness in the client, who already may feel at a loss about viable options. Haldeman emphasized that before coming to a conclusion regarding treatment goals, LMHP should seek to validate the client's wish to reduce suffering and normalize the conflicts at the root of distress, as well as create a therapeutic alliance that recognizes the issues important to the client (cf. Beckstead & Israel, 2007; Glassgold, 2008; Liddle, 1996; Yarhouse, 2008).

Affirmative client-centered approaches consider sexual orientation to be uniquely individual and inseparable from an individual's personality and sense of self (Glassgold, 1995, 2008). This includes (a) being aware of the client's unique personal, social, and historical context; (b) exploring and countering the harmful impact of stigma and stereotypes on the

client's self-concept (including the prejudice related to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status); and (c) maintaining a broad view of acceptable life choices. LMHP who work with religious clients who are distressed by their sexual orientation may wish to consult the literature from the psychology of religion. This literature reminds us that religion is a complex way of making meaning that includes not only beliefs and values but also community, relationships, traditions, family ties, coping, and social identity (Mark, 2008; Pargament & Mahoney, 2002, 2005; Pargament et al., 2005; Park, 2005).

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A Comprehensive Assessment

In our review of the research and clinical literature, we found that the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation included providing a comprehensive assessment in order to obtain a fuller understanding of the multiple issues that influence that client's presentation. Such an assessment allows the LMHP and client to see the client's sexual orientation as part of the whole person and to develop interventions based on all significant variables (Beckstead & Israel, 2007; Gonsiorek, 2004; Haldeman, 2004; Lasser & Gottlieb, 2004). This comprehensive assessment includes understanding how a client's distress may involve (a) psychological disequilibrium from trying to manage the stressors (e.g., anxiety, depression, substance abuse and dependence, sexual compulsivity, posttraumatic stress disorder) and (b) negative effects from developmental experiences and traumas and the impact of cultural and family norms. Assessing the influence of factors such as age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status on the experience and expression of sexual orientation and sexual orientation identity may aid the LMHP in understanding the complexity of the client's distress.

The literature indicated that most of the individuals who are extremely distressed about their same-sex sexual orientation and who are interested in SOCE have conservative religious beliefs. A first step to addressing the conflicts regarding faith and sexual orientation is a thorough assessment of clients' spiritual and religious beliefs, religious identity and motivations, and spiritual functioning (Exline, 2002; Hathaway, Scott, & Garver, 2004; Pargament et al., 2005). This helps the LMHP understand how the current dilemmas impact clients' spiritual functioning (and vice versa) and assess resources for growth and renewal.

This assessment could include (a) understanding the specific religious beliefs of the client; (b) assessing the religious and spiritual conflicts and distress experienced by the client (Hathaway et al., 2004); (c) assessing the client's religious goals (Emmons & Paloutzian, 2003) and motivations (e.g., internal, external, quest, fundamentalism) and positive and negative ways of coping within his or her religion (Pargament, Koenig, Tasakeshwas, & Hahn, 2001; Pargament & Mahoney, 2005; Pargament et al., 1998); (d) seeking to understand the impact of religious beliefs and religious communities on the experience of the client's self-stigma, sexual prejudice, and sexual orientation identity (Beckstead & Morrow, 2004; Buchanan et al., 2001; Fulton et al., 1999; Herek, 1987; Hunsberger & Jackson, 2005; J. P. Schwartz & Lindley, 2005; Schulte & Battle, 2004); (e) developing an understanding of the client's faith identity development (Fowler, 1981, 1991; Oser, 1991; Reich, 1991; Streib, 2005) and its intersection with his or her sexual orientation identity development (Harris, Cook, & Kashubeck-West, 2008; Hoffman et al., 2007; Knight & Hoffman, 2007; Mahaffy, 1996; Yarhouse & Tan, 2005a; Yarhouse et al., 2005); and (f) enhancing with the client, when applicable, the search for meaning, significance, and a relationship with the definitions of the sacred in his or her life (Fowler, 2001; Goldstein, 2007; Pargament & Mahoney, 2005; Shafranske, 2000). Finally, an awareness of the varieties of religious faith, issues for religious minorities, and the unique role of religion in ethnic minority communities is important (Trujillo, 2000; Zea, Mason, & Muruia, 2000).

Some individuals who present with requests for SOCE may have clinical concerns that go beyond their sexual orientation conflicts. These may include mental health disorders, personality disorders, or trauma-related conditions that influence the presentation of sexual orientation conflicts and distress (cf. Brown, 2006; Drescher, 1998b; Glassgold, 2008; Haldeman,

2001; Iwasaki & Ristock, 2007; Lasser & Gottlieb, 2004; Mohr & Fassinger, 2003; S. L. Morrow, 2000; Pachankis et al., 2008; Schneider et al., 2002; Sherry, 2007; Szymanski & Kashubeck-West, 2008). Such conditions may require intervention separate from or in conjunction with the intervention directed at the sexual orientation distress. For instance, some clients who seek SOCE may have histories of trauma (Ponticelli, 1999), and in some individuals sexual abuse can cause sexual orientation identity confusion and other sexuality-related concerns (Gartner, 1999). Some heterosexual individuals may obsess over the fear of being gay and require a unique treatment model to help them accept their fear (M. Williams, 2008). Other individuals seeking SOCE may make homosexuality the explanation for all they feel is wrong with their lives (Beckstead & Morrow, 2004; Erzen, 2006; Ponticelli, 1999; Shidlo & Schroeder, 2002). This displacement of self-hatred onto homosexuality can be an attempt to resolve a sense of badness and shame (cf. Brandchaft, 2007; Drescher, 1998b), and clients may thus need effective interventions to deal with this self-hatred and shame (Brandchaft, 2007; Linehan, Dimeff, & Koerner, 2007; Zaslav, 1998).

Sexual stigma impacts a client's appraisal of sexuality, and since definitions and norms of healthy sexuality vary among individuals, LMHP, and religious and societal institutions, potential conflicts can arise for clients about what a person should do to be sexually acceptable and healthy. O'Sullivan, McCrudden, and Tolman (2006) emphasized that sexuality is an integral component of psychological health, involving mental and emotional health, physical health, and relational health.[46] Initiating sensitive but open and educated discussions with clients about their views of and experiences with sexuality may be helpful, especially for those who have never had the opportunity or the permission to talk about such issues (Schneider et al., 2002).

Active Coping

In our review of the research and clinical literature, we found that the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation seeks to increase clients' capacity for active coping to mitigate distress. Coping strategies refer to the efforts that individuals use to resolve, endure, or diminish stressful life experiences, and active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it (Folkman & Lazarus, 1980). Research has indicated that active coping is superior to other efforts, such as passive coping, and that individuals use both cognitive and emotional strategies to address stressful events (Folkman & Lazarus, 1980). These strategies are described in more depth in the following sections.

Active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it.

COGNITIVE STRATEGIES

Research on those individuals who resolve their sexual orientation conflicts indicate that cognitive strategies helped to reduce cognitive dissonance (Coyle & Rafalin, 2000; Mahaffy, 1996). One of the dilemmas for many clients who seek sexual orientation change is that they see their situation as a dichotomy. For instance, their same-sex sexual attractions make them unworthy or bad, and only if they are heterosexual can they be worthy (Beckstead & Morrow, 2004; Haldeman, 2001, 2004; Lasser & Gottlieb, 2004; D. F. Morrow, 2003; Wolkomir, 2001, 2006). Cognitive strategies can reduce the all-or-nothing thinking, mitigate self-stigma, and alter negative self-appraisals (Beckstead & Israel, 2007; Johnson, 2001, 2004; Lasser & Gottlieb, 2004; Martell et al., 2004). For example, Buchanan et al. (2001), using a narrative therapy approach, described a process of uncovering and deconstructing dominant worldviews and assumptions with conflicted clients that enabled them to redefine their attitudes toward their spirituality and sexuality (cf. Bright, 2004; Comstock, 1996; Graham, 1997; Yarhouse, 2008). Similarly, rejection of stereotypes about LGB individuals was found to be extremely important for increased psychological well-being in a mixed sample of LGB individuals (Luhtanen, 2003).

Recent developments in cognitive–behavior therapy, such as mindfulness-based cognitive therapy, dialectical

[46] The Pan American Health Organization and the World Health Organization (2000) defined sexual health in the following manner: "Sexual health is the ongoing process of physical, psychological, and sociocultural well-being in relationship to sexuality. Sexual health can be identified through the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching life within an ethical framework. It is not merely the absence of dysfunction, disease and/or infirmity. For sexual health to be attained and maintained it is necessary that sexual rights be recognized and exercised" (p. 9).

behavior therapy, and acceptance and commitment therapy techniques are relevant (e.g., Hayes, Strosahl, & Wilson, 2003; Linehan et al., 2007). Acceptance of the presence of same-sex sexual attractions and sexual orientation paired with exploring narratives or reframing cognitions, meanings, or assumptions about sexual attractions have been reported to be helpful (cf. Beckstead & Morrow, 2004; Buchanan et al., 2001; Moran, 2007; Rodriguez, 2006; Tan, 2008; Yarhouse, 2005a, 2005c; Yarhouse & Beckstead, 2007). For instance, using these techniques, Beckstead and Morrow (2004) and Tan (2008) found that clients were able to cope with their sexual arousal experiences and live with them rather than negatively judge or fight against them. Male participants in Beckstead and Morrow's (2004) investigation, regardless of their ultimate sexual orientation identity, described their ability to accept, reframe, or "surrender" to their attractions as reducing their distress by decreasing their self-judgments and reducing their fear, anxiety, and shame. However, acceptance of same-sex sexual attractions and sexual orientation may not mean the formation of an LGB sexual orientation identity; alternate identities may develop instead (Beckstead & Morrow, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008; Yarhouse et al., 2005).

Acceptance of same-sex sexual attractions and sexual orientation may not mean the formation of an LGB sexual orientation identity; alternate identities may develop instead.

For clients with strong values (religious or secular), an LMHP may wish to incorporate techniques that promote positive meaning-making, an active process through which people revise or reappraise an event or series of events (Baumeister & Vohs, 2002; cf. Taylor, 1983) to resolve issues that arise out of crises, loss, and suffering (cf. Frankl, 1992; Nolen-Hoeksema & Davis, 2002; O'Neill & Ritter, 1992; Pargament et al., 2005; Ritter & O'Neill, 1989, 1995). Such new meanings involve creating a new purpose in life, rebuilding a sense of mastery, and increasing self-worth (Nolen-Hoeksema & Davis, 2002; Pargament & Mahoney, 2002).

EMOTION-FOCUSED STRATEGIES

For those who seek SOCE, the process of addressing one's sexual orientation can be very emotionally challenging, as the desired identity does not fit the individual's psychological, emotional, or sexual predispositions and needs. The experience of irreconcilability of one's sexual orientation to one's deeply felt values, life situation, and life goals may disrupt one's core sense of meaning, purpose, efficacy, and self-worth (Beckstead & Morrow, 2004; Yarhouse, 2008; cf. Baumeister & Vohs, 2002; L. A. King & Smith, 2004) and result in emotional conflict, loss, and suffering (Glassgold, 2008; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995). Thus, emotion-focused strategies that facilitate mourning losses have reportedly been helpful to some (Beckstead & Israel, 2007; Glassgold, 2008; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Yarhouse, 2008; cf. Wolkomir, 2001, 2006).

Therapeutic outcomes that have been reported include (a) coming to terms with the disappointments and losses and with the dissonances between psychological and emotional needs and possible and impossible selves (Bartoli & Gillem, 2008; Drescher, 1998b; L.A. King & Hicks, 2007; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995); (b) clarifying and prioritizing values and needs (Glassgold, 2008; Yarhouse, 2008); and (c) learning to tolerate and adapt to the ambiguity, conflict, uncertainty, and multiplicity with a positive attitude (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; Buchanan et al., 2001; Corbett, 2001; Drescher, 1998b; Glassgold, 2008; Halbertal & Koren, 2006; Haldeman, 2002; Miville & Ferguson, 2004).

RELIGIOUS STRATEGIES

Although many individuals desire to live their lives consistently with their values, primarily their religious values, we concluded that telic congruence grounded in self-stigma and shame was unlikely to result in psychological well-being (Beckstead & Morrow, 2004; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Mark, 2008; Shidlo & Schroeder, 2002). Psychotherapeutic interventions can focus the client on positive religious coping (e.g., Ano & Vasconcelles, 2005; Pargament et al., 2005; Park, 2005; Silberman, 2005; T. B. Smith, McCullough, & Poll,

Connecting clients to core and overarching values and virtues such as charity, hope, forgiveness, gratitude, kindness, and compassion may shift the focus from their religion's rejection of homosexuality to the more accepting elements of their religion, which may provide more self-acceptance, direction, and peace.

2003) that may present the client with alternatives to the concreteness of the conflict between sexual orientation and religious values. For instance, several publications indicate that active engagement with religious texts can reduce identity conflicts by reducing the salience of negative messages about homosexuality and increasing self-authority or understanding (Brzezinski, 2000; Comstock, 1996; Coyle & Rafalin, 2000; Glassgold, 2008; Gross, 2008; Mahaffy, 1996; Ritter & O'Neill, 1989, 1995; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Schnoor, 2006; Schuck & Liddle, 2001; Thumma, 1991; Wilcox, 2001, 2002; Yip, 2002, 2003, 2005). Additionally, connecting clients to core and overarching values and virtues such as charity, hope, forgiveness, gratitude, kindness, and compassion may shift the focus from their religion's rejection of homosexuality to the more accepting elements of their religion, which may provide more self-acceptance, direction, and peace (Lease et al., 2005; McMinn, 2005). Exploration of how to integrate religious values and virtues into their sexuality may further development (cf. Helminiak, 2004).

Reframing the meaning of suffering and the burden of being conflicted as spiritual challenges rather than as divine condemnation (Glassgold, 2008; Hall & Johnson, 2001) and believing that God continues to love and accept them, because of or despite their sexual orientation, may be helpful in resolving distress (Graham, 1997; Ritter & O'Neill, 1989, 1995). For some, reframing spiritual struggles not only as a crisis of faith but also as an opportunity to increase faith or delve more deeply into it may be productive (Bartoli & Gillem, 2008; de la Huerta, 1999; Glassgold, 2008; Horne & Noffisnger-Frazier, 2003, Ritter & Terndrup, 2002).

Examining the intersection between mental health concerns and the presentation of religious beliefs can be helpful in understanding the client (Johnson, 2001, 2004; Nielsen, 2001; Pargament et al., 2005; Robb, 2001; Shrafranske, 2004). For instance, Johnson (2004) described a rational emotive behavior therapy case study that focused on reducing excessive self-criticism, which lessened the self-stigma surrounding same-sex sexual attractions. This approach seeks to understand the core depressive cognitive structures and other problematic schemata that can become associated with the clients' religious values or distort their religious values (Johnson, 2001, 2004; Nielsen, 2001; Robb, 2001).

Social Support

In our review of the research and clinical literature, we found that the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation seeks to increase clients' access to social support. As Coyle (1993) and others have noted (e.g., Wright & Perry, 2006), struggling with a devalued identity without adequate social support has the potential to erode psychological well-being. Increasing social support through psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) may relieve some distress. For instance, participants reported benefits from mutual support groups, both sexual-minority-affirming and ex-gay groups (Kerr, 1997; Ponticelli, 1999; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Rodriguez, 2006; Thumma, 1991; Wolkomir, 2001). These groups counteracted and buffered minority stress, marginalization, and isolation. Religious denominations that provide cognitive and affective strategies that aid in the resolution of cognitive dissonance and increase religious coping were helpful to religious individuals as well (Kerr, 1997; Maton, 2000; Ponticelli, 1999; Rodriguez & Ouellette, 2000: Wolkomir, 2001, 2006).

LMHP can provide clients with information about a wide range of diverse sexual minority communities and religious and faith organizations available locally, nationally, or internationally in person or over the Internet.[47] These settings can provide contexts in which clients may explore and integrate identities, find role models, and reduce self-stigma (Heinz, Gu, Inuzuka, & Zender, 2002; Johnson & Buhrke, 2006; Schneider et al., 2002). However, some groups may reinforce prejudice and stigma by providing inaccurate or stereotyped information about homosexuality, and LMHP may wish to weigh with clients alternative options in these circumstances (Schneider et al., 2002).

For those clients who cannot express all aspects of themselves in the community settings currently available to them, LMHP can help the client to consider more flexible and strategic ways of expressing the multiple aspects of self that include managing self-disclosure and multiple identities (Bing, 2004; Glassgold, 2008; Halbertal & Koran, 2006; LaFromboise, Coleman, & Gerton, 1993). Social support may be difficult to find

[47] There are growing numbers of communities available that address unique concerns and identities (see, e.g., www.safraproject.org/ for Muslim women or http://www.al-fatiha.org/ for LGB Muslims; for Orthodox Jews, see http://tirtzah.wordpress.com/).

for clients whose communities stigmatize their sexual orientation identity and other identities (e.g., ethnic, racial, religious), and these clients may benefit from considering the alternate frame that the problem does not lie with the client but with the community that is not able to affirm their sexual orientation or particular identity or meet their developmental needs (Blechner, 2008; Buchanan et al., 2001; Lasser & Gottlieb, 2004; Mark, 2008; Tremble, 1989).

Individuals with same-sex attractions in other-sex marriages may struggle with the loss (or fear of the loss) of social support and important relationships. Several authors (e.g., Alessi, 2008; Auerback & Moser, 1987; Bridges & Croteau, 1994; Brownfain, 1985; Buxton, 1994, 2001, 2004, 2007; Carlsson, 2007; Coleman, 1989; Corley & Kort, 2006; Gochros, 1989; Hernandez & Wilson, 2007; Isay, 1998; Klein & Schwartz, 2001; Malcolm, 2000; Schneider et al. 2002; Treyger, Ehlers, Zajicek, & Trepper, 2008; Yarhouse et al., 2003) have laid out counseling strategies for individuals in marriages with the other sex who consider SOCE. These strategies for individual, couples, and group counseling do not focus solely on one outcome (e.g., divorce, marriage) but on exploring the underlying personal and contextual problems, motivations, realities, and hopes for being in, leaving, or restructuring the relationship.

Identity Exploration and Development

In our review of the research and clinical literature, we found that identity issues, particularly the ability to explore and integrate aspects of the self, are central to the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation. As described in earlier sections of this report, conflicts among disparate elements of identity appear to play a major role in the distress of those seeking SOCE, and identity exploration and development appear to be ways in which individuals resolve or avoid distress (e.g., Balsam & Mohr, 2007; Beckstead & Morrow, 2004; Coyle & Rafakin, 2000; Drescher, 1998b; Glassgold, 2008; Herek & Garnets, 2007; Mahaffy, 1996; Yarhouse et al., 2005; Yip, 2002, 2003, 2005).

Ideally, identity comprises a coherent sense of one's needs, beliefs, values, and roles, including those aspects of oneself that are the bases of social stigma, such as age, gender, race, ethnicity, disability, national origin, socioeconomic status, religion, spirituality, and sexuality (G. R. Adams & Marshall, 1996; Bartoli & Gillem, 2008; Baumeister & Vohs, 2002; LaFramboise et al., 1993; Marcia, 1966; Meyers et al., 1991; R. L. Worthington et al., 2002). Marcia (1966) generated a model in which identity development is an active process of exploring and assessing one's identity and establishing a commitment to an integrated identity. R. L. Worthington et al. (2002) hypothesized that sexual orientation identity could be conceptualized along these same lines and advanced a model of heterosexual identity development based on the assumption that congruence among the dimensions of individual identity is the most adaptive status, which is achieved by active exploration. There is some empirical research supporting this model (R. L. Worthington, Navarro, Savoy, & Hampton, 2008). Additionally, research has found that the formation of a collective identity has important mental health benefits for sexual minorities by buffering individuals from sexual stigma and increasing self-esteem (Balsam & Mohr, 2007; Crawford et al., 2002; Herek & Garnets, 2007).

An affirmative approach is supportive of clients' identity development without an a priori treatment goal for how clients identify or live out their sexual orientation.

An affirmative approach is supportive of clients' identity development without an a priori treatment goal for how clients identify or live out their sexual orientation. Sexual orientation identity exploration can be helpful for those who eventually accept or reject their same-sex sexual attractions; the treatment does not differ, although the outcome does. For instance, the existing research indicates that possible outcomes of sexual orientation identity exploration for those distressed by their sexual orientation may be:

- LGB identities (Glassgold, 2008; Haldeman, 2004; Mahaffy, 1996; Yarhouse, 2008)
- Heterosexual sexual orientation identity (Beckstead & Morrow, 2004)
- Disidentifying from LGB identities (e.g., ex-gay) (Yarhouse, 2008; Yarhouse & Tan, 2004; Yarhouse et al., 2005)
- Not specifying an identity (Beckstead & Morrow, 2004; Haldeman, 2004; Tan, 2008)

The research literature indicates that there are variations in how individuals express their sexual orientation and label their identities based on ethnicity,

culture, age and generation, gender, nationality, acculturation, and religion (Boykin, 1996; Carrillo, 2002; Chan, 1997; Crawford et al., 2002; Denizet-Lewis, 2003; Kimmel & Yi, 2004; Martinez & Hosek, 2005; Miville & Ferguson, 2004; Millett, Malebranche, Mason, & Spikes, 2005; Stokes, Miller, & Mundhenk, 1998; Toro-Alfonso, 2007; Weeks, 1995; Yarhouse, 2008; Yarhouse et al., 2005; Zea et al., 2003). Some authors have provided analyses of identity that take into account diversity in sexual identity development and ethnic identity formation (Helms, 1995; LaFramboise et al., 1993; Myers et al., 1991; Yi & Shorter-Gooden, 1999), religious identity (Fowler, 1981, 1991; Oser, 1991; Strieb, 2001), as well as combinations of religious and sexual orientation identities (Coyle & Rafalin, 2000; Hoffman et al., 2007; Kerr, 1997; Knight & Hoffman, 2007; Ritter & O'Neill, 1989, 1995; Thumma, 1991; Throckmorton & Yarhouse, 2006; Yarhouse & Tan 2004).

In some of the literature on SOCE, religious beliefs and identity are presented as fixed, whereas sexual orientation is considered changeable (cf. Rosik, 2003). Given that there is a likelihood that some individuals will change religious affiliations during their lifetime (Pew Forum on Religion and Public Life, 2008) and that many scholars have found that both religious identity and sexual orientation identity evolve (Beckstead & Morrow, 2004; Fowler, 1981; Glassgold, 2008; Haldeman, 2004; Mahaffy, 1996; Ritter & Terndrup, 2002; Yarhouse & Tan, 2005b), it is important for LMHP to explore the development of religious identity and sexual orientation identity (Bartoli & Gillem, 2008). Some authors hypothesize that developmental awareness or stage of religious or sexual orientation identity may play a role in identity outcomes (Knight & Hoffman, 2007; Mahaffy, 1996; cf. Yarhouse & Tan, 2005a). Other authors have described a developmental process that includes periods of crisis, mourning, reevaluation, identity deconstruction, and growth (Comstock, 1996; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995). Others have found that individuals disidentify or reject LGB identities (Ponticelli, 1999; Wolkomir, 2001, 2006; Yarhouse et al., 2005). Thus, LMHP seeking to take an affirmative attitude recognize that individuals will define sexual orientation identities in a variety of ways (Beckstead, as cited in Shidlo, Schroeder, & Drescher, 2002; Diamond, 2003; 2006; 2008; Savin-Williams, 2005; Yarhouse et al., 2005).

Some religious individuals may wish to resolve the tension between values and sexual orientation by choosing celibacy (sexual abstinence), which in some faiths, but not all, may be a virtuous path (Olson, 2007). We found limited empirical research on the mental health consequences of that course of action.[48] Some clinical articles and surveys of individuals indicate that some may find such a life fulfilling (S. L. Jones & Yarhouse, 2007); however, there are others who cannot achieve such a goal and might struggle with depression and loneliness (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2001; Horlacher, 2006; Rodriguez, 2006; Shidlo & Schroeder, 2002). In a similar way, acting on same-sex sexual attractions may not be fulfilling solutions for others (Beckstead & Morrow, 2004; Yarhouse, 2008).

LMHP may approach such a situation by neither rejecting nor promoting celibacy but by attempting to understand how this outcome is part of the process of exploration, sexual self-awareness, and understanding of core values and goals. The therapeutic process could entail exploration of what drives this goal for clients (assessing cultural, family, personal context and issues, sexual self-stigma), the possible short- and long-term consequences/rewards, and impacts on mental health while providing education about sexual health and exploring how a client will cope with the losses and gains of this decision (cf. L. A. King & Hicks, 2007; Ritter & O'Neill, 1989, 1995).

On the basis of the aforementioned analyses, we adopted a perspective that recognizes the following:

- The important functional aspects of identity (G. R. Adams & Marshall, 1996).
- The multiplicity inherent in experience and identity, including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (Bartoli & Gillem, 2008; Miville & Ferguson, 2004; Myers et al., 1991).
- The influence of social context and the environment on identity (Baumeister & Muraven, 1996; Bronfenbrenner, 1979; Meeus, Iedema, Helsen, & Vollebergh, 1999; Myers et al., 1991; Steenbarger, 1991).
- That aspects of multiple identities are dynamic and can be in conflict (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008; D. F. Morrow, 2003; Tan, 2008; Yarhouse, 2008).

[48] However, Sipe (1990, 2003) has surveyed clergy and found difficulty in maintaining behavior consistent with aspirations. Other studies indicate that this goal is only achieved for a minority of participants who choose it (Brzezinski, 2000; S. L. Jones & Yarhouse, 2007).

- Identities can be explored, experienced, or integrated without privileging or surrendering one or another at any age (Bartoli & Gillem, 2008; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Myers et al., 1991; Phillips, 2004; Shallenberger, 1996).

Approaches based on models of biculturalism (LaFromboise et al., 1993) and pluralistic models of identity, including combining models of ethnic, sexual orientation, and religious identity that help individuals develop all aspects of self simultaneously or some sequentially, can encourage identity development and synthesis rather than identity conflict, foreclosure, or compartmentalization (Dworkin, 1997; Harris et al., 2008; Hoffman et al., 2007; Knight & Hoffman, 2007; Myers et al., 1991; Omer & Strenger, 1992; Ritter & O'Neill, 1989, 1995; Rosario, Schrimshaw, & Hunter, 2004; Rosario, Yali, Hunter, & Gwadz, 2006; Sophie, 1987; Troiden, 1988, 1993).

Sexual orientation identity exploration can help clients create a valued personal and social identity that provides self-esteem, belonging, meaning, direction, and future purpose, including the redefining of religious beliefs, identity, and motivations and the redefining of sexual values, norms, and behaviors (Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Mark, 2008; Tan, 2008; Yarhouse, 2008). We encourage LMHP to support clients in determining their own (a) goals for their identity process; (b) behavioral expression of sexual orientation; (c) public and private social roles; (d) gender role, identity, and expression; (e) sex and gender of partner; and (f) form of relationship(s).

Understanding gender roles and gender expression and developing a positive gender identity[49] continue to be concerns for many individuals who seek SOCE, especially as nonconformity with social expectations regarding gender can be a source of distress and stigma (APA, 2008e; Beckstead & Morrow, 2004; Corbett, 1996, 1998; Wolkomir, 2001). Some SOCE teach men how to adopt traditional masculine behaviors as a means of altering their sexual orientation (e.g., Nicolosi, 1991, 1993) despite the absence of evidence that such interventions affect sexual orientation. Such theoretical positions have been characterized as products of stigma and bias that are without an evidentiary basis and may increase distress (American Psychoanalytic Association, 2000; Isay, 1987, 1999; Drescher, 1998b; Haldeman, 1994, 2001). For instance, Haldeman (2001) emphasized in his clinical work with men who had participated in SOCE that some men were taught that their homosexuality made them less masculine—a belief that was ultimately damaging to their self-esteem. Research on the impact of heterosexism and traditional gender roles indicates that an individual's adoption of traditional masculine norms increases sexual self-stigma and decreases self-esteem and emotional connection with others, thus negatively affecting mental health (Szymanski & Carr, 2008).

Advances in the psychology of men and masculinity provide more appropriate conceptual models for considering gender concerns—for instance, in such concepts as gender role strain or gender role stress (cf. Butler, 2004; Enns, 2008; Fischer & Good, 1997; Heppner & Heppner, 2008; Levant, 1992; Levant & Silverstein, 2006; O'Neil, 2008; Pleck, 1995; Wester, 2008). This literature suggests exploring with clients the role of traditional gender norms in distress and reconceptualizing gender in ways that feel more authentic to the client. Such approaches could also reduce the gender stereotypes associated with same-sex sexual orientation (Corbett, 1998; Haldeman, 2001; Schwartzberg & Rosenberg, 1998). Most literature in this area suggests that for clients who experience distress with their gender-role nonconformity, LMHP provide them with a more complex theory of gender that affirms a wider range of gender diversity and expands definitions and expressions of masculinity and femininity (Butler, 2004; Corbett, 1996, 1998, 2001; Haldeman, 2001; Levant & Silverstein, 2006).

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Some women find current categories for conceptualizing their sexual orientation and sexual orientation identity limiting, as concepts in popular culture and professional literature do not mirror their experiences of fluidity and variation in sexuality and relationships (Chivers et al., 2007; Diamond, 2006, 2008; Peplau & Garnets, 2000). Some women, for example, may experience relationships with others as

[49] *Gender* refers to the roles, behaviors, activities, and attributes that a particular society considers appropriate for men and women. *Gender identity* is a person's own psychological sense of identification as male or female, another gender, or identifying with no gender. *Gender expression* is the activities and behaviors that purposely or inadvertently communicate our gender identity to others, such as clothing, hairstyles, mannerisms, way of speaking, and social roles.

important parts of sexuality and may place sexuality, sexual orientation, and sexual orientation identity in the context of interpersonal bonds and contexts (Diamond, 2003, 2006, 2008; Diamond & Savin-Williams, 2000; Garnets & Peplau, 2000; Kinnish, Strassberg, & Turner 2005; Kitzinger, & Wilkinson, 1994; Miller, 1991; Morgan & Thompson, 2006; Peplau & Garnets, 2000; Surrey, 1991). Specific psychotherapy approaches that focus on an understanding of emotional and erotic interpersonal connections in sexuality rather than simply on sexual arousal can aide LMHP in providing a positive framework and goals for therapy with women (Garnets & Peplau, 2000; Glassgold, 2008; Miller, 1991; Surrey, 1991).

For many women, religious or cultural influences discourage exploration of sexuality and do not portray female sexuality as positive or self-directed (Brown, 2006; Espin, 2005; Fassinger & Arseneau, 2006; Mahoney & Espin, 2008; Moran, 2007; Stone, 2008). Treatment might involve deconstructing cultural scripts in order to explore possibilities for religion, sexuality, sexual orientation, identity, and relationships (Avishai, 2008; Biaggio, Coan, & Adams, 2002; Morgan & Thompson, 2006; Rose & Zand, 2000).

Conclusion

The appropriate application of affirmative therapeutic interventions to adults is built on three key findings in the research: (a) An enduring change to an individual's sexual orientation as a result of SOCE was unlikely, and some participants were harmed by the interventions; (b) sexual orientation identity—not sexual orientation—appears to change via psychotherapy, support groups, and life events; and (c) clients perceive a benefit when offered interventions that emphasize acceptance, support, and recognition of important values and concerns.

On the basis of these findings and the clinical literature on this population, we suggest client-centered approaches grounded on the following scientific facts:

- Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they are not indicators of mental or developmental disorders.
- Same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientations and sexual orientation identities.
- Gay men, lesbians, and bisexual individuals can live satisfying lives as well as form stable, committed relationships and families that are equivalent to heterosexual relationships in essential respects.
- No empirical studies or peer-reviewed research support theories attributing same-sex sexual orientation to family dysfunction or trauma.

Affirmative client-centered approaches consider sexual orientation uniquely individual and inseparable from an individual's personality and sense of self (Glassgold, 1995, 2008). This includes (a) being aware of the client's unique personal, social, and historical context; (b) exploring and countering the harmful impact of stigma and stereotypes on the client's self-concept (including the prejudice related to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status); and (c) maintaining a broad view of acceptable life choices.

Psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) provide social support that can mitigate distress caused by isolation, rejection, and lack of role models.

We developed a framework for the appropriate application of affirmative therapeutic interventions for adults that has the following central elements: (a) acceptance and support, (b) comprehensive assessment, (c) active coping, (d) social support, and (e) identity exploration and development.

Acceptance and support include (a) unconditional positive regard for and empathy with the client, (b) an openness to the client's perspective as a means of understanding their concerns, and (c) encouragement of the client's positive self-concept.

Comprehensive assessment includes an awareness of the complete person, including mental health concerns that could impact distress about sexual orientation.

Active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it and includes both cognitive and emotional strategies.

Psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) provide social support that can

mitigate distress caused by isolation, rejection, and lack of role models.

Conflicts among disparate elements of identity play a major role in the conflicts and mental health concerns of those seeking SOCE. Identity exploration is an active process of exploring and assessing one's identity and establishing a commitment to an integrated identity that addresses the identity conflicts without an a priori treatment goal for how clients identify or live out their sexual orientation. The process may include a developmental process that includes periods of crisis, mourning, reevaluation, identity deconstruction, and growth.

LMHP address specific issues for religious clients by integrating aspects of the psychology of religion into their work, including obtaining a thorough assessment of clients' spiritual and religious beliefs, religious identity and motivations, and spiritual functioning; improving positive religious coping; and exploring the intersection of religious and sexual orientation identities. This framework is consistent with modern multiculturally competent approaches and evidence-based psychotherapy practices and can be integrated into a variety of theoretical systems.

7. ETHICAL CONCERNS AND DECISION MAKING IN PSYCHOTHERAPY WITH ADULTS[50]

Ethical concerns relevant to sexual orientation change efforts (SOCE)[51] have been a major theme in the literature and a central aspect of the debate around SOCE (e.g., Benoit, 2005; Cramer et al., 2008; Davison, 1976, 1978, 1991; Drescher, 1999, 2001, 2002; Gonsiorek, 2004; Haldeman, 1994, 2002, 2004; Herek, 2003; Lasser & Gottlieb, 2004; Rosik, 2003; Schreier, 1998; Schroeder & Shidlo, 2001; Sobocinski, 1990; Tozer & McClanahan, 1999; Wakefield, 2003; Yarhouse, 1998a; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002). The major concerns raised in these publications have been (a) the potential for harm, (b) the client's right to choose SOCE and other issues generally related to the ethical issue of client autonomy, and (c) questions of how to appropriately balance respect for two aspects of diversity—religion and sexual orientation. SOCE presents an ethical dilemma to practitioners because these publications have urged LMHP to pursue multiple and incompatible courses of action (cf. Kitchener, 1984).

In 1997 APA adopted the Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998). This resolution highlighted the provisions of the then-current *Ethical Principles for Psychologists and Code of Conduct* (APA, 1992) that APA believed to be relevant to situations in which clients request treatments to alter sexual orientation and psychologists provide such treatments, including the provisions regarding bias and discrimination, false or deceptive information, competence, and informed consent to treatment. For a discussion of the resolution's application to clinical situations, readers are referred to Schneider et al. (2002). In the resolution, APA also reaffirmed (a) its position that homosexuality is not a mental disorder; (b) its opposition to stigma, prejudice, and discrimination based on sexual orientation; and (c) its concern about the contribution of the promotion of SOCE to the continuation of sexual stigma in U.S. culture.

The APA's charge to the task force included "to review and update the APA Resolution on Appropriate Therapeutic Responses to Sexual Orientation." In the process of fulfilling this aspect of our charge, we considered the possibility of recommending revisions to the 1997 resolution to update it with the specific principles and standards of the 2002 APA Ethics Code. Ultimately, we decided against a revision,[52] because the relevant concepts in the two versions of the principles and code are similar. Instead, this chapter examines the relevant sections of the 2002 APA *Ethical Principles for Psychologists and Code of Conduct* [hereafter referred to as the Ethics Code] in light of current debates regarding

[50] Ethical concerns for children and adolescents are considered in Chapter 8.

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

[52] We developed a new resolution that APA adopted in August 2009 (see Appendix A)..

ethical decision making in this area.[53] We build our discussion on the concepts outlined in the 1997 resolution and discuss some of the ethical controversies in light of the newer APA Ethics Code (2002b) and of the systematic research review presented in Chapters 3 and 4 of this report. Although many of the principles and standards in the Ethics Code are potentially pertinent,[54] the principles and standards most relevant to this discussion are (in alphabetical order):

1. Bases for Scientific and Professional Judgments (Standard 2.04) and Competence (e.g., 2.01a, 2.01b)[55]
2. Principle A: Beneficence and Nonmaleficence
3. Principle D: Justice
4. Principle E: Respect for People's Rights and Dignity

Bases for Scientific and Professional Judgments and Competence

Many of the standards of the Ethics Code are derived from the ethical and valuative foundations found in the principles (Knapp & VandeCreek, 2004). Two of the more important standards are competence and the bases for scientific and professional judgments. These standards are linked, as competence is based on knowledge of the scientific evidence relevant to a case (Glassgold & Knapp, 2008). When practicing with those who seek sexual orientation change for themselves or for others, commentators on ethical practice have recommended that the practitioner understand the scientific research on sexual orientation and SOCE (Glassgold & Knapp, 2008; Schneider et al., 2002). It is obviously beyond the task force's scope to provide a systematic review of the whole body of research on sexual orientation, but we have tried to provide a systematic review of the research on SOCE in Chapters 3 and 4. From this review, we have drawn two key conclusions.

The first finding from our review is that there is insufficient evidence that SOCE are efficacious for changing sexual orientation. Furthermore, there is some evidence that such efforts cause harm. On the basis of this evidence, we consider it inappropriate for psychologists and other LMHP to foster or support in clients the expectation that they will change their sexual orientation if they participate in SOCE. We believe that among the various types of SOCE, the greatest level of ethical concern is raised by SOCE that presuppose that same-sex sexual orientation is a disorder or a symptom of a disorder.[56] Treatments based on such assumptions raise the greatest level of ethical scrutiny by LMHP because they are inconsistent with the scientific and professional consensus that homosexuality per se is not a mental disorder. Instead, we counsel LMHP to consider other treatment options when clients present with requests for sexual orientation change.

On the basis of this evidence, we consider it inappropriate for psychologists and other LMHP to foster or support in clients the expectation that they will change their sexual orientation if they participate in SOCE.

The second key finding from our review is that those who participate in SOCE, regardless of the intentions of these treatments, and those who resolve their distress through other means, may evolve during the course of their treatment in such areas as self-awareness, self-concept, and identity. These changes may include (a) sexual orientation identity, including changes in private and public identification, behavior, group membership, and affiliation; (b) emotional adjustment, including reducing self-stigma and shame; and (c) personal beliefs, values, and norms, including changes in religious and moral beliefs and behaviors and motivations (Buchanon et al., 2001; Diamond, 1998, 2006; Rust, 2003; Savin-Williams, 2004; R. L.

[53] This section is for descriptive and educational purposes. It is not designed to interpret the APA (2002b) Ethics Code. The APA Ethics Committee alone has the authority to interpret the APA (2002b) Ethics Code and render decisions about whether a course of treatment is ethical. Furthermore, this section is not intended to provide guidelines or standards for practice. Guidelines and standards for practice are created through a specific process that is outside the purview of the task force.

[54] The following are some of the pertinent standards: 2. Competence, 2.01 Boundaries of Competence, 2.03 Maintaining Competence, 2.04 Bases for Scientific and Professional Judgments; 3. Human Relations, 3.01 Unfair Discrimination, 3.03 Other Harassment, 3.04 Avoiding Harm, 3.10 Informed Consent; 5.01 Avoidance of False or Deceptive Statements, 5.04 Media Presentations; 7.01 Design of Education and Training Programs; 8.02 Informed Consent to Research; 10.01 Informed Consent to Therapy, 10.02 Therapy Involving Couples or Families.

[55] Knapp and VandeCreek (2004) proposed that Ethical Standard 2 (Competence) is derived from Principle A: Beneficence & Nonmaleficence, as it is more likely that an LMHP can provide benefit if he or she is competent; however, for our purposes, this chapter will discuss these issues sequentially.

[56] See, e.g., Socarides (1968), Hallman (2008), and Nicolosi (1991); these theories assume homosexuality is always a sign of developmental defect or mental disorder.

Worthington, 2002, 2004, 2005; Yarhouse, 2008). These areas become targets of LMHP interventions in order to reduce identity conflicts and distress and to explore and enhance the client's identity integration.

Because a large number of individuals who seek SOCE are from conservative faiths and indicate that religion is very important to them, integrating research on the psychology of religion into treatment may be helpful. For instance, individual religious motivations can be examined, positive religious coping increased, and religious identity and sexual orientation identity explored and integrated (Beckstead & Israel, 2007; Fowler, 1981; Glassgold, 2008; Haldeman, 2004; Knight & Hoffman, 2007; O'Neill & Ritter, 1992; Yarhouse & Tan, 2005a, 2005b). This is consistent with advances in the understanding of human diversity that place LGB-affirmative approaches within current multicultural perspectives that include age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (e.g., Bartoli & Gillem, 2008; Brown, 2006; Fowers & Davidov, 2006), consistent with Principle D (Justice) and Principle E (Respect for People's Rights and Dignity).

However, in some of the debates on these issues, there are tensions between conservative religious perspectives and affirmative and scientific perspectives (Haldeman, 2002; Rosik, 2003; Throckmorton & Welton, 2005; Yarhouse, 1998a; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002). Although there are tensions between religious and scientific perspectives, the task force and other scholars do not view these perspectives as mutually exclusive (Bartoli & Gillem, 2008; Haldeman, 2004; S. L. Morrow & Beckstead, 2004; Yarhouse, 2005b).

APA (2008a) delineates a perspective that affirms the importance of science in exploring and understanding human behavior while respecting religion as an important aspect of human diversity.

As we noted in the introduction, in its Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice, APA (2008a) delineates a perspective that affirms the importance of science in exploring and understanding human behavior while respecting religion as an important aspect of human diversity. Scientific findings from the psychology of religion can be incorporated into treatment, thus respecting all aspects of diversity while providing therapy that is consistent with scientific research.

Most important, respecting religious values does not require using techniques that are unlikely to have an effect. We proposed an approach that respects religious values and welcomes all of the client's actual and potential identities by exploring conflicts and identities without preconceived outcomes. This approach does not prioritize one identity over another and may aide a client in creating a sexual orientation identity consistent with religious values (see Chapter 6) (Bartoli & Gillem, 2008; Beckstead & Israel, 2007; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Tan, 2008; Yarhouse, 2008).

Benefit and Harm

Principle A of the APA Ethics Code, Beneficence and Nonmaleficence, establishes that psychologists aspire to provide services that maximize benefit and minimize harm (APA, 2002b). Many ethicists and scholars consider the avoidance of harm to be the priority of modern health care and medical ethics (Beauchamp & Childress, 2008; Herek, 2003; S. L. Morrow, 2000). The literature on effective treatments and interventions stresses that to be considered effective, interventions must not have serious negative side effects (Beutler, 2000; Flay et al., 2005). When applying this principle in the context of providing interventions, LMHP assess the risk of harm, weigh that risk with the potential benefits, and communicate this to clients through informed consent procedures that aspire to provide the client with an understanding of potential risks and benefits that are accurate and unbiased. Some of the published considerations of ethical issues related to SOCE have focused on the limited evidence for its efficacy, the potential for client harm, and the potential for misrepresentation of these issues by proponents of SOCE (Cramer et al., 2008; Haldeman, 1994, 2002, 2004; Herek, 2003; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002). Other discussions focus on other harms of SOCE, such as reinforcing bias, discrimination, and stigma against LGB individuals (Davison, 1976, 1978, 1991; Drescher, 1999, 2001, 2002; Gonsiorek, 2004).

In weighing the harm and benefit of SOCE, LMHP can review with clients the evidence presented in this report. Research on harm from SOCE is limited, and some of the research that exists suffers from methodological limitations that make broad and definitive conclusions difficult. Early well-designed experiments that used aversive and behavioral

interventions did cause inadvertent and harmful mental health effects such as increased anxiety, depression, suicidality, and loss of sexual functioning in some participants. Additionally, client dropout rate is sometimes an indication of harmful effects (Lilienfeld, 2007). Early studies with aversive procedures are characterized by very high dropout rates, perhaps indicating harmful effects, and substantial numbers of clients unwilling to participate further. Other perceptions of harm mentioned by recipients of SOCE include increased guilt and hopelessness due to the failure of the intervention, loss of spiritual faith, and a sense of personal failure and unworthiness (Beckstead & Morrow, 2004; Haldeman, 2001, 2004; Shidlo & Schroeder, 2002). Other indirect harms from SOCE include the time, energy, and cost of interventions that were not beneficial (Beckstead & Morrow, 2004; Lilienfeld, 2007; G. Smith et al., 2004).

We found limited research evidence of benefits from SOCE. There is qualitative research that describes clients' positive perceptions of such efforts, such as experiencing empathy and a supportive environment to discuss problems and share similar values, which seemed to reduce their stress about their same-sex sexual attractions (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001). The literature on SOCE support groups, for instance, illustrates results similar to those found for LGB-affirming groups and mutual help groups in general (e.g., Kerr, 1997; Levine et al., 2004; Thumma, 1991). The positive experiences clients report in SOCE are not unique. Rather, they are benefits that have been found in studies of therapeutic relationships and support groups in a number of different contexts (Levine et al., 2004; Norcross, 2002; Norcross & Hill, 2004). Thus, the benefits reported by participants in SOCE may be achieved through treatment approaches that do not attempt to change sexual orientation.

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Perceptions of risks and rewards of certain courses of action influence the individual's decisions, distress, and process of exploration in psychotherapy. The client and LMHP may define these risks and rewards differently, leading to different perceptions of benefit and harm. Recognizing, understanding, and clarifying these different perceptions of risks and rewards are crucial for a thorough ethical analysis of each client's unique situation and are aspects of client-centered approaches. For instance, an LMHP may attempt to provide information to the client to reduce sexual stigma and increase life options by informing the client about the research literature on same-sex couples. Such relationships may be threatening to the client when such a life course is perceived as being inconsistent with existing religious beliefs and motivations and potentially having negative repercussions on existing relationships with religious communities. Thus, the client and LMHP may perceive the benefits and harms of the same course of action differently. Yet, discussing positive coping resources with clients regarding how to manage such inconsistencies, stigma, and negative repercussions may provide the client with more informed and empowered solutions from which to choose, thus increasing benefit and autonomy and reducing harm.

Justice and Respect for Rights and Dignity

In this section, we focus on two concepts, Justice (Principle D) and Self-Determination (Principle E, Respect for People's Rights and Dignity). The first considers justice, both distributive and procedural justice (Knapp & VandeCreek, 2004), and the second focuses on recognizing diversity and maximizing a client's ability to choose. The APA Ethics Code uses the term *self-determination* to encompass the meanings for which many ethicists have used the term autonomy; we define self-determination as the process by which a person controls or determines the course of her or his own life (*Oxford American Dictionary*, 2007). Client self-determination encompasses the ability to seek treatment, consent to treatment, and refuse treatment. The informed consent process is one of the ways by which self-determination is maximized in psychotherapy.

Informed consent and self-determination cannot be considered without an understanding of the individual, community, and social contexts that shape the lives of sexual minorities. By understanding self-determination as context-specific and by working to increase clients' awareness of the influences of context on their decision making, the LMHP can increase clients' self-determination and thereby increase their ability to make informed life choices (Beckstead & Israel, 2007; Glassgold, 1995; 2008; Haldeman, 2004). For instance, some have suggested that social stigma and prejudice are fundamental reasons for sexual minorities' desire

to change their sexual orientation (Davison, 1976, 1978, 1982, 1991; Haldeman, 1994; Silverstein, 1991; G. Smith et al., 2004; Tozer & Hayes, 2004). As stigma, prejudice, and discrimination continue to be prevalent,[57] we recommend that LMHP strive to understand their clients' request for SOCE in the context of sexual stigma and minority stress (e.g., DiPlacido, 1998; Meyer, 2001). We further recommend that providers explore with their clients the impact of these factors on their clients' decision making in order to assess the extent to which self-determination is compromised (cf. G. Smith et al., 2004).

For instance, repressive, coercive, or invalidating cultural, social, political, and religious influences can limit autonomous expression of sexual orientation, including the awareness and exploration of options for expression of sexual orientation within an individual life (e.g., Glassgold, 2008; Mark, 2008; McCormick, 2006; G. Smith et al., 2004; Wax, 2008). We recommend that LMHP consider the impact of discrimination and stigma on the client and themselves (e.g., Beckstead & Israel, 2007; Haldeman, 2001, 2002). This consideration can become quite complex when the client or the community of the client or the LMHP believes that homosexuality is sinful and immoral (see Beckstead & Israel, 2007). Further exploration of religious beliefs and the cognitive assumptions underlying those beliefs may be helpful in understanding the client's beliefs and perception of choices (Buchanan et al., 2001; Fischer & DeBord, 2007; Johnson, 2004; Yarhouse, 2008; Yip, 2000, 2002, 2005).

The issue of self-determination has become controversial, and some have suggested that SOCE be offered in the spirit of maximizing client autonomy so that clients have access to a treatment they request (e.g., Rosik, 2003; Yarhouse & Throckmorton, 2002). Others have cautioned against providing interventions that have very limited evidence of effectiveness, run counter to current scientific knowledge, and have the potential for harm, despite client requests (Drescher, 1999, 2002; Forstein, 2001; Gonsiorek, 2004; Haldeman, 2002; Herek, 2003). With regard to claims that client autonomy is the defining concern in treatment decision making, elevating one aspect of ethical reasoning, such as autonomy, above all others is not consistent with the current framework of the APA Ethics Code or medical ethics that focus on the interrelatedness of ethical principles (Beauchamp & Childress, 2008; Knapp & VandeCreek, 2004).

For instance, current ethics guidance focuses on the interrelatedness of ethical principles and understanding a clinical situation fully so as to appropriately balance the various pertinent principles (e.g., Knapp & VandeCreek, 2004). Self-determination and autonomy can vary in degree due to interpersonal and intrapersonal concerns and can be considered in relation to other ethical principles, such as providing services that (a) are likely to provide benefit, (b) are not effective, or (c) have the potential for harm.

We believe that simply providing SOCE to clients who request it does not necessarily increase self-determination but rather abdicates the responsibility of LMHP to provide competent assessment and interventions that have the potential for benefit with a limited risk of harm. We also believe that LMHP are more likely to maximize their clients' self-determination by providing effective psychotherapy that increases a client's abilities to cope, understand, acknowledge, explore, and integrate sexual orientation concerns into a self-chosen life in which the client determines the ultimate manner in which he or she does or does not express sexual orientation (Bartoli & Gillem, 2008; Beckstead & Israel, 2007; S. L. Morrow & Beckstead, 2004; Haldeman, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008).

We also believe that LMHP are more likely to maximize their clients' self-determination by providing effective psychotherapy that increases a client's abilities to cope, understand, acknowledge, explore, and integrate sexual orientation concerns into a self-chosen life in which the client determines the ultimate manner in which he or she does or does not express sexual orientation.

Relational Issues in Treatment

Ideal or desired outcomes may not always be possible, and at times the client may face difficult decisions that

[57] For instance, the criminalization of certain forms of same-sex sexual behavior between consenting adults in private was constitutional in the United States until 2003 (see *Lawrence v. Texas*, 2003). The federal government and most U.S. states do not provide civil rights protections to LGB individuals and their families (National Gay and Lesbian Task Force: http://www.thetaskforce.org). In some other countries, homosexual behavior is still illegal and subject to extreme consequences, even death (e.g., Human Rights Watch, 2008; Wax, 2008; see also International Gay & Lesbian Human Rights Commission (IGLHRC): http://www.iglhrc.org). In extremely repressive environments, sexual orientation conversion efforts are provided in a coercive manner and have been the subject of human rights complaints (e.g., IGLHRC, 2001).

require different types and degrees of disappointment, distress, and sacrifice, as well as benefits, fulfillment, and rewards (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Yarhouse, 2008). LMHP may face strong emotions regarding the limits of their ability to provide relief from such difficult decisions or their consequences. Such emotions are understandable in this complex area, yet acting on such emotions within treatment has the potential to be harmful to the client (Knapp & VandeCreek, 2004; Pope & Vasquez, 2007). In these situations, in order to aid the client, the LMHP may have to address his or her own emotional reactions to the client's dilemmas. As the client must address regrets, losses (such as impossible and possible selves; see L. A. King & Hicks, 2007), and definitions of what is a fulfilling and worthwhile life, the LMHP must address his or her own values and beliefs about such issues. The LMHP's self-awareness, self-care, and judicious use of consultation can be helpful in these circumstances (Pope & Vasquez, 2007; Porter, 1995).

Moreover, LMHP may have their own internalized assumptions about sexual orientation, sexual orientation identity, sexuality, religion, race, ethnicity, and cultural issues (APA, 2000, 2002b; Garnets et al., 1991; McIntosh, 1990; Pharr, 1988; Richards & Bergin, 2005). The ethical principles of justice and respect for people's rights and dignity encourage LMHP to be aware of discrimination and prejudice so as to avoid condoning or colluding with the prejudices of others, including societal prejudices. As a way to increase awareness of their assumptions and promote the resolution of their own conflicts, R. L. Worthington, Dillon, and Becker-Schutte (2005) advised LMHP to develop their own competence surrounding sexual orientation, sexual minorities, and heterosexual privilege. Such competence requires self-reflection, contact with diverse sexual minority communities, and self-management of biases and sexual prejudice (cf. Israel, Ketz, Detrie, Burke, & Shulman, 2003).

Several authors (e.g., Faiver & Ingersoll, 2005; Lomax, Karff, & McKenny, 2002; Richards & Bergin, 2005; Yarhouse & Tan, 2005a; Yarhouse & VanOrman, 1999) have described potential ethical concerns related to working with religious clients. LMHP can strive to be aware of how their own religious values affect treatment and can aspire to focus on the client's perspective and aspire to become informed about the importance and content of specific religious beliefs and the psychology of religion (Bartoli, 2007; Yarhouse & Fisher, 2002; Yarhouse & VanOrman, 1999). Yet, for LMHP, the goal of treatment is determined by mental health concerns rather than directed by religious values (Gonsiorek, 2004). Although LMHP strive to respect religious diversity and to be aware of the importance of religion to clients' worldviews, LMHP focus on scientific evidence and professional judgment in determining mental health interventions (APA, 2008a; Beckstead, 2001; Glassgold, 2008; Haldeman, 2004; Yarhouse & Burkett, 2002).

Although LMHP strive to respect religious diversity and to be aware of the importance of religion to clients' worldviews, LMHP focus on scientific evidence and professional judgment in determining mental health interventions.

Summary

The principles and standards of the 2002 *Ethical Principles for Psychologists and Code of Conduct* most relevant to working with sexual minorities who seek to alter their sexual orientation are (a) Bases for Scientific and Professional Judgments (Standard 2.04) and Competence (2.01); (b) Beneficence and Nonmaleficence (Principle A); (c) Justice (Principle D); and (d) Respect for People's Rights and Dignity (Principle E). The key scientific findings relevant to the ethical concerns that are important in the area of SOCE are the limited evidence of efficacy or benefit and the potential for harm. LMHP are cautioned against promising sexual orientation change to clients. LMHP are encouraged to consider affirmative treatment options when clients present with requests for sexual orientation change. Such options include the therapeutic approaches included in Chapter 6. Self-determination is increased by approaches that support a client's exploration and development of sexual orientation identity. These approaches balance an understanding of the role of sexual stigma and respect other aspects of diversity in a client's exploration and maximize client self-determination.

8. ISSUES FOR CHILDREN, ADOLESCENTS, AND THEIR FAMILIES

Task Force Charge and Its Social Context

The task force was asked to report on three issues for children and adolescents:

- The appropriate application of affirmative therapeutic interventions for children and adolescents[58] who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.
- The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.[59]
- Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

These issues reflected recent events in the current social context. Advocacy groups (Sanchez, 2007), law journals (Goishi, 1997; Morey, 2006; Weithorn, 1987), and the news media (A. Williams, 2005) have reported on involuntary[60] sexual orientation change efforts (SOCE)[61] among adolescents. Publications by LMHP directed at parents and outreach from religious organizations advocate SOCE for children and youth as interventions to prevent adult same-sex sexual orientation (e.g., Nicolosi & Nicolosi, 2002; Rekers, 1982; see also Cianciotto & Cahill, 2006; Kennedy & Cianciotto, 2006; Sanchez, 2007).

Reports by LGB advocacy groups (e.g., Cianciotto & Cahill, 2006; Kennedy & Cianciotto, 2006) have claimed that there has been an increase in attention to youths by religious organizations that believe homosexuality is a mental illness or an adverse developmental outcome. These reports further suggested that there has

[58] In this report, we define *adolescents* as individuals between the ages of 12 and 18 and children as individuals under age 12. The age of 18 was chosen because many jurisdictions in the United States use this age as the legal age of majority, which determines issues such as consent to treatment and other relevant issues.

[59] We define *coercive treatments* as practices that compel or manipulate a child or adolescent to submit to treatment through the use of threats, intimidation, trickery, or some other form of pressure or force. The threat of future harm leads to the cooperation or obedience. Threats of negative consequences can be physical or emotional, such as threats of rejection or abandonment from or disapproval by family, community, or peer-group; engendering feelings of guilt/obligation or loss of love; exploiting physical, emotional, or spiritual dependence.

[60] We define *involuntary treatment* as that which is performed without the individual's consent or assent and which may be contrary to his or her expressed wishes. Unlike coercive treatment, no threats or intimidation are involved.

[61] In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals,

been an increase in outreach to youths that portrays homosexuality in an extremely negative light and uses fear and shame to fuel this message. These reports expressed concern that such efforts have a negative impact on adolescents' and their parents' perceptions of their sexual orientation or potential sexual orientation, increase the perception that homosexuality and religion are incompatible, and increase the likelihood that some adolescents will be exposed to SOCE without information about evidence-based treatments.

One aspect of these concerns expressed by LGB advocacy groups has been the presence of residential programs in which adolescents have been placed by their parents, in some cases with reported lack of assent from the adolescent (e.g., Cianciotto & Cahill, 2006; Kennedy & Cianciotto, 2006). In addition, a longstanding concern raised by advocacy groups for both LGB people and transgender people has been the alleged use of residential psychiatric commitment and gender-normative behavioral treatments for children and adolescents whose expression of gender or sexuality violates gender norms (Goishi, 1997; Morey, 2006; Weithorn, 1988).

To fulfill our charge, we reviewed the literature on SOCE in children and adolescents and affirmative psychotherapy for children, adolescents, and their families. We considered the literature on best practices in child and adolescent treatment, inpatient treatment, and legal issues regarding involuntary or coercive treatments and consent to and refusal of treatment. We also reviewed the literature on the development of sexual orientation in children and adolescents.

Literature Review

Literature on Children

There is a lack of published research on SOCE among children. Research on sexuality in childhood is limited and seldom includes sexual orientation or sexual orientation identity (Perrin, 2002). Although LGB adults and others with same-sex sexual attractions often report emotional and sexual feelings and attractions from their childhood or early adolescence and recall a sense of being different even earlier in childhood (Beckstead & Morrow, 2004; Bell et al., 1981; D'Augelli & Hershberger, 1993; Diamond & Savin-Williams, 2000; Troiden, 1989), such concerns have not been studied directly in young children (cf. Bailey & Zucker, 1995; Cohen & Savin-Williams, 2004).

There is no published research suggesting that children are distressed about their sexual orientation per se. Parental concern or distress about a child's behavior, mental health, and possible sexual orientation plays a central role in referrals for psychotherapy (Perrin, 2002; C. Ryan & Futterman, 1997). Parents may be concerned about behaviors in the child that are stereotypically associated with a same-sex sexual orientation (e.g., affection directed at another child of the same sex, lack of interest in the other sex, or behaviors that do not conform to traditional gender norms) (American Academy of Pediatrics [AAP], 1999; Haldeman, 2000). This situation contrasts with the condition of gender dysphoria in childhood and adolescence, for which there is clear evidence that some children and adolescents experience distress regarding their assigned sex, and some experience distress with the consequences of their gender and biological sex (i.e., youth struggling with social discrimination and stigma surrounding gender nonconformity) (APA, 2008e; R. Green, 1986, 1987; J. D. Menveille, 1998; E. J. Menveille & Tuerk, 2002; Zucker & Bradley, 1995).

Childhood interventions to prevent homosexuality have been presented in non-peer-reviewed literature (see Nicolosi & Nicolosi, 2002; Rekers, 1982).[62] These interventions are based on theories of gender and sexual orientation that conflate stereotypic gender roles or interests with heterosexuality and homosexuality or that assume that certain patterns of family relationships cause same-sex sexual orientation. These treatments focus on proxy symptoms (such as nonconforming gender behaviors), since sexual orientation as it is usually conceptualized does not emerge until puberty, with the onset of sexual desires and drives (see APA, 2002a; Perrin, 2002). These interventions assume a same-sex sexual orientation is caused by certain family relationships that form gender identity and assume that encouraging gender stereotypic behaviors and certain family relationships will alter sexual orientation (Burack & Josephson, 2005; see, e.g., Nicolosi & Nicolosi, 2002; Rekers, 1979, 1982).

[62] The only peer-reviewed literature did not focus on sexual orientation but rather on children with gender identity disorder or who exhibited nonconformity with gender roles (e.g., Rekers, 1979, 1981; Rekers, Bentler, Rosen, & Lovaas, 1977; Rekers, Kilgus, & Rosen, 1990; Rekers & Lovaas, 1974). However, the relevance of such work to this topic is limited, as none of these children reported experiencing same-sex sexual attractions or were followed into adulthood. Gender nonconformity differs from gender identity disorder, and children with gender identity disorder are not necessarily representative of the larger population of those children who will experience same-sex sexual attractions in adulthood (Bailey & Zucker, 1995; Bradley & Zucker, 1998; Zucker, 2008).

The theories on which these interventions are based have not been confirmed by empirical study (Perrin, 2002; Zucker, 2008; Zucker & Bradley, 1995). Although retrospective research indicates that some gay men and lesbians recall gender nonconformity in childhood (Bailey & Zucker, 1995; Bem, 1996; Mathy & Drescher, 2008), there is no research evidence that childhood gender nonconformity and adult homosexuality are identical or are necessarily sequential developmental phenomena (Bradley & Zucker, 1998; Zucker, 2008). Theories that certain patterns of family relationships cause same-sex sexual orientation have been discredited (Bell et al., 1981; Freund & Blanchard, 1983; R. R. Green, 1987; D. K. Peters & Cantrell, 1991).

The research that has been attempted to determine whether interventions in childhood affect adult sexual orientation exists only within the specific population of children with gender identity disorder (GID). R. Green (1986, 1987) and Zucker and Bradley (1995) (to a limited degree) examined prospectively whether psychotherapy in children with GID influenced adult or adolescent sexual orientation and concluded that it did not (for a review of the issues for children with GID, see APA, 2009, *Report of the Task Force on Gender Identity and Gender Variance*). Thus, we concluded that there is no existing research to support the hypothesis that psychotherapy in children alters adult sexual orientation.

Literature on Adolescents

We found no empirical research on adolescents who request SOCE, but there were a few clinical articles reporting cases of psychotherapy with religious adolescents who expressed confusion regarding their sexual orientation and conflicts between religious values and sexual orientation (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a; Yarhouse et al., 2005). In some of these cases, the adolescents or their families sought SOCE or considered SOCE (Cates, 2007; Yarhouse & Tan, 2005a; Yarhouse et al., 2005). The general body of research on adolescents who identify themselves as same-sex oriented does not suggest that the normal development of a same-sex sexual orientation in adolescence is typically characterized by distress that results in requests for sexual orientation change (e.g., D'Augelli, 2002; Garofalo & Harper, 2003; Savin-Williams & Cohen, 2004).

The general body of research on adolescents who identify themselves as same-sex oriented does not suggest that the normal development of a same-sex sexual orientation in adolescence is typically characterized by distress that results in requests for sexual orientation change.

The absence of evidence for adolescent sexual orientation distress that results in requests for SOCE and the few studies in the literature on religious adolescents seeking psychotherapy related to sexual orientation suggest that sexual orientation distress is most likely to occur among adolescents in families for whom religious views that homosexuality is sinful and undesirable are important. Yarhouse and colleagues (Yarhouse, 1998b; Yarhouse, Brooke, Pisano, & Tan, 2005; Yarhouse & Tan, 2005a) discussed clinical examples of distress caused by conflicts between faith and sexual orientation identity. For instance, a female adolescent client struggled with guilt and shame and fears that God would not love her, and a male adolescent experienced a conflict between believing God created him with same-sex feelings and believing that God prohibited their expression (Yarhouse & Tan, 2005a). Cates (2007) described three cases of Caucasian males who were referred by schools, courts, or parents for concerns that included their sexual orientation. All three youths perceived that within their faith community and family, an LGB identity was unacceptable and would probably result in exclusion and rejection (Cates, 2007). Because of the primacy of religious beliefs, the adolescents or their families requested religiously based therapy or SOCE. For instance, Cates described the treatment of an adolescent who belonged to the Old Amish Community and who requested SOCE. The young man perceived that there was no place for him in his faith community as a gay man and did not want to leave that community.

Research on Parents' Concerns About Their Children's Sexual Orientation

We did not find specific research on the characteristics of parents who bring their children to SOCE. Thus, we do not know whether this population is similar to or different from the more general population of parents who may have concerns or questions regarding their children's sexual orientation or future sexual orientation. We cannot conclude that parents who present to LMHP with a request for SOCE are motivated by factors that cause distress in other parents of adolescents with emerging LGB identities.

As reported in case studies and clinical papers, parents' religious beliefs appear to be factors in their request for SOCE for their children. These articles identified a population of parents who have strong conservative religious beliefs that reject LGB identities and perceive homosexuality as sinful (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a; Yarhouse et al., 2005).

Other reports suggest that parents of adolescents with emerging same-sex sexual orientation and conservative religious beliefs that perceive homosexuality negatively appear to be influenced by religious authorities and LMHP who promote SOCE. For instance, Burack and Josephson (2005) and Cianciotto and Cahill (2006) reported that fear and stereotypes appeared to be contributing factors in parents who resort to residential SOCE or other related coercive treatment on youth. Cianciotto and Cahill found that some advocacy groups do outreach to parents that encourages commitment to SOCE residential programs even if the children do not assent. These programs also appear to provide information to parents that stresses that sexual orientation can be changed (Burack & Josephson, 2005; Cianciotto & Cahill, 2006), despite the very limited empirical evidence for that assertion.

Residential and Inpatient Services

We were asked to report on "the presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation." We performed a thorough review of the literature on these programs. Upon completion of this review, we decided that the best way to address this task was to evaluate issues of the appropriateness of these programs for adolescents in light of issues of harm and benefit based on the literature on adolescent development, standards for inpatient and residential treatment, and ethical issues such as informed consent.

There are several accounts of inpatient and residential treatment, sometimes involuntary or coerced, for adolescents who were LGB-identified, confused or questioning their sexual orientation, gender nonconforming, or transgender (Arriola, 1998; Burack & Josephson, 2005; Goishi, 1997; Molnar, 1997; Weithorn, 1988). These incidents mostly occurred because the parent or guardian was distressed regarding the child's actual sexual orientation or potential and perceived sexual orientation. An account of an adolescent boy who was placed in a program sponsored by Love in Action, a religious-based program, was reported widely in the press (A. Williams, 2005). This program was reported to focus on religious approaches to SOCE as well as approaches that stress conformity to traditional gender roles and behaviors.

Concerns have arisen over the conduct of some private psychiatric hospitals that use alternative diagnoses—such as GID, conduct disorders, oppositional defiant disorders, or behaviors identified as self-defeating or self-destructive—to justify hospitalization of LGB and questioning youth and expose adolescents to SOCE (Arriola, 1998; Morey, 2006). Data on these issues are incomplete, as each state has different reporting requirements for public and private hospitals, and laws regarding confidentiality understandably protect client information.

ADOLESCENTS' RIGHTS TO CONSENT TO TREATMENT

In researching involuntary treatment, we reviewed the recent literature on the growing movement to increase adolescents' rights to consent to outpatient and inpatient mental health treatment so as to reduce involuntary hospitalization (Mutcherson, 2006; Redding, 1993). It is now recognized that adolescents are cognitively able to participate in some health care treatment decisions, and such participation is helpful (Hartman, 2000, 2002; Mutcherson, 2006; Redding, 1993). The APA *Guidelines for Psychotherapy for Lesbian, Gay, and Bisexual Clients* (2000) and the APA Ethics Code (2002b) encourage professionals to seek the assent of minor clients for treatment. Within the field of adolescent mental health and psychiatry, there are developmental assessment models to determine an adolescent's competence to assent or consent to and potentially refuse treatment (Forehand & Ciccone, 2004; Redding, 1993; Rosner, 2004a, 2004b). Some states now permit adolescents some rights regarding choosing or refusing inpatient treatment, participating in certain interventions, and control over disclosure of records (Koocher, 2003).

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INPATIENT TREATMENT

The use of inpatient and residential treatments for SOCE is inconsistent with the recommendations of the

field. For instance, the American Academy of Child and Adolescent Psychiatry (1989) recommended that inpatient treatment, when it does occur, be of the shortest possible duration and reserved for the most serious psychiatric illnesses, such as those of a psychotic nature or where there is an acute danger to self or others. For less serious mental health conditions, the Academy recommended that inpatient hospitalization occur only after less restrictive alternatives (i.e., outpatient and community resources) are shown to be ineffective. In *Best Practice Guidelines: Serving LGBT Youth in Out-of-Home Care* (Wilber, Ryan, & Marksamer, 2006), the Child Welfare League of America recommended that, if necessary, hospitalization or residential substance abuse treatment for adolescents be in a setting that provides mental health treatments that are affirmative of LGB people and for which the staff is competent to provide such services. Further, in a review of the psychiatric literature, Weithorn (1988) concluded that the deprivation of normal social contacts and prevention of attendance at school and other normal social settings can be harmful as well as punitive.

PROGRAMS WITH RELIGIOUS AFFILIATIONS

Programs such as Love in Action's Refuge[63] provided religiously based interventions that claimed to change sexual orientation, control sexual behavior, or prevent the development of same-sex sexual orientation (Burack & Josephson, 2005; Sanchez, 2007; A. Williams, 2005). Because such programs are religious in nature and are not explicitly mental health facilities,[64] they are not licensed or regulated by state authorities. Burack and Josephson reported that there was effort by religious organizations and sponsors of these programs to communicate to parents that homosexuality is abnormal and sinful and could be changed.[65] Such religious organizations, according to the authors of the report, encouraged parents to seek treatment for their children. Based on anecdotal accounts of current and past residents, these programs, to influence adolescents' life decisions, allegedly used fear and even threats about negative spiritual, health, and life consequences and thus are viewed as coercive (Burack & Josephson, 2005; Sanchez, 2007).

To provide an overview of the issues with residential programs for youth, we reviewed information gathered by the APA (2002a) Committee on Children, Youth, and Families in collaboration with the APA State Advocacy Office and the testimony and subsequent published report by members of the U.S. General Accounting Office before the Committee on Education and Labor of the U.S. House of Representatives (Kutz & O'Connell, 2007). These reports and testimony evaluated some current problems in adolescent residential mental health care. There are a large number of unlicensed and unregulated programs marketed to parents struggling to find behavioral or mental health programs for their adolescent children. Although many of these programs avoid regulation by not identifying themselves as mental health programs, they do advertise mental health, behavioral, and/or educational goals, especially for those youth perceived as troubled by their parents. Many of these programs are involuntary and coercive and use seclusion or isolation and escort services to transport unwilling youth to program locations (Kutz & O'Connell, 2007). The testimony and report described the negative mental health impacts of these programs and expressed grave concerns about them, including questions about quality of care and harm caused by coercive or involuntary measures (Kutz & O'Connell, 2007).

Although religious doctrines themselves are not the purview of psychologists, how religious doctrine is inculcated through educational and socialization practices is a psychological issue and an appropriate subject of psychological examination, especially if there are concerns regarding substantiation of benefit or harm, unlicensed and unregulated facilities, and coercive and involuntary treatment.

Thus, residential and outpatient programs that are involuntary and coercive and provide inaccurate scientific information about sexual orientation or are excessively fear-based pose both clinical and ethical concerns, whether or not they are based on religious doctrine. Although religious doctrines themselves are not the purview of psychologists, how religious doctrine is inculcated through educational and socialization practices is a psychological issue and an appropriate subject of psychological examination, especially if there are concerns regarding substantiation of benefit

[63] The program "Refuge," directed at adolescents, was closed in 2007 and is no longer advertised. However, Love in Action still sponsors residential programs for adults.

[64] These programs advertise helping with addiction, "negative self-talk and irrational belief systems," and behavior change (see www.loveinaction.org.

[65] See www.loveinaction.org.

or harm, unlicensed and unregulated facilities, and coercive and involuntary treatment.

As noted earlier, we define coercive treatments as practices that compel or manipulate an individual to submit to treatment through the use of threats, intimidation, manipulation, trickery, or some other form of pressure, including threats of future harm. Harm can be physical or psychological. Harmful psychological consequences include disapproval; loss of love; rejection or abandonment by family, community, or peer group; feelings of guilt/obligation; and exploitation of physical, emotional, or spiritual dependence. Working with a variety of client populations presents ethical dilemmas for providers (APA, 2002b; Beauchamp & Childress, 2008; Davis, 2002); however, with children and adolescents, such concerns are heightened (Molnar, 1997; Weithorn, 1988). Children and adolescents are more vulnerable to such treatments because of the lack of legal rights and cognitive and emotional maturity and emotional and physical dependence on parents, guardians, and LMHP (Molnar, 1997; Weithorn, 1988). The involuntary nature of particular programs raises issues similar to those of other involuntary mental health settings; however, because they are religious programs, not mental health programs, they pose complex issues for licensure and regulation (A. Williams, 2005). On the basis of ethical principles (APA, 2002b; Beauchamp & Childress, 2008), LMHP should strive to maximize autonomous decision making and self-determination and avoid coercive and involuntary treatments.

Appropriate Application of Affirmative Interventions With Children and Adolescents

Multicultural and Client-Centered Approaches for Adolescents

A number of researchers and practitioners have advised LMHP that when working with children or adolescents and their families, they should address concerns regarding sexual orientation and base their interventions on the current developmental literature on children and adolescents and the scholarly literature on parents' responses to their child's sexual orientation (e.g., Ben-Ari, 1995; Bernstein, 1990; Holtzen & Agriesti, 1990; Mattison & McWhirter, 1995; Perrin, 2002; C. Ryan, Huebner, Diaz, & Sanchez, 2009; Salzburg, 2004, 2007; Yarhouse & Tan, 2005a).[66] This literature recommends that LMHP learn about the law and scholarship on developmental factors in informed consent and take steps to ensure that minor clients have a developmentally appropriate understanding of treatment, are afforded complete information about their rights, and are provided treatment in the least restrictive environment. LMHP can review the recommendations for assent to treatment recommended in the *Guidelines for Psychotherapy for Lesbian, Gay, and Bisexual Clients* (APA, 2000) and can seek an adolescent's consent consistent with evolving considerations of developmental factors (Forehand & Ciccone, 2004; Redding, 1993; Rosner, 2004a, 2004b).

APA policies (APA, 1993, 2000) and the vast majority of current publications on therapy for LGB and questioning adolescents who are concerned about their sexual orientation recommend that LMHP support adolescents' exploration of identity by

- accepting homosexuality and bisexuality as normal and positive variants of human sexual orientation,
- accepting and supporting youths as they address the stigma and isolation of being a sexual minority,
- using person-centered approaches as youths explore their identities and experience important developmental milestones (e.g., exploring sexual values, dating, and socializing openly),
- reducing family and peer rejection and increasing family and peer support (e.g., APA, 2000, 2002a; D'Augelli & Patterson, 2001; Floyd & Stein, 2002; Fontaine & Hammond, 1996; Hart & Heimberg, 2001; Hetrick & Martin, 1987; Lemoire & Chen, 2005; Mallon, 2001; A. D. Martin, 1982; Perrin, 2002; Radkowsky & Siegel, 1997; C. Ryan, 2001; C. Ryan et al., 2009; C. Ryan & Diaz, 2005; C. Ryan & Futterman, 1997; Schneider, 1991; Slater, 1988; Wilber, Ryan & Marksamer, 2006; Savin-Williams & Cohen, 2004; Yarhouse & Tan, 2005a).

When sexual minority and questioning youth require residential or inpatient treatment for mental health, behavioral, or family issues, it has been recommended that such treatment be safe from discrimination and

[66] Due to the limited research on children, adolescents, and families who seek SOCE, our recommendations for affirmative therapy for children, youth, and their families distressed about sexual orientation are based on general research and clinical articles addressing these and other issues, not on research specific to those who specifically request SOCE. We acknowledge that limitation in our recommendations.

prejudice and affirming of sexual orientation diversity by staff who are knowledgeable about LGB identities and life choices (Mallon, 2001; Wilber et al., 2006).

Other aspects of human diversity, such as age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status, may be relevant to an adolescent's identity development, and these differences may intersect with sexual orientation identity (Diamond & Savin-Williams, 2000; Rosario, Rotheram-Borus, & Reid, 1996; Rosario, Schrimshaw, & Hunter, 2004; Rosario, Schrimshaw, Hunter, & Braun, 2006). Some adolescents are more comfortable with fluid or flexible identities due to gender differences and generational or developmental concerns, and their sexual orientation identities may not be exclusive or dichotomous (Diamond, 2006; Morgan & Thompson, 2006; Savin-Williams, 2005).

Only a few articles addressed the specific conflicts between religious identities and sexual orientation identities among youth (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a). For instance, Yarhouse and Tan proposed solutions that respect religious beliefs and emphasized nondirective exploration of religious and sexual orientation identity that does not advocate a particular sexual orientation identity outcome. As adolescents may experience a crisis of faith and distress linked to religious and spiritual beliefs, the authors explored interventions that integrate the psychology of religion into interventions that stress improving the client's positive religious coping and relationship with the sacred (e.g., Exline, 2002; Pargament & Mahoney, 2005; Pargament et al., 1998, 2005). Cates (2007), from a more secular frame, emphasized a client-centered approach that stresses the LMHP's unconditional acceptance of the client and client choices even if the client cannot accept his or her own sexual orientation.

The ethical issues outlined in Chapter 7 are also relevant to children and adolescents; however, working with adolescents presents unique ethical dilemmas to LMHP (Koocher, 2003). Children and adolescents are often unable to anticipate the future consequences of a course of action and are emotionally and financially dependent on adults. Further, they are in the midst of developmental processes in which the ultimate outcome is unknown. Efforts to alter that developmental path may have unanticipated consequences (Perrin, 2002). LMHP should strive to be mindful of these issues, particularly as these concerns affect assent and consent to treatment and goals of treatment (Koocher, 2003; Rosner, 2004a, 2004b; Sobocinski, 1990). Possible approaches include open-ended and scientifically based age-appropriate exploration with children, adolescents, and parents regarding these issues.

Multicultural and Client-Centered Approaches for Parents and Families

Parental attitudes and behaviors play a significant role in children's and adolescents' adjustment (Radkowsky & Siegel, 1997; C. Ryan & Diaz, 2005; C. Ryan et al., 2009; Savin-Williams, 1989b, 1998; Wilber et al., 2006; Yarhouse, 1998b). One retrospective research study of adults indicated that LGB children are more likely to be abused by their families than by nonrelated individuals (Corliss, Cochran, & Mays, 2002). Another found that family rejection is a key predictor of negative health outcomes in White and Latino LGB young adults (C. Ryan et al., 2009). Reducing parental rejection, hostility, and violence (verbal or physical) may contribute to the mental health and safety of the adolescent (Remafedi et al., 1991; C. Ryan et al., 2009; Savin-Williams, 1994; Wilber et al., 2006). Further, to improve parents' responses, LMHP can find ways to ameliorate parents' distress about their children's sexual orientation. Exploring parental attributions and values regarding same-sex sexual orientation is especially important in order to facilitate engagement in treatment, resolution of ethical dilemmas, and more beneficial psychotherapy (Morrissey-Kane & Prinz, 1999; Sobocinski, 1990).

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

Family therapy for families who are distressed by their child's sexual orientation may be helpful in facilitating dialogues, increasing acceptance and support, reducing rejection, and improving management of conflicts or misinformation that may exacerbate an adolescent's distress (Mattison & McWhirter, 1995; C. Ryan et al., 2009; Salzburg, 2004, 2007). Such therapy can include family psychoeducation to provide accurate information and teach coping skills and problem-solving strategies for dealing more effectively with the challenges sexual minority youth may face and the concerns the families and caretakers may have (Ben-Ari, 1995; Perrin, 2002; C. Ryan & Diaz, 2005; Ryan & Futterman, 1997; C. Ryan et al., 2009; Salzburg, 2004, 2007; Yarhouse, 1998b). C. Ryan and Futterman (1997) termed this *anticipatory*

guidance: LMHP provide family members with accurate information regarding same-sex sexual orientation and dispel myths regarding the lives, health, and psychological well-being of LGB individuals.

Perrin (2002) recommended that providers, when working with families of preadolescent children, counsel parents who are concerned that their young children may grow up to be lesbian or gay to tolerate the ambiguity inherent in the limited knowledge of development. In addition, Perrin suggested a two-pronged approach: (a) provide information to reduce heterosexism within the family and increase the family's capacity to provide support and (b) introduce information about LGB issues into family discussions to aid the child's own self-awareness and self-acceptance and to counter stigma. For adolescents, C. Ryan et al. (2009) recommended that LMHP assess family reactions to LGB youth, specifically the presence of family rejection. Further, the authors advocated explaining to families the link between family rejection and negative health problems in children and adolescents, providing anticipatory guidance to families that includes recommendations for support on the part of the family, and helping families to modify highly rejecting behaviors.

Families with strong religious beliefs that condemn homosexuality may struggle with a child's same-sex sexual orientation (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a). Yarhouse and Tan (2005a) suggested that family therapy reframe the religious beliefs to focus on aspects of faith that encourage love and acceptance of their child rather than on a religion's prohibitions. The authors stressed that these positive elements of faith can lay a constructive foundation for communication and problem solving and reduce family discord and rejection.

Providing anticipatory guidance to parents to address their unique personal concerns can be helpful (C. Ryan & Futterman, 1997). The LMHP can help the parents plan in an affirmative way for the unique life challenges that they may face as parents of a sexual minority child. Parents must deal with their own unique choices and process of "coming out" and resolve fears of enacted stigma if they risk disclosure within their communities, at work, and to other family members (Bernstein, 1990). Further, the LMHP can address other stresses, such as managing life celebrations and transitions and coping with feelings of loss, and aid parents in advocating for their children in school situations—for example, when they face bullying or harassment. Multiple family groups led by LMHP might be helpful to counter the isolation that many parents experience (J. D. Menveille & Tuerk, 2002).

Community Approaches for Children, Adolescents, and Families

Research has illuminated the potential that school-based and community interventions have for increasing safety and tolerance of sexual minorities, preventing distress and negative mental health consequences, and increasing the psychological well-being and health of sexual minority youth (APA, 1993; D'Augelli & Patterson, 2001; Goodenow, Szalacha, & Westheimer, 2006; Harper, Jamil, & Wilson, 2007; Kosciw & Diaz, 2006; A. J. Peters, 2003; Roffman, 2000; Safren & Heimberg, 1999; Schneider, 1991; Treadway & Yoakum, 1992). For instance, sexual minority adolescents in schools with support groups for LGB students reported lower rates of suicide attempts and victimization than those without such groups (Goodenow et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003). Kosciw and Diaz (2006) found that such support groups were related to improved academic performance and college attendance. The support groups that were examined in the research provided accurate affirmative information and social support, and the groups' presence was also related to increased school tolerance and safety for LGB youth (Goodenow et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003). School policies that increased staff support and positive school climate have been found to moderate suicidality and to positively affect sexual minority youth school achievement and mental health (Goodenow et al., 2006).

School and community interventions have the potential for introducing other sources of peer and adult support that may buffer children and adolescents from rejection that may occur in certain family, community, and religious contexts. These school and community interventions may provide alternative sources of information regarding LGB identities and lives. However, such school and community interventions are unlikely to directly affect the core attitudes and beliefs of the religious institutions and communities in which sexual orientation distress and family rejection might occur. These programs may have an indirect effect on communities and religious institutions because of their potential to change the general social context in which families deal with conflicts between their children's emerging sexual orientations and identities. We hope that such change will reduce the level of psychological

distress that such conflicts between religion and sexuality create and reduce the level of hostility and punitiveness to which some children and adolescents are exposed as a result of their sexual orientation.

For families, groups such as Parents, Families, and Friends of Lesbians and Gays (PFLAG) and the Straight Spouse Network may also provide a safe, nonjudgmental space in which to discuss their concerns, receive accurate information, reduce isolation, and reduce feelings of perceived stigma (Goldfried & Goldfried, 2001). PFLAG offers extensive literature for parents based on affirmative approaches to same-sex sexual attractions as well as a nationwide network of support groups. Such groups, by providing affirmative sources of information, could reduce the distress for parents that is and increase family support of their sexual minority children, thus positively affecting sexual minority youth and children whose families are concerned about their future sexual orientation.

Parents who are religious may benefit from finding support through religious organizations and groups. One concern is that some groups may provide parents with information that presents same-sex sexual orientation in a negative light (e.g., defective, "broken"), which could increase stigma and rejection of children and adolescents; thus, such groups should rarely be considered. Alternatively, some groups provide resources that are both LGB affirming and religious.[67]

Conclusion

We were asked to report on three issues for children and adolescents. First, we were asked to provide recommendations regarding treatment protocols that attempt to prevent homosexuality in adulthood by promoting stereotyped gender-normative behavior in children to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood. We found no empirical evidence that providing any type of therapy in childhood can alter adult same-sex sexual orientation. Some advocates of these treatments see homosexuality as a mental disorder, a concept that has been rejected by the mental health professions for more than 35 years. Further, the theories that such efforts are based on have not been corroborated by scientific evidence or evaluated for harm. Thus, we recommend that LMHP avoid such efforts and provide instead multicultural, client-centered, and affirmative treatments that are developmentally appropriate (Perrin, 2002).

Some advocates of these treatments see homosexuality as a mental disorder, a concept that has been rejected by the mental health professions for more than 35 years.

Second, we were asked to comment on the presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation. We found that serious questions are raised by involuntary and coercive interventions and residential centers for adolescents due to their advocacy of treatments that have no scientific basis and potential for harm due to coercion, stigmatization, inappropriateness of treatment level and type, and restriction of liberty. Although the prevalence of these treatment centers is unknown, we recommend that some form of oversight be established for such youth facilities, such as licensure and monitoring, especially as a means of reporting abuse or neglect.

States have different requirements and standards for obtaining informed consent to treatment for adolescents; however, it is recognized that adolescents are cognitively able to participate in some health care treatment decisions and that such participation is helpful. We recommend that when it comes to treatment that purports to have an impact on sexual orientation, LMHP assess the adolescent's ability to understand treatment options, provide developmentally appropriate informed consent to treatment, and, at a minimum, obtain the youth's assent to treatment. SOCE that focus on negative representations of homosexuality and lack a theoretical or evidence base provide no documented benefits and can pose harm through increasing sexual stigma and providing inaccurate information. We further concluded that involuntary or coercive residential or inpatient programs that provide SOCE to children and adolescents may pose serious risk of harm, are potentially in conflict with ethical imperatives to maximize autonomous decision making and client self-determination, and have no documented benefits. Thus, we recommend that parents, guardians, or youth not consider such treatments.

Finally, we were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change their sexual orientation or their behavioral

[67] See, e.g., "Family Fellowship" (www.ldsfamilyfellowship.org/) for parents who belong to the Church of Jesus Christ of Latter-Day Saints. The Institute of for Sexual Orientation and Judaism also lists resources: www.huc.edu/ijso/.

expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.

We recommend that LMHP provide multiculturally competent and client-centered therapies to children, adolescents, and their families rather than SOCE.

We recommend that LMHP provide multiculturally competent and client-centered therapies to children, adolescents, and their families rather than SOCE. Such approaches include an awareness of the interrelatedness of multiple identities in individual development as well an understanding of cultural, ethnic, and religious variation in families. Specific approaches can include (a) supporting children and youth in their developmental processes and milestones, (b) reducing internalized stigma in children and sexual stigma in parents, and (c) providing affirmative information and education on LGB identities and lives.

These approaches would support children and youth in identity exploration and development without seeking predetermined outcomes. Interventions that incorporate knowledge from the psychology of religion and that increase acceptance, love, and understanding among individuals, families, and communities are recommended for populations for whom religion is important. Family therapy that provides anticipatory guidance to parents to increase their support and reduce rejection of children and youth addressing these issues is essential. School and community interventions are also recommended to reduce societal-level stigma and provide information and social support to children and youth.

9. SUMMARY AND CONCLUSIONS

APA's charge to the task force included three major tasks that this report has addressed:

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

The substance of the second task has been achieved in the preceding chapters of this report. In Chapters 3 and 4, we reviewed the body of research on the efficacy and safety of sexual orientation change efforts (SOCE).[68] In Chapter 5 we synthesized the literature on the nature of distress and identified conflicts in adults, which provided the basis for our recommendations for affirmative approaches to psychotherapy practice that are described in Chapter 6. Chapter 7 discussed ethical issues in SOCE for adults. In Chapter 8 we considered the more limited body of research on children and adolescents, including a review of SOCE with children and adolescents and affirmative approaches for psychotherapy.

In this final chapter, we summarize the report and focus on those two tasks—one and three—that have not been addressed in the report. With regard to the policy, we recommended that the 1997 policy be retained and

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

that a new policy be adopted to complement it. The new policy that we proposed (see Appendix A) was adopted by APA's Council of Representatives in August 2009. With regard to APA's response to groups that advocate for SOCE, we provide those recommendations at the end of this chapter in the section on policy.

To achieve the charge given by APA, we decided to conduct a systematic review of the empirical literature on SOCE. This review covered the peer-reviewed journal articles in English from 1960 to 2007.[69] The review is reported in Chapters 3 and 4: Chapter 3 addresses methodological issues in the research; and Chapter 4, the outcomes, such as safety, efficacy, benefit, and harm of SOCE.

We also reviewed the recent literature on the psychology of sexual orientation. There is a growing body of literature that concludes that social stigma, known specifically as sexual stigma, manifested as prejudice and discrimination directed at same-sex sexual orientations and identities, is a major source of stress for sexual minorities. This stress, known as minority stress, is a major cause of the mental health disparities of sexual minorities. On the basis of this literature, we recommend that all interventions and policy for these populations include efforts to mitigate minority stress and reduce stigma.

Further, we found that religious individuals with beliefs that homosexuality is sinful and morally unacceptable are prominent in the population that currently undergoes SOCE. These individuals seek SOCE because the disapproving stance of their faiths toward homosexuality produces conflicts between, on the one hand, their beliefs and values and, on the other, their sexual orientation. These conflicts result in significant distress due to clients' perceptions that they are unable to integrate their faith and sexual orientation. To respond as well as possible to this population, we included in our review some of the empirical and theoretical literature from the psychology of religion, recently adopted APA policies on religion and science, and specific interventions that have been proposed in the literature for religious populations.

SOCE has been quite controversial, and the controversy has at times become polemical because of clashes between differing political viewpoints about LGB individuals and communities and the differing values between some faith-based organizations and scientific and professional organizations (Drescher, 2003; Zucker, 2008). Psychology, as a science, and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints. The APA has affirmed that proven methods of scientific inquiry are the best methods to explore and understand human behavior and are the basis for the association's policies (APA, 2007a, 2008a). The APA affirms that discrimination directed at religions and their adherents or derived from religious beliefs is unacceptable and that religious faith should be respected as an aspect of human diversity (APA, 2008c).

APA has affirmed that proven methods of scientific inquiry are the best methods to explore and understand human behavior and are the basis for the association's policies.

Summary of the Systematic Review of the Literature

To fulfill the charge given by APA, we undertook a systematic review to address the key questions: What are the outcomes of SOCE and their potential benefits and harms? Is SOCE effective or safe? The first step was to evaluate the research to determine if such conclusions could be drawn from the research—in other words, was the research performed with the appropriate degree of methodological rigor to provide such answers? The next question was to determine, if such research existed, what answers it provided.

Efficacy and Safety

We found few scientifically rigorous studies that could be used to answer the questions regarding safety, efficacy, benefit, and harm (e.g., Birk et al., 1971; S. James, 1978; McConaghy, 1969, 1976; McConaghy et al., 1972; Tanner, 1974, 1975). Few studies could be considered true experiments or quasi-experiments that would isolate and control the factors that might effect change (see the list of studies in Appendix B). These studies were all conducted in the period from 1969 to 1978 and used aversive or other behavioral methods.

Recent SOCE differ from those interventions explored in the early research studies. The recent nonreligious interventions are based on the assumption that homosexuality and bisexuality are mental

[69] The articles in English include material on populations outside the United States, including Canada, Mexico, Western Europe, and some material on Middle Eastern, South Asian, and East Asian populations. No articles based on new research have been published since 2007. One article published in 2008 is a restatement of Schaeffer et al. (2000).

disorders or deficits and are based on older discredited psychoanalytic theories (e.g., Socarides, 1968; see American Psychoanalytic Association, 1991, 1992, 2000; Drescher, 1998b; Mitchell, 1978, 1981). Some focus on increasing behavioral consistency with gender norms and stereotypes (e.g., Nicolosi, 1991). None of these approaches is based on a credible scientific theory, as these ideas have been directly discredited through evidence or rendered obsolete. There is longstanding scientific evidence that homosexuality per se is not a mental disorder (American Psychiatric Association, 1973; Bell & Weinberg, 1978; Bell et al., 1981; Conger, 1975; Gonsiorek, 1991; Hooker, 1957), and there are a number of alternate theories of sexual orientation and gender consistent with this evidence (Bem, 1996; Butler, 2004; Chivers et al., 2007; Corbett, 1996, 1998, 2001; Diamond, 1998, 2006; Drescher, 1998b; Enns, 2008; Heppner & Heppner, 2008; Levant & Silverstein, 2006; Mustanksi et al., 2002; O'Neil, 2008; Peplau & Garnets, 2000; Pleck, 1995; Rahman & Wilson, 2005; Wester, 2008).

Other forms of recent SOCE are religious, are not based on theories that can be scientifically evaluated, and have not been subjected to rigorous examination of efficacy and safety. These approaches are based on religious beliefs that homosexuality is sinful and immoral and, consequently, that identities and life paths based on same-sex sexual orientation are not religiously acceptable. The few high-quality studies of SOCE conducted from 1999 to 2004 are qualitative (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001) and these, due to the research questions explored, aid in understanding the population that seeks sexual orientation change but do not provide the kind of information needed for definitive answers to questions of the safety and efficacy of SOCE.

Thus, we concluded that the early evidence, though extremely limited, is the best basis for predicting what would be the outcome of psychological interventions. Scientifically rigorous older work in this area (e.g., Birk et al., 1971; S. James, 1978; McConaghy, 1969, 1976; McConaghy et al., 1972; Tanner, 1974, 1975) shows that enduring change to an individual's sexual orientation is uncommon and that only a very small number of people in these studies show any credible evidence of reduced same-sex sexual attraction, though some show lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and increased sexual attraction to and engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. Many individuals continued to experience same-sex sexual attractions following SOCE and seldom reported significant change to other-sex sexual attractions. Thus, we concluded the following about SOCE: *The results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex sexual attractions or increase other-sex attractions through SOCE.*

The few early research investigations that were conducted with scientific rigor raise concerns about the safety of SOCE, as some participants suffered unintended harmful side effects from the interventions. These negative side effects included loss of sexual feeling, depression, suicidality, and anxiety. The high dropout rate in these studies may indicate that some research participants may have experienced these treatments as harmful and discontinued treatment (Lilienfeld, 2007). There are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom.

Individuals Who Undergo SOCE and Their Experiences

Although scientific evidence shows that SOCE is not likely to produce its intended outcomes and can produce harm for some of its participants, there is a population of consumers who participate in SOCE. To address the questions of appropriate application of affirmative interventions for this population, which was a major aspect of APA's charge to the task force, we returned to the research literature on SOCE, expanding beyond the scope of the systematic review to include other literature in order to develop an understanding of the current population that participates in SOCE. The research does reveal something about those individuals who undergo SOCE, how they evaluate their experiences, and why they may seek SOCE, even if the research does not indicate whether SOCE has anything to do with the changes some clients perceive themselves have experienced. We sought this information to be as comprehensive as possible and to develop an information base that would serve as a basis for considering affirmative interventions.

SOCE research identifies a population of individuals who experience conflicts and distress related to same-sex sexual attractions. The population of adults included in recent SOCE research is highly religious, participating

in faiths that many would consider traditional or conservative (e.g., the Church of Jesus Christ of Latter-Day Saints [Mormon], evangelical Christian, or Orthodox Jewish). Most of the participants in recent studies are White men who report that their religion is extremely important to them (Nicolosi et al., 2000; Schaeffer et al., 2000; Shidlo & Schroeder, 2002; Spitzer, 2003). These recent studies include a small number of participants who identify as members of ethnic minority groups. Recent studies include more women than in early studies, and one qualitative study focused exclusively on women (Ponticelli, 1999). Most of the individuals studied tried a variety of methods to change their sexual orientation, including psychotherapy, support groups, and religious efforts. Many of the individuals studied were recruited from groups endorsing SOCE. The body of literature overall is based on convenience samples; thus, the relationship between the characteristics of these individuals compared to the entire population of people who seek SOCE is unknown.

Comparisons of the early and recent research indicate changes in the demographics of those who seek SOCE. The individuals who participated in early research on SOCE were also predominantly White males, but those studies included men who were court-referred to treatment, men who were referred to treatment for a range of psychiatric and sexual concerns, and men who were fearful of criminal or legal sanctions, in addition to men who were distressed by their sexual attractions. There are no data on the religious beliefs of those in the early studies. As noted previously, the individuals in recent studies indicated that religion is very important to them.

We concluded that some of the controversy surrounding SOCE can be explained by different understandings of the nature of sexual orientation and sexual orientation identity. Recent research in the field of sexual orientation indicates a range of sexual attractions and desires, sexual orientations, and multiple ways of self-labeling and self-identifying (e.g., Carrillo, 2002; Diamond, 1998, 2006, 2008; Fox, 1995; Hoburg et al., 2004; Savin-Williams, 2005). Some researchers have found that distinguishing the constructs of sexual orientation and sexual orientation identity adds clarity to an understanding of the variability in reports of these two variables (R. L. Worthington & Reynolds, 2009). *Sexual orientation* refers to an individual's patterns of sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics. Sexual orientation is tied to physiological drives and biological systems that are beyond conscious choice and involve profound emotional feelings such as "falling in love" and emotional attachment. Other dimensions commonly attributed to sexual orientation (e.g., sexual behavior with men and/or women; sexual values, norms, and motivations; social affiliations with LGB or heterosexual individuals and communities; emotional attachment preferences for men or women; gender role and identity; lifestyle choices) are potential correlates of sexual orientation rather than principal dimensions of the construct. *Sexual orientation identity* refers to recognition and internalization of sexual orientation and reflects self-awareness, self-recognition, self-labeling, group membership and affiliation, culture, and self-stigma. Sexual orientation identity is a key element in determining relational and interpersonal decisions, as it creates a foundation for the formation of community, social support, role models, friendship, and partnering (APA, 2003; Jordan & Deluty, 1998; McCarn & Fassinger, 1996; Morris, 1997).

Recent studies of SOCE participants frequently do not distinguish between sexual orientation and sexual orientation identity. We concluded that the failure to distinguish these aspects of human sexuality in this recent SOCE research has obscured an understanding of what aspects of human sexuality might and might not change through intervention. The available evidence, from both early and recent studies, suggests that although sexual orientation is unlikely to change, some individuals modified their sexual orientation identity (i.e., individual or group membership and affiliation, self-labeling) and other aspects of sexuality (i.e., values and behavior). They did so in a variety of ways and with varied and unpredictable outcomes, some of which were temporary (Beckstead, 2003; Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). For instance, in recent research, many individuals claim that through participating in SOCE, they became skilled in ignoring or tolerating their attractions or limiting the impact of their attractions on their sexual behavior (Beckstead & Morrow, 2004; McConaghy, 1976; Shidlo & Schroeder, 2002). Early nonexperimental case studies described

The available evidence, from both early and recent studies, suggests that although sexual orientation is unlikely to change, some individuals modified their sexual orientation identity (i.e., individual or group membership and affiliation, self-labeling) and other aspects of sexuality (i.e., values and behavior).

individuals who reported that they went on to lead outwardly heterosexual lives, including, for some, developing a sexual relationship with an other-sex partner and adopting a heterosexual identity (Birk, 1974; Larson, 1970). Some of these individuals reported heterosexual experience prior to treatment. People whose sexual attractions were initially limited to people of the same sex report much lower increases (if any) in other-sex attractions compared to those who report initial attractions to both men and women (Barlow et al., 1975). However, the low degree of scientific rigor in these studies makes any conclusion tentative.

Recent research indicates that former participants in SOCE report diverse evaluations of their experiences. Some individuals perceive that they have benefited from SOCE, while other individuals perceive that they have been harmed by SOCE (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002). Across studies, it is unclear what specific individual characteristics and diagnostic criteria would prospectively distinguish those individuals who will later perceive that they have succeeded and benefited from SOCE from those who will later perceive that they have failed or been harmed.

Some individuals who participated in the early research reported negative side effects such as loss of sexual arousal, impotence, depression, anxiety, and relationship dysfunction. Individuals who participated in recent research and who failed to change sexual orientation, while believing they should have changed with such efforts, described their experiences as a significant cause of emotional distress and negative self-image (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Overall, those in this recent research who indicated that they were harmed reported feelings of distress, anxiety, depression, suicidal ideation, self-blame, guilt, and loss of hope among other negative feelings. Some who experienced religious interventions and perceived them negatively said that they felt disillusioned with religion; others felt they had failed their religion by having same-sex attraction (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Indirect harm from the associated costs (time, effort, money, disillusionment with psychotherapy) spent in ineffective treatment is significant. Both the early and recent research provide little clarity on the associations between claims to modify sexual orientation from same-sex to other-sex and subsequent improvements or harm to mental health.

Other individuals reported that they perceived SOCE to be helpful by providing a place to discuss their conflicts, reduce isolation, and receive support (Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Shidlo & Schroeder, 2002; Spitzer, 2003; Wolkomir, 2001, 2006). Some reported that SOCE helped them view their sexual orientation in a different light that permitted them to live in a manner consistent with their faith, which they perceived as positive (Nicolosi et al., 2000). Some individuals described finding a sense of support and community through SOCE and valued having others with whom they could identify (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001). These effects mirror those provided by mutual support groups for a range of problems. And the positive benefits reported by participants in SOCE, such as reduction of isolation, change of meaning, and stress reduction, are consistent with the findings of social support literature (Levine et al., 2004). Given the findings of limited efficacy of change of sexual orientation, it is unlikely that SOCE provides any unique benefits other than those documented for the social support mechanisms of mutual help groups. For those who had received psychotherapy, the positive perceptions of SOCE seem inconsistent with the documented effects of the supportive function of psychotherapy relationships (e.g., Norcross, 2002).

Literature on Children and Adolescents

The task force was asked to report on the following: (a) the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change; (b) the presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation; and (c) recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

We reviewed the limited research on child and adolescent issues and drew the following conclusions: There is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation. The few studies of children with gender identity disorder found no evidence that psychotherapy provided to those children had an impact on adult sexual orientation (R. Green, 1986,

1987; Zucker, 2008; Zucker & Bradley, 1995). There is currently no evidence that teaching or reinforcing stereotyped gender-normative behavior in childhood or adolescence can alter sexual orientation (Mathy & Drescher, 2008). We are concerned that such interventions may increase the self-stigma, minority stress, and ultimately the distress of children and adolescents. We have serious concerns that the coercive or involuntary treatment of children or adolescents has the potential to be harmful and may potentially violate current clinical and practice guidelines, standards for ethical practice, and human rights.

Recommendations and Future Directions

Affirmative Psychotherapy With Adults

The appropriate application of affirmative therapeutic interventions with adults is built on three key findings in the research: (a) an enduring change to an individual's sexual orientation as a result of SOCE was unlikely, and some participants were harmed by the interventions; (b) for some individuals, sexual orientation identity, not sexual orientation, shifted and evolved via psychotherapy, support groups, or life events; and (c) clients benefit from psychotherapeutic approaches that emphasize acceptance, support, and recognition of important values and concerns.

On the basis of these findings and the clinical literature on this population, we suggest client-centered, multiculturally competent approaches grounded in the following scientific facts: (a) same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they are not indicators of mental or developmental disorders; (b) same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientations and sexual orientation identities; (c) gay men, lesbians, and bisexual individuals can live satisfying lives and form stable, committed relationships and families that are equivalent to those of heterosexual individuals in essential respects; and (d) no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma.

Based on these findings summarized above and our comprehensive review of the research and clinical literature, we developed a framework for the appropriate application of affirmative therapeutic interventions for adults that has the following central elements:

- Acceptance and support
- A comprehensive assessment
- Active coping
- Social support
- Identity exploration and development

Acceptance and support include (a) unconditional positive regard for and empathy with the client, (b) openness to the client's perspective as a means of understanding his or her concerns, and (c) encouragement of the client's positive self-concept.

A comprehensive assessment considers sexual orientation uniquely individual and inseparable from an individual's personality and sense of self. This includes (a) being aware of the client's unique personal, social, and historical context and (b) exploring and countering the harmful impact of stigma and stereotypes on the client's self-concept (including the prejudice related to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status).

Active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it and include both cognitive and emotional strategies. These may include cognitive strategies to reframe conflicts and emotional strategies to manage potential losses.

Psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) provide social support that can mitigate distress caused by isolation, rejection, and lack of role models. Conflicts among disparate elements of identity play a major role in the conflicts and mental health concerns of those seeking SOCE (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004).

Identity exploration is an active process of exploring and assessing one's identity and establishing a commitment to an integrated identity. LMHP facilitate this exploration by not having an a priori treatment goal for how clients identify or live out their sexual orientation. The process may include a developmental process that includes periods of crisis, mourning, reevaluation, identity deconstruction and reconstruction, and growth.

Treatments that are based on the assumption that homosexuality or same-sex sexual attractions are a mental disorder or based on inaccurate stereotypes regarding LGB people are to be avoided because they run counter to empirical data and because reports of harm suggest that such treatments can reinforce restricting stereotypes, increase internalized stigma, and limit a client's development (Beckstead & Morrow, 2004; Haldeman, 2001; Shidlo & Schroeder, 2002; G. Smith et al., 2004; see Lilienfeld, 2007, for information on psychotherapy harms).

Psychotherapy With Children and Adolescents

We were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or the behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change. Consistent with the current scientific evidence, those working with children and adolescents strive to have a developmentally appropriate perspective that includes a client-centered multicultural perspective to reduce self-stigma and mitigate minority stress. This includes interventions that (a) reduce stigma and isolation, (b) support the exploration and development of identity, (c) facilitate achievement of developmental milestones, and (d) respect age-appropriate issues regarding self-determination. Such services are ideally provided in the least restrictive setting and with, at a minimum, the assent of the youth. However, LMHP are encouraged to acquire developmentally appropriate informed consent to treatment.

Affirmative approaches encourage families to reduce rejection and increase acceptance of their child and adolescent (Perrin, 2002; Ryan et al., 2009). Parents who are concerned or distressed by their children's sexual orientation can be provided accurate information about sexual orientation and sexual orientation identity and offered anticipatory guidance and psychotherapy that supports family reconciliation (e.g., communication, understanding, and empathy) and maintenance of their child's total health and well-being. Interventions that increase family, school, and community acceptance and safety of sexual minority children and youth appear particularly helpful. Such interventions are offered in ways that are consistent with aspects of diversity such as age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status.

Special Concerns of Religious Individuals and Families

Many religious sexual minorities experience significant psychological distress and conflict due to the divergence between their sexual orientation and religious beliefs. To support clients who have these concerns, LMHP can provide psychological acceptance, support, and recognition of the importance of faith to individuals and communities while recognizing the science of sexual orientation. LMHP working with religious individuals and families can incorporate research from the psychology of religion into the client-centered multicultural framework summarized previously. The goal of treatment is for the client to explore possible life paths that address the reality of his or her sexual orientation while considering the possibilities for a religiously and spiritually meaningful and rewarding life. Such psychotherapy can enhance clients' search for meaning, significance, and a relationship with the sacred in their lives (e.g., Pargament & Maloney, 2005). Such an approach would focus on increasing positive religious coping, understanding religious motivations, integrating religious and sexual orientation identities, and reframing sexual orientation identities to reduce or eliminate self-stigma.

The goal of treatment is for the client to explore possible life paths that address the reality of his or her sexual orientation while considering the possibilities for a religiously and spiritually meaningful and rewarding life.

Ethical Considerations

LMHP strive to provide interventions that benefit clients and avoid harm, consistent with current professional ethics. Psychologists aspire to provide treatment that is consistent with the APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002b) and relevant APA guidelines and resolutions (e.g., APA, 2000, 2002c, 2004, 2005a, 2007b) with a special focus on ethical principles such as Beneficence and Nonmaleficence; Justice; and Respect for People's Rights and Dignity (including self-determination). LMHP reduce potential harms and increase potential benefits by basing their professional judgments

and actions on the most current and valid scientific evidence, such as that provided in this report (see APA, 2002b, Standard 2.04, Bases for Scientific and Professional Judgments).

LMHP enhance principles of social justice when they strive to understand and mitigate the effects of sexual stigma, prejudice, and discrimination on the lives of individuals, families, and communities. Further, LMHP aspire to respect diversity in all aspects of their work, including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, and socioeconomic status.

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

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

Education, Training, and Research

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

EDUCATION AND TRAINING

Professional education and training

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

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

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

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

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

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

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

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

Public education

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

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

cultural issues, and sexual orientation and sexual orientation identity.

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

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

RESEARCH

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations for basic research

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

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

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

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

Recommendations for research in psychotherapy

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

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

Policy

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

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

Thus, the task force urges APA to:

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

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

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EXHIBIT

3-C

(Deposition of Christopher Rosik, Ph.D.)

APPENDIX A: RESOLUTION ON APPROPRIATE AFFIRMATIVE RESPONSES TO SEXUAL ORIENTATION DISTRESS AND CHANGE EFFORTS

Research Summary

The longstanding consensus of the behavioral and social sciences and the health and mental health professions is that homosexuality per se is a normal and positive variation of human sexual orientation (Bell, Weinberg, & Hammersmith, 1981; Bullough, 1976; Ford & Beach 1951; Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). Homosexuality per se is not a mental disorder (APA, 1975). Since 1974, the American Psychological Association (APA) has opposed stigma, prejudice, discrimination, and violence on the basis of sexual orientation and has taken a leadership role in supporting the equal rights of lesbian, gay, and bisexual individuals (APA, 2005).

APA is concerned about ongoing efforts to mischaracterize homosexuality and promote the notion that sexual orientation can be changed and about the resurgence of sexual orientation change efforts (SOCE).[A1] SOCE has been controversial due to tensions between the values held by some faith-based organizations, on the one hand, and those held by lesbian, gay, and bisexual rights organizations and professional and scientific organizations, on the other (Drescher, 2003; Drescher & Zucker, 2006).

Some individuals and groups have promoted the idea of homosexuality as symptomatic of developmental defects or spiritual and moral failings and have argued that SOCE, including psychotherapy and religious efforts, could alter homosexual feelings and behaviors (Drescher & Zucker, 2006; Morrow & Beckstead, 2004). Many of these individuals and groups appeared to be embedded within the larger context of conservative religious political movements that have supported the stigmatization of homosexuality on political or religious grounds (Drescher, 2003; Drescher & Zucker, 2006; Southern Poverty Law Center, 2005). Psychology, as a science, and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints. The APA concludes that psychology must rely on proven methods of scientific inquiry based on empirical data, on which hypotheses and propositions are confirmed or disconfirmed, as the basis to explore and understand human behavior (APA, 2008a, 2008c).

In response to these concerns, APA appointed the Task Force on Appropriate Therapeutic Responses to Sexual Orientation to review the available research on SOCE and to provide recommendations to the association. The task force reached the following findings.

Recent studies of participants in SOCE identify a population of individuals who experience serious distress related to same-sex sexual attractions. Most of these participants are Caucasian males who report that their religion is extremely important to them (Beckstead & Morrow, 2004; Nicolosi, Byrd, & Potts,

[A1] APA uses the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a same-sex sexual orientation to heterosexual, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Shidlo & Schroeder, 2002, Spitzer, 2003). These individuals report having pursued a variety of religious and secular efforts intended to help them change their sexual orientation. To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals.

There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation. Scientifically rigorous older work in this area (e.g., Birk, Huddleston, Miller, & Cohler, 1971; James, 1978; McConaghy, 1969, 1976; McConaghy, Proctor, & Barr, 1972; Tanner, 1974, 1975) found that sexual orientation (i.e., erotic attractions and sexual arousal oriented to one sex or the other, or both) was unlikely to change due to efforts designed for this purpose. Some individuals appeared to learn how to ignore or limit their attractions. However, this was much less likely to be true for people whose sexual attractions were initially limited to people of the same sex.

Although sound data on the safety of SOCE are extremely limited, some individuals reported being harmed by SOCE. Distress and depression were exacerbated. Belief in the hope of sexual orientation change followed by the failure of the treatment was identified as a significant cause of distress and negative self-image (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002).

Although there is insufficient evidence to support the use of psychological interventions to change sexual orientation, some individuals modified their sexual orientation identity (i.e., group membership and affiliation), behavior, and values (Nicolosi et al., 2000). They did so in a variety of ways and with varied and unpredictable outcomes, some of which were temporary (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Based on the available data, additional claims about the meaning of those outcomes are scientifically unsupported.

On the basis of the task force's findings, the APA encourages mental health professionals to provide assistance to those who seek sexual orientation change by utilizing affirmative multiculturally competent (Bartoli & Gillem, 2008; Brown, 2006) and client-centered approaches (e.g., Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Lasser & Gottlieb, 2004) that recognize the negative impact of social stigma on sexual minorities (Herek, 2009; Herek & Garnets, 2007)[A2] and balance ethical principles of beneficence and nonmaleficence, justice, and respect for people's rights and dignity (APA, 1998, 2002; Davison, 1976; Haldeman, 2002; Schneider, Brown, & Glassgold, 2002).

Resolution

WHEREAS, The American Psychological Association expressly opposes prejudice (defined broadly) and discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status (APA, 1998, 2000, 2002, 2003, 2005, 2006, 2008c);

WHEREAS, The American Psychological Association takes a leadership role in opposing prejudice and discrimination (APA, 2008b, 2008c), including prejudice based on or derived from religion or spirituality, and encourages commensurate consideration of religion and spirituality as diversity variables (APA, 2008c);

WHEREAS, Psychologists respect human diversity including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (APA, 2002) and psychologists strive to prevent bias from their own spiritual, religious, or nonreligious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists (APA, 2008c);

WHEREAS, Psychologists are encouraged to recognize that it is outside the role and expertise of psychologists, as psychologists, to adjudicate religious or spiritual tenets, while also recognizing that psychologists can appropriately speak to the psychological implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist (APA, 2008c);

WHEREAS, Those operating from religious/spiritual traditions are encouraged to recognize that it is outside their role and expertise to adjudicate empirical scientific issues in psychology, while

[A2] We use the term *sexual minority* (cf. Blumenfeld, 1992; McCarn & Fassinger, 1996; Ullerstam, 1966) to designate the entire group of individuals who experience significant erotic and romantic attractions to adult members of their own sex, including those who experience attractions to members of both their own and the other sex. This term is used because we recognize that not all sexual minority individuals adopt an LGB bisexual identity.

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

WHEREAS, The American Psychological Association encourages collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles (APA, 2008c);

WHEREAS, Societal ignorance and prejudice about a same-sex sexual orientation places some sexual minorities at risk for seeking sexual orientation change due to personal, family, or religious conflicts, or lack of information (Beckstead & Morrow, 2004; Haldeman, 1994; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001);

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

WHEREAS, Sexual minority children and youth are especially vulnerable populations with unique developmental tasks (Perrin, 2002; Ryan & Futterman, 1997) who lack adequate legal protection from involuntary or coercive treatment (Arriola, 1998; Burack & Josephson, 2005; Molnar, 1997) and whose parents and guardians need accurate information to make informed decisions regarding their development and well-being (Cianciatto & Cahill, 2006; Ryan & Futterman, 1997); and

WHEREAS, Research has shown that family rejection is a predictor of negative outcomes (Remafedi, Farrow, & Deisher, 1991; Ryan, Huebner, Diaz, & Sanchez, 2009; Savin-Williams, 1994; Wilber, Ryan, & Marksamer, 2006) and that parental acceptance and school support are protective factors (D'Augelli, 2003; D'Augelli, Hershberger, & Pilkington, 1998; Goodenow, Szalacha, & Westheimer, 2006; Savin-Williams, 1989) for sexual minority youth;

THEREFORE, BE IT RESOLVED, That the American Psychological Association affirms that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

BE IT FURTHER RESOLVED, That the American Psychological Association reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that the emerging knowledge on affirmative multiculturally competent treatment provides a foundation for an appropriate evidence-based practice with children, adolescents and adults who are distressed by or seek to change their sexual orientation (Bartoli & Gillem, 2008; Brown, 2006; Martell, Safren, & Prince, 2004; Norcross, 2002; Ryan & Futterman, 1997);

BE IT FURTHER RESOLVED, That the American Psychological Association advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages practitioners to consider the ethical concerns outlined in the 1997 APA Resolution on Appropriate Therapeutic Response to Sexual Orientation (APA, 1998), in particular the following standards and principles:

Bases for Scientific and Professional Judgments, Beneficence and Harm, Justice, and Respect for People's Rights and Dignity;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages practitioners to be aware that age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status may interact with sexual stigma and contribute to variations in sexual orientation identity development, expression, and experience;

BE IT FURTHER RESOLVED, That the American Psychological Association opposes the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion and will take a leadership role in responding to such distortions;

BE IT FURTHER RESOLVED, That the American Psychological Association supports the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based in lack of knowledge about sexual orientation; and

BE IT FURTHER RESOLVED, That the American Psychological Association encourages advocacy groups, elected officials, mental health professionals, policymakers, religious professionals and organizations, and other organizations to seek areas of collaboration that may promote the well-being of sexual minorities.

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APPENDIX B: STUDIES INCLUDED (*N* = 55) IN THE SYSTEMATIC REVIEW (CHAPTERS 3 AND 4)

Study	*N*	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Experimental studies							
McConaghy, 1969	40	100	Clinical (6 by court order; 18 with arrest history)	3 withdrawals	4 treatment group randomized experiment	Immediate and delayed aversion apomorphine therapy and aversion relief therapy	Penile circumference
McConaghy, 1976	157	100	Clinical (21 by court order)	None reported	4 experimental substudies (*n*s = 40, 40, 46, 31, respectively) with random assignment to one of two or three treatment alternatives	Aversive apomorphine therapy or aversion-relief; aversive therapy or apomorphine or avoidance conditioning; classical, or avoidance, or backward conditioning; classical aversive therapy or positive conditioning	Sexual feelings; sexual behavior; penile circumference; sexual orientation
McConaghy & Barr, 1973	46	100	Clinical	26 had incomplete treatment exposure; 2 of 20 with complete exposure lost to follow-up	3 treatment group randomized experiment	Classical conditioning, avoidance conditioning, backward conditioning	Heart rate; penile circumference; galvanic skin response
McConaghy, Proctor, & Barr, 1972	40	100	Clinical (police and psychiatric referrals)	16 with incomplete follow-up data and 2 withdrawals	4 treatment group randomized experiment	Immediate and delayed aversive apomorphine therapy; immediate and delayed anticipatory avoidance learning	Penile circumference
Tanner, 1974	16	100	Clinical	None reported	Random assignment experiment with wait list control	Aversive shock therapy	Penile circumference; sexual behavior; personality
Tanner, 1975	10	100	Clinical	None reported	2 treatment group randomized experiment	Aversive shock therapy with/without booster sessions	Penile circumference; self-reported arousal; sexual behavior; personality

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Quasi-experimental studies							
Birk, Huddleston, Miller, & Cohler, 1971	18	100	Clinical	2 withdrew participation	Nonequivalent 2 treatment group comparison design	Aversive shock therapy vs. associative conditioning	Sexual behavior; clinical judgment; personality
S. James, 1978	40	100	Court-referred	None reported	Nonequivalent 2 treatment group comparison design	Anticipatory avoidance, desensitization, hypnosis, anticipatory avoidance	Sexual orientation; personality
McConaghy, Armstrong, & Blaszczynski, 1981	20	100	Clinical	None reported	Nonequivalent 2 treatment group comparison design	Aversive therapy; covert sensitization	Sexual feelings
Nonexperimental studies							
Bancroft, 1969	16	100	Clinical	6 withdrew participation prior to treatment and 1 during treatment	Case study	Aversive shock therapy	Sexual behavior
Barlow & Agras, 1973	3	100	Clinical	None reported	Case study	Fading	Penile circumference; sexual urges; sexual fantasies
Barlow, Agrus, Abel, Blanchard, & Young, 1975	3	100	Clinical	None reported	Single case pre–post within-subject	Biofeeback	Penile circumference
Beckstead & Morrow, 2004	50	80	Purposive	None	Qualitative retrospective, grounded theory	Conversion therapy, ex-gay ministries, and/or support groups	Subjective experiences of treatment; subjective appraisal of sexual orientation identity, attraction, & behavior
Birk, 1974	66	100	Clinical	13 withdrew participation	Pre–post within-subject	Psychotherapy	Sexual orientation
Blitch & Haynes, 1972	1	0	Clinical	None reported	Case study	Relaxation therapy and masturbation reconditioning	Sexual behavior
Callahan & Leitenberg, 1973	23	100	Clinical with 2 by court order	9 men withdrew participation and 8 excluded from data analyses	Pre–post within-subject	Aversion shock therapy and covert sensitization	Penile circumference
Colson, 1972	1	100	Clinical	None reported	Case study	Olfactory aversion therapy	Sexual behavior

Study	*N*	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Conrad & Wincze, 1976	4	100	Clinical	None reported	Case study	Orgasmic reconditioning	Sexual behavior; sexual fantasies; penile circumference
Curtis & Presly, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Sexual orientation
Feldman & MacCulloch, 1965	43	100	Clinical	7 withdrawals	Pre–post within-subject	Anticipatory avoidance	Sexual orientation
Fookes, 1960	27	100	Clinical (7 exhibitionists, 5 fetishists, and 15 bisexual and homosexual men)	None reported	Pre–post within-subject	Aversion shock therapy and calorie deprivation	Clinical judgment
Freeman & Meyer, 1975	9	100	Clinical	None reported	Pre–post within-subject	Aversion shock therapy and masturbation reconditioning	Sexual behavior; sexual orientation
Freund, 1960	67	100	Clinical	20 withdrawals	Pre–post within-subject	Aversion apomorphine therapy	Clinical judgment
Gray, 1970	1	100	Clinical	None reported	Case study	Desensitization and masturbation reconditioning	Sexual behavior
Hallam & Rachman, 1972	7	100	Clinical (2 pedophiles, 1 fetishist, 3 bisexual and homosexual men, and 1 voyeur)	None reported	Pre–post within-subject	Aversion shock therapy	Heart rate; galvanic skin response
Hanson & Adesso, 1972	1	100	Clinical	None reported	Case study	Desensitization and aversive counter-conditioning	Sexual behavior
Herman, Barlow, & Agras, 1974	4	100	Clinical	None reported	Case study	Counter-conditioning	Penile circumference; self-reported arousal
Herman & Prewett, 1974	1	100	Clinical	None reported	Case study	Biofeedback	Penile circumference
Huff, 1970	1	100	Clinical	None reported	Case study	Desensitization	Sexual behavior; personality
B. James, 1962	1	100	Clinical	Treatment stopped due to adverse reaction	Case study	Aversion apomorphine therapy	Sexual fantasies; sexual behavior
Kendrick & McCullough, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Sexual fantasies; sexual behavior
Larson, 1970	3	100	Clinical	None reported	Case study	Anticipatory avoidance	Sexual fantasies; sexual behavior
Levin, Hirsch, Shugar, & Kapche, 1968	1	100	Clinical	None reported	Case study	Desensitization, avoidance conditioning	Personality

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
LoPiccolo, 1971	1	100	Clinical	None reported	Case study	Desensitization	Masturbation fantasies
LoPiccolo, Stewart, & Watkins, 1972	1	100	Clinical	None reported	Case study	Orgasmic reconditioning	Sexual behavior
MacCulloch & Feldman, 1967	43	?	Clinical (18 by court order and 4 psychiatric referrals)	7 withdrawals	Pre–post within-subject	Anticipatory avoidance with aversion shock therapy	Sexual orientation; sexual behavior
MacCulloch, Feldman, & Pinshoff, 1965	4	100	Clinical (3 by court order)	1 withdrawal	Case study	Anticipatory avoidance with aversion shock therapy	Attractions; pulse rate
Marquis, 1970	14	79	Clinical	None reported	Case study	Orgasmic reconditioning	Clinical judgment
McCrady, 1973	1	100	Clinical	None reported	Case study	Forward fading	Sexual preference, sexual behavior
Mintz, 1966	10	100	Clinical	5 withdrawals	Case study	Therapy	Clinical judgment
Nicolosi, Byrd, & Potts, 2000	882	78	Convenience (NARTH and ex-gay ministry members)	None reported	Retrospective pretest	Conversion therapy	Sexual orientation; sexual behavior
Pattison & Pattison, 1980	11	100	Convenience	None reported; 19 declines to participate	Qualitative retrospective case study	Religious folk therapy	Subjective experience
Ponticelli, 1999	15	0	Purposive (ex-gay ministry)	None reported	Ethnography	Ex-gay ministry	None
Quinn, Harbison, & McAllister, 1970	1	100	Clinical	None reported	Case study	Desensitization and hydration deprivation	Penile circumference
Rehm & Rozensky, 1974	1	100	Clinical	None reported	Case study	Therapy and orgasmic reconditioning	Sexual behavior
Sandford, Tustin, & Priest, 1975	2	100%	Clinical	1 withdrawal reported	Case study	Differential reinforcement and punishment	Penile circumference
Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000	248	74	Convenience (Exodus International conference attendees)	None reported	Retrospective pretest	Varied counseling and conversion therapies	Sexual behavior; sexual feelings; sexual orientation identity
Schroeder & Shidlo, 2001	150	91	Convenience	None reported	Qualitative retrospective case study	Varied, including behavior therapy; psychoanalysis; aversive therapies; hypnosis; spiritual counseling; psychotropic medication; in-patient treatment.	Perceived harmfulness or helpfulness of SOCE

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Segal & Sims, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Self-report of continued need for treatment
Shidlo & Schroeder, 2002	202	90	Convenience	None reported	Qualitative retrospective case study	Varied including behavior therapy; psychoanalysis; aversive therapies; hypnosis; spiritual counseling; psychotropic medication; in-patient treatment.	Sexual orientation; sexual orientation identity
Solyom & Miller, 1965	6	100	Clinical	None reported	Case study	Aversive shock therapy	Galvanic skin responses; penile circumference
Spitzer, 2003	200	71	Convenience (Ex-gay ministry members)	None reported; 74 not eligible	Retrospective pretest	Varied including ex-gay and religious support groups and therapy.	Sexual attraction; sexual orientation identity; sexual behavior;
Thorpe, Schmidt, & Castell, 1963	1	100	Clinical	None reported	Case study	Classical conditioning	Sexual fantasy; ability to orgasm in response to female stimuli
Thorpe, Schmidt, Brown, & Castell, 1964	8	75	Clinical (referred for variety of mental health concerns)	2 withdrawals	Case study	Aversion relief	Anxiety; personality
Wolkomir, 2001	n/a		Purposive	None reported	Ethnography	2 Bible study support groups	Subjective experience

Homosexuality and Adolescence

Committee on Adolescence

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

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

ETIOLOGY AND PREVALENCE

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

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

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

SPECIAL CONCERNS

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

HIV

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

Issue of Trust

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

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

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

TABLE 1. Definitions of Terms

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

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

SPECIAL ASPECTS OF CARE

History

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

Physical Examination

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

Laboratory Studies

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

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

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

PSYCHOSOCIAL ISSUES

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

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

TABLE 2. Stages of Homosexual Identity Formation*

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

* From Troiden.[17]

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

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

Disclosure

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

Concept of Therapy

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

SUMMARY OF PHYSICIAN GUIDELINES

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

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

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Homosexuality and Adolescence

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Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)

Approved by the Board of Trustees, March 2000
Approved by the Assembly, May 2000

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Preamble

In December of 1998, the Board of Trustees issued a position statement (see attached) that the American Psychiatric Association opposes any psychiatric treatment, such as "reparative" or conversion therapy, which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual homosexual orientation. In doing so, the APA joined many other professional organizations that either oppose or are critical of "reparative" therapies, including the American Academy of Pediatrics, the American Medical Association, the American Psychological Association, The American Counseling Association, and the National Association of Social Workers (1).

The following Position Statement expands and elaborates upon the statement issued by the Board of Trustees in order to further address public and professional concerns about therapies designed to change a patient's sexual orientation or sexual identity. It *augments* rather than replaces the 1998 statement.

Position Statement

In the past, defining homosexuality as an illness buttressed society's moral opprobrium of same-sex relationships (2). In the current social climate, claiming homosexuality is a mental disorder stems from efforts to discredit the growing social acceptance of homosexuality as a normal variant of human sexuality. Consequently, the issue of changing sexual orientation has become highly politicized. The integration of gays and lesbians into the mainstream of American society is opposed by those who fear that such an integration is morally wrong and harmful to the social fabric. The political and moral debates surrounding this issue have obscured the scientific data by calling into question the motives and even the character of individuals on both sides of the issue. This document attempts to shed some light on this heated issue.

The validity, efficacy and ethics of clinical attempts to change an individual's sexual orientation have been challenged (3,4,5,6). To date, there are no scientifically rigorous outcome studies to determine either the actual efficacy or harm of "reparative" treatments. There is sparse scientific data about selection criteria, risks versus benefits of the treatment, and long-term outcomes of "reparative" therapies. The literature consists of anecdotal reports of individuals who have claimed to change, people who claim that attempts to change were harmful to them, and others who claimed to have changed and then later recanted those claims (7,8,9).

Even though there are little data about patients, it is still possible to evaluate the theories which rationalize the conduct of "reparative" and conversion therapies. Firstly, they are at odds with the scientific position of the American Psychiatric Association which has maintained, since 1973, that homosexuality per se, is not a mental disorder. The theories of "reparative" therapists define homosexuality as either a developmental arrest, a severe form of psychopathology, or some combination of both (10-15). In recent years, noted practitioners of "reparative" therapy have openly integrated older psychoanalytic theories that pathologize homosexuality with traditional religious beliefs condemning homosexuality (16,17,18).

The earliest scientific criticisms of the early theories and religious beliefs informing "reparative" or conversion therapies came primarily from sexology researchers (19-27). Later, criticisms emerged from psychoanalytic sources as well (28-39). There has also been an increasing body of religious thought arguing against traditional, biblical interpretations that condemn homosexuality and which underlie religious types of "reparative" therapy (40-46).

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Position Statement on Psychiatric Treatment and Sexual Orientation

Approved by the Board of Trustees, December 1998
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Reaffirmed , March 2000

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

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

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

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

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

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

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

APA Background Statement

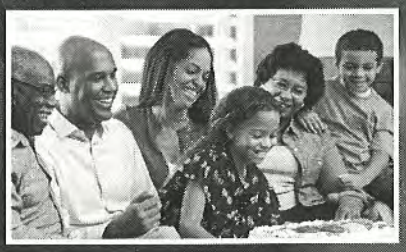
Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies): SUPPLEMENT

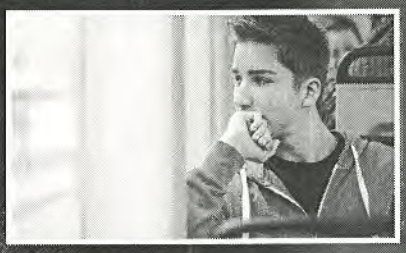
Recommendations:

1. APA affirms its 1973 position that homosexuality per se is not a diagnosable mental disorder. Recent publicized efforts to repathologize homosexuality by claiming that it can be cured are often guided not by rigorous scientific or psychiatric research, but sometimes by religious and political forces opposed to full civil rights for gay men and lesbians. APA recommends that the APA respond quickly and appropriately as a scientific organization when claims that homosexuality is a curable illness are made by political or religious groups.

2. As a general principle, a therapist should not determine the goal of treatment either coercively or through subtle influence. Psychotherapeutic modalities to convert or "repair" homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of "cures" are counterbalanced by anecdotal claims of psychological harm. In the last four decades, "reparative" therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, APA recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to First, do no harm.

3. The "reparative" therapy literature uses theories that make it difficult to formulate scientific selection criteria for their treatment modality. This literature not only ignores the impact of social stigma in motivating efforts to cure homosexuality, it is a literature that actively stigmatizes homosexuality as well. "Reparative" therapy literature also tends to overstate the treatment's accomplishments while neglecting any potential risks to patients. APA encourages and supports research in the NIMH and the academic research community to further determine "reparative" therapy's risks versus its benefits.





Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth

October 2015

Substance Abuse and Mental Health Services Administration
SAMHSA

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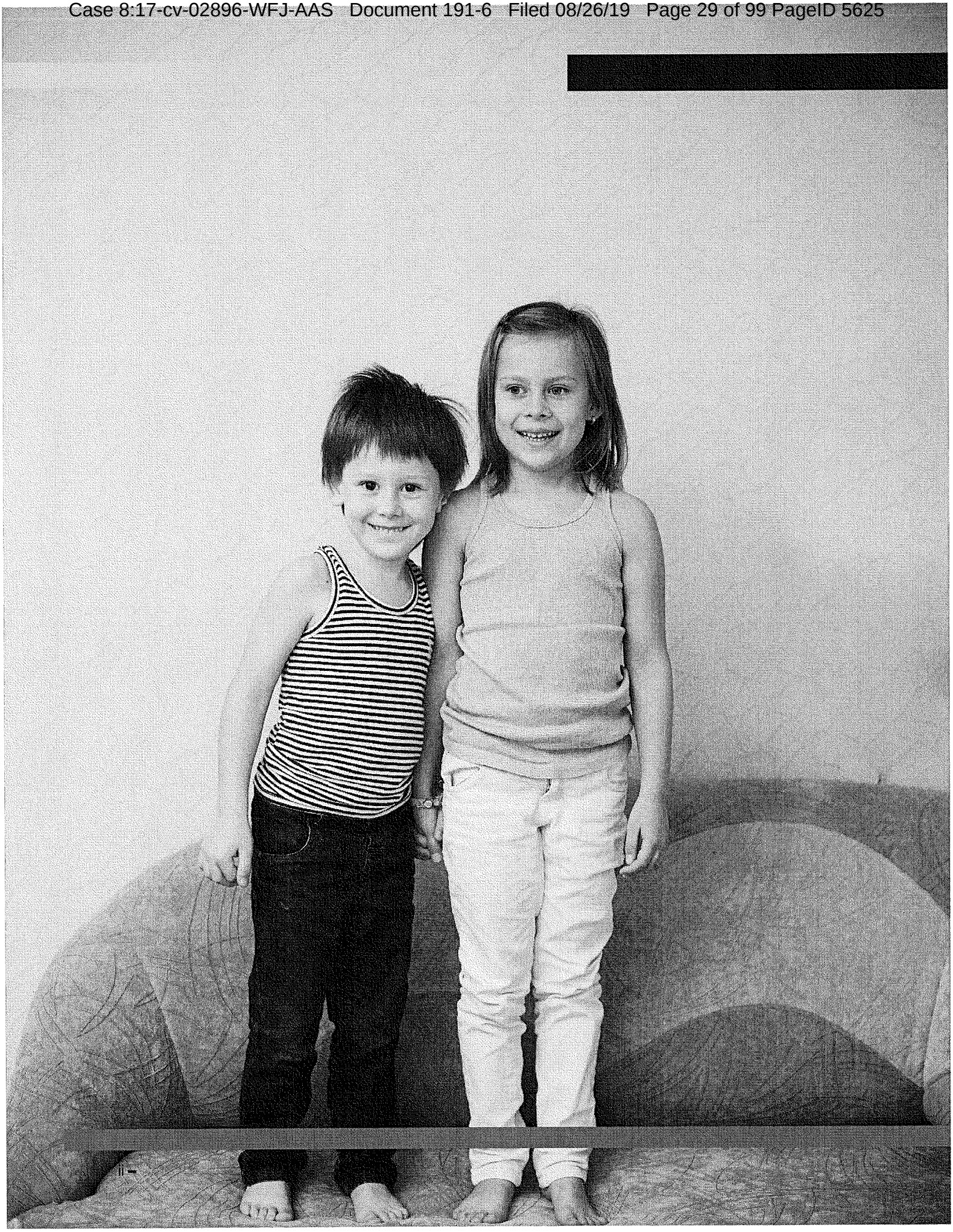

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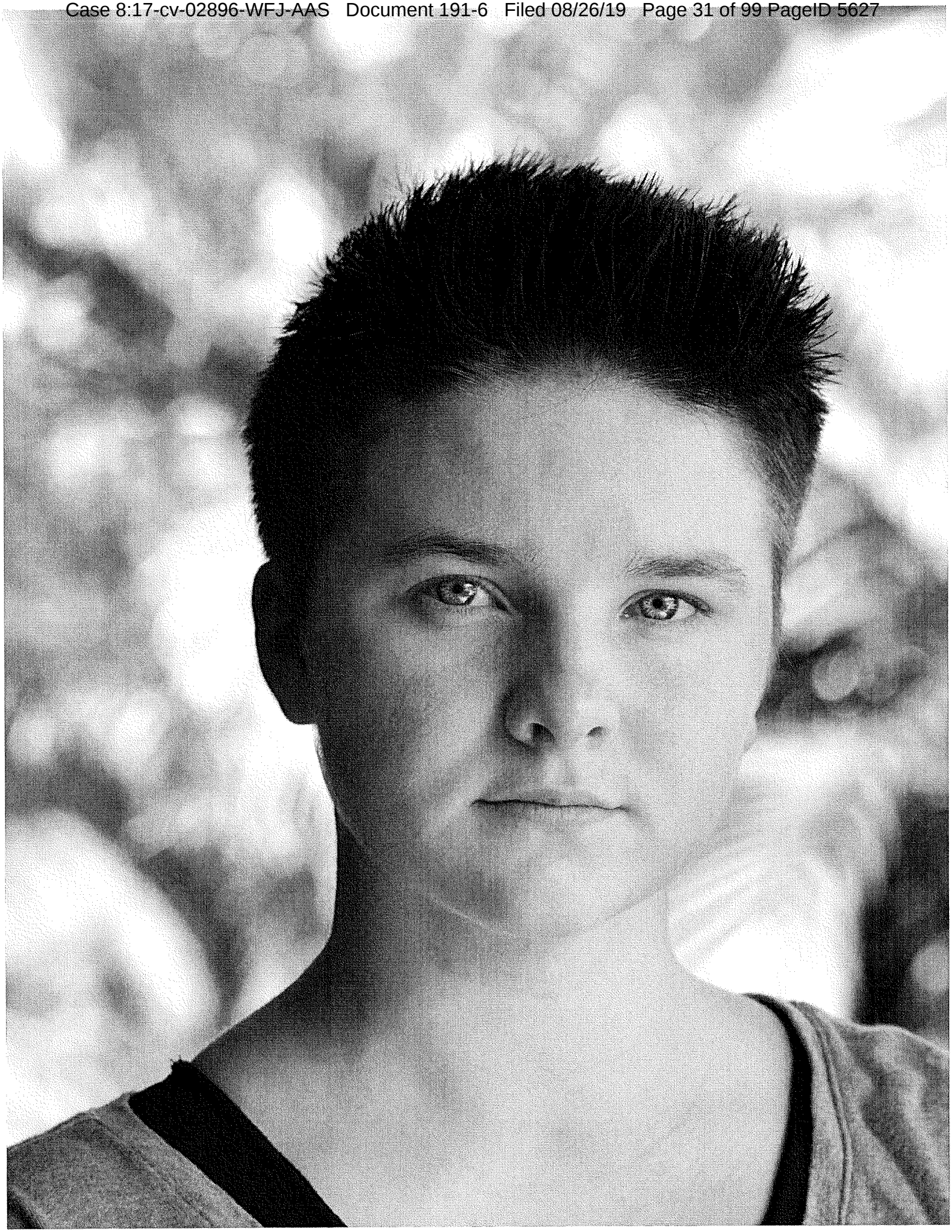

Executive Summary

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

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

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

Key Findings

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

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

Understanding Sexual Orientation and Gender Identity in Children and Youth

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

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

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

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

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

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

Therapeutic Efforts with Sexual and Gender Minority Youth[4]

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

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

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

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

Ending the Use of Conversion Therapy for Minors

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

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Introduction

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

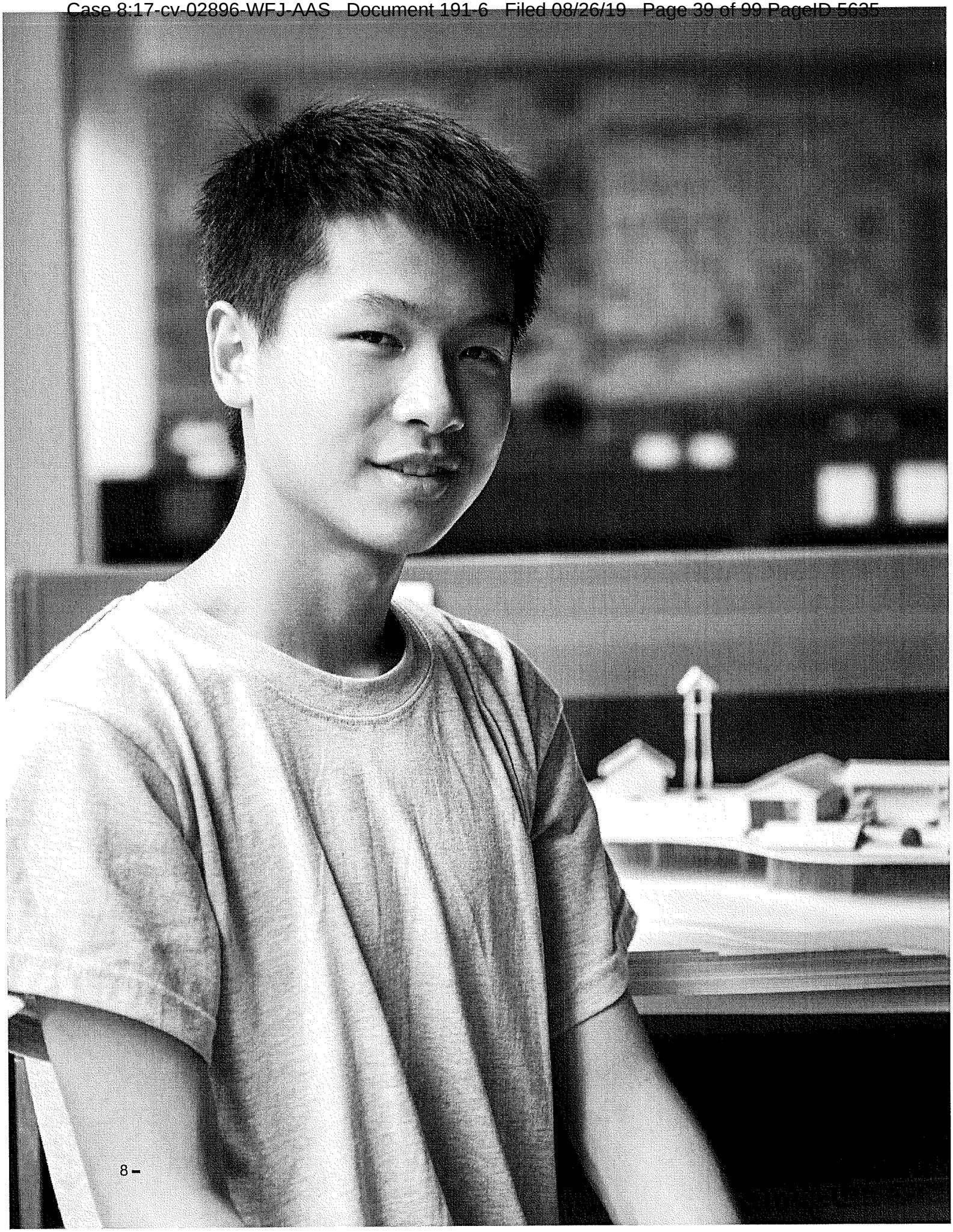
This work is the result of a collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Psychological Association (APA), which convened a panel of behavioral health professionals (e.g., psychologists, researchers and clinicians from psychology, social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

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

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

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

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



Professional Consensus Process

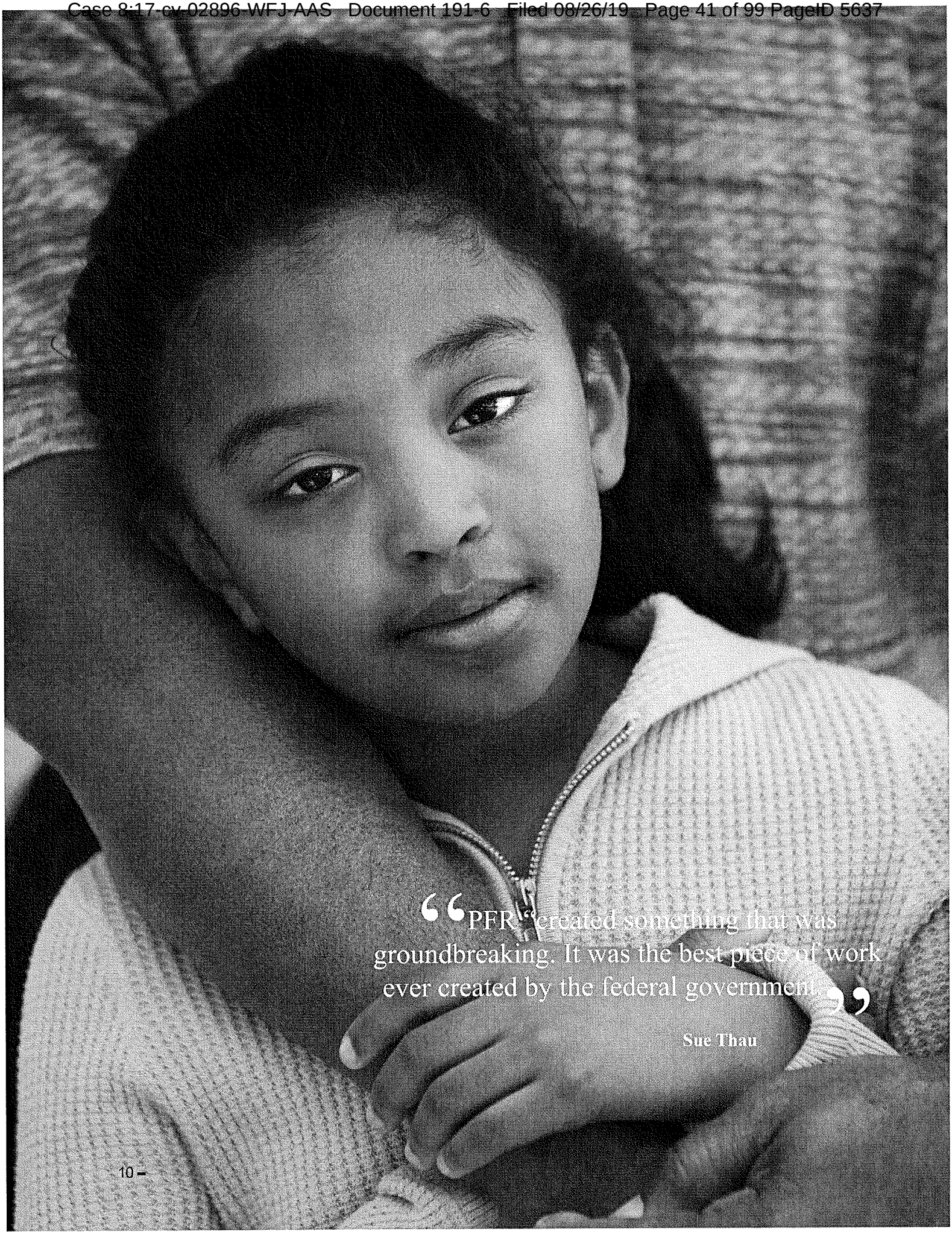
In early April 2015, representatives from SAMHSA and APA agreed to collaborate to address the concerns of professional associations, policy makers, and the public regarding efforts to change gender identity and sexual orientation in children and adolescents (also referred to as conversion therapy). Through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

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

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

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

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


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

Statements of Professional Consensus

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

Guiding Principles

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

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

Professional Consensus on Conversion Therapy with Minors

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

Professional Consensus on Sexual Orientation in Youth

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

Professional Consensus on Gender Identity and Gender Expression in Youth

Consensus on the Overall Phenomena of Gender Identity and Gender Expression

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

Consensus on Efforts to Change Gender Identity

3. There is a lack of published research on efforts to change gender identity among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.

4. It is clinically inappropriate for behavioral health professionals to have a prescriptive goal related to gender identity, gender expression, or sexual orientation for the ultimate developmental outcome of a child's or adolescent's gender identity or gender expression.

5. Mental health and behavioral interventions aimed at achieving a fixed outcome, such as gender conformity, including those aimed at changing gender identity or gender expression, are coercive, can be harmful, and should not be part of treatment. Directing the child or adolescent to conform to any particular gender expression or identity, or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes.

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

6. Children and adolescents experiencing gender-related concerns are an especially vulnerable population with unique developmental tasks. Parents and guardians need accurate scientific information to make informed decisions about appropriate mental health and behavioral interventions, including whether or not to initiate a social gender transition or, in the case of peri-pubertal, pubertal, and post-pubertal adolescents, medical intervention. Treatment discussions should respect the child's and adolescent's developing autonomy, recognizing that adolescents are still transitioning into adult decision-making capacities.

7. Approaches that focus on developmentally-appropriate identity exploration, integration, the reduction of distress, adaptive coping, and family acceptance to improve psychological well-being are recommended for children and adolescents of all ages experiencing gender-related concerns.

Pre-Pubertal Children

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

Peri-Pubertal Adolescents

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

Pubertal and Post-Pubertal Adolescents

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

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

Research Overview

Sexual Orientation

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

Gender

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

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

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

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

Sexual Orientation and Gender in Childhood

Sexual Orientation in Childhood

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

Gender Identity and Gender Expression in Childhood

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

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

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

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

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

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

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

Clinical Issues in Childhood

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

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

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

Sexual Orientation and Gender in Adolescence

Sexual Orientation in Adolescence

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

Gender Identity in Adolescence

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

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

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

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

Influences on Health and Well-Being

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

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

Family

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

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

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

Religion & Spirituality

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

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

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

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

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

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

School

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

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

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

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

Identity Development

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

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

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

Intersecting Identities

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

Therapeutic Efforts with Sexual and Gender Minority Youth

Introduction[16]

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

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

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

Conversion Therapy

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

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

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

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

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

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

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

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

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

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

Client-Centered Individual Approaches

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

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

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

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

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

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

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

Family Approaches

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

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

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

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

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

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

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

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

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

School and Community Interventions

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

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

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

Additional Appropriate Approaches with Gender Minority Youth

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

Social Transition

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

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

Medical Intervention

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

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

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

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

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

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

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

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

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

Future Directions for Research

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

Development of sexual orientation and gender identity

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

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

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

Addressing the needs of disconnected LGBTQ youth

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

Long-term Outcomes

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

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

Integration, Collaboration, and Dissemination

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

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

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

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

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

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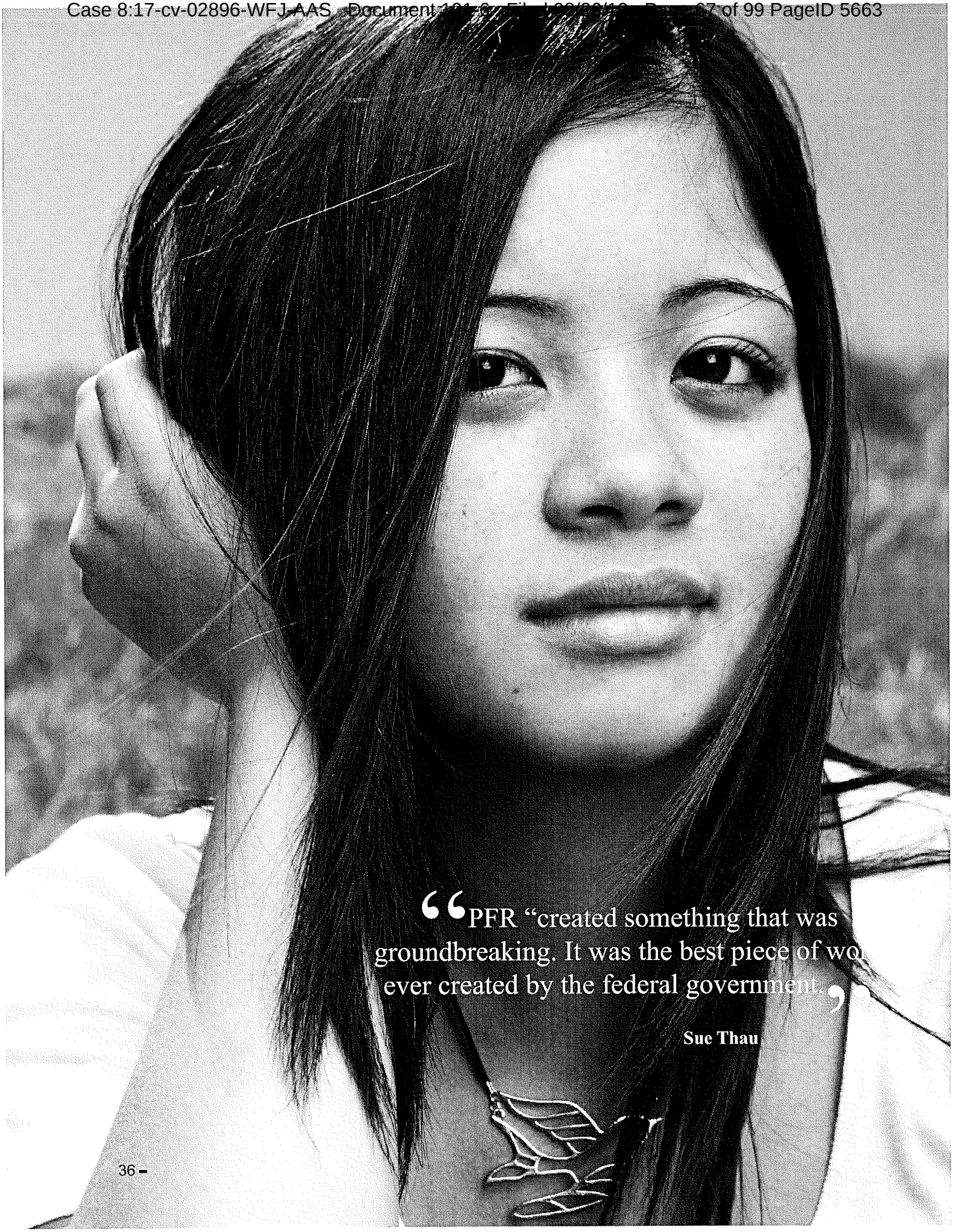

"PFR "created something that was groundbreaking. It was the best piece of wo ever created by the federal government."

Sue Thau

Approaches to Ending the Use of Conversion Therapy

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

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

Reducing discrimination and negative social attitudes towards LGBT identities and individuals

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

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

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

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

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

Dissemination of information, training and education for behavioral health providers

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

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

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

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

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

Legislative, regulatory, and legal efforts

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

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

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

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

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

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

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

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

Guidance for Families, Providers, and Educators

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

Promoting Family and Community Acceptance and Support

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

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

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

Key Points:

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

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

Resources

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

Gender Spectrum: www.genderspectrum.org

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

PFLAG : www.pflag.org

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

Bullying, Harassment, and Other School-Based Issues

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

Key points:

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

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

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

Resources:

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

GLSEN: www.glsen.org

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

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

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

PFLAG: www.pflag.org

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

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

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U.S. Department of Justice. (2013). Resolution Agreement: Between the Arcadia Unified School District, the U.S. Department of Education, Office for Civil Rights, and the U.S. Department of Justice, Civil Rights Division, from http://www.justice.gov/sites/default/files/crt/legacy/2013/07/26/arcadiaagree.pdf

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

Pediatric Care Considerations for LGBTQ Children and Adolescents

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

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

Key points:

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

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

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

Resources:

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

Makadon, H., Mayer K., Potter J., & Goldhammer, H. (Eds.). (2015). *The Fenway Guide to lesbian, bisexual, and transgender health* (2 ed.). Philadelphia, PA: American College of Physicians.

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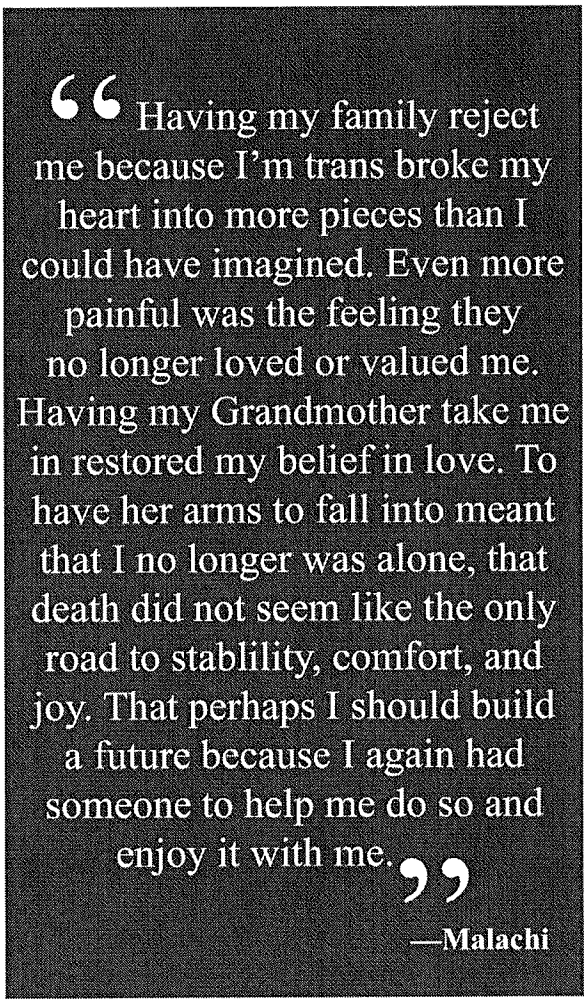

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Affirmative Care for Gender Minority Youth

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

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

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

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

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

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

Resources

TransYouth Family Allies: www.imatyfa.org/

Trans Youth Equality Foundation: www.transyouthequality.org

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

Gender Spectrum: www.genderspectrum.org

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

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

—Mathew

Summary and Conclusion

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

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

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

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

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

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Appendix A: Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Acknowledgments

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

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

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

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

Endnotes

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

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

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