

12-17681

IN THE UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT

**DAVID H. PICKUP; et al. ,**

Plaintiffs-Appellants,

v.

**EDMUND G. BROWN, Jr. Governor of the  
State of California, in his official capacity;  
et al.,**

Defendants-Appellees.

On Appeal from the United States District Court  
for the Eastern District of California

No. 2:12-cv-02497-KJM-EFB  
The Honorable Kimberly J. Mueller, Judge

**OPPOSITION TO EMERGENCY MOTION  
FOR TEMPORARY INJUNCTION PENDING  
APPEAL (CIRCUIT RULE 27-3)**

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## INTRODUCTION

Senate Bill 1172 prohibits state-licensed mental health providers in California from engaging in a type of therapy known as “sexual orientation change efforts” with clients who are under 18 years old. The statute is based on a scientific and professional consensus reached decades ago that homosexuality is a normal expression of human sexuality and not a disease, condition, or disorder in need of a “cure.” It is also based on the conclusions of every mainstream professional mental health organization that sexual orientation change efforts (SOCE) are both ineffective and harmful.

Appellants seek to enjoin this important legislation. They reject the scientific and professional consensus on sexual orientation and SOCE and contend that licensed therapists and their patients have a constitutional right to provide and obtain mental health treatments deemed ineffective and unsafe by the State. Appellants’ motion distills to the idea that because a district court judge in another case granted a limited preliminary injunction enjoining enforcement of Senate Bill 1172 only as to the three plaintiffs in that case,<sup>1</sup> and because Appellants firmly believe that the law is unconstitutional and will cause them harm, this Court should

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<sup>1</sup> See *Welch et al. v. Brown et al.*, No. 12-02484 (E.D. Cal. Dec. 3, 2012). In that case, the Honorable William B. Shubb enjoined the enforcement of Senate Bill 1172 as against the three named *Welch* plaintiffs. See Appellants’ Exhibit B. The State will appeal Judge Shubb’s December 3 Order.

broadly enjoin a state law duly enacted to protect public health and safety. This falls short of justifying the extraordinary relief they seek.

Appellants cannot meet their burden. In a comprehensive and well-reasoned opinion denying the motion for preliminary injunction, the Honorable Kimberly J. Mueller held that Senate Bill 1172 regulates professional conduct and not expressive speech, and that Appellants are therefore unlikely to succeed on the merits of their First Amendment claims. Judge Mueller's Order is rooted in well-settled law holding that the government has broad authority to regulate and prohibit unprofessional conduct, and particularly of medical professionals, notwithstanding that the conduct may be initiated and/or carried out through speech. Given the State's significant interest in regulating the mental health profession and protecting the public from harm, Judge Mueller properly held that the law is constitutional.

Appellants cannot demonstrate a violation of the First Amendment or of any other constitutional right, nor can they demonstrate irreparable injury from the State's restriction of treatments that, according to every mainstream authority, do not work and pose potentially serious risks of harm. By contrast, an injunction would harm the State and the public interest. It would expose vulnerable children and adolescents to treatment that the State and every major mental health organization in the country have condemned as an outmoded, ineffective, and

potentially dangerous relic from an era when homosexuality was pathologized and criminalized. Accordingly, the law, the balance of equities, and the public interest all weigh in favor of denying Appellant’s emergency motion to enjoin Senate Bill 1172.

## **BACKGROUND**

### **I. THE STATUTE**

Senate Bill (SB) 1172 prohibits any “mental health provider” from engaging in “sexual orientation change efforts” with patients under 18 years of age. Cal. Stats. 2012, ch. 835, § 2 (to be codified at Cal. Bus. & Prof. Code §§ 865.1, 865(a)).<sup>2</sup> Further, “[a]ny 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.” *Id.* (to be codified at Cal. Bus. & Prof. Code § 865.2).

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<sup>2</sup> The term “mental health provider” means a “physician and surgeon specializing in the practice of psychiatry, a psychologist, a psychological assistant, intern, or trainee, a licensed marriage and family therapist, a registered marriage and family therapist, intern, or trainee, a licensed educational psychologist, a credentialed school psychologist, a licensed clinical social worker, an associate clinical social worker, a licensed professional clinical counselor, a registered clinical counselor, intern, trainee, or any other person designated as a mental health professional under California law or regulation.” Cal. Stats. 2012, ch. 835, § 2 (to be codified at Cal. Bus. & Prof. Code § 865(a)).

SB 1172 defines “[s]exual orientation change efforts” as “any practices by mental health providers that seek to change an individual’s sexual orientation. This includes efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.” Cal. Stats. 2012, ch. 835, § 2 (to be codified at Cal. Bus. & Prof. Code § 865(b)(1)). SOCE does not include “psychotherapies that: (A) provide acceptance, support, and understanding of clients or the facilitation of clients’ coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices; and (B) do not seek to change sexual orientation.” *Id.* (to be codified at Cal. Bus. & Prof. Code § 856(b)(2)). SOCE is sometimes called reparative or conversion therapy.

The Legislature based SB 1172 on findings that “[b]eing lesbian, gay, or bisexual is not a disease, disorder, illness, deficiency, or shortcoming. The major professional associations of mental health practitioners and researchers in the United States have recognized this fact for nearly 40 years.” Cal. Stats. 2012, ch. 835, § 1(a). The Legislature further determined, based on extensive research and study by the American Psychological Association, the American Psychiatric Association, and other respected professional psychological and counseling associations, that: (1) there is little or no empirical evidence that SOCE works; and

(2) SOCE poses potentially severe risks of harm to patients, including but not limited to depression; anxiety; problems in sexual and emotional intimacy; loss of faith; self-destructive behavior; alienation from family; and suicidality. *Id.* § 1(b)-(m).

In light of the broad professional consensus against the use of SOCE, the Legislature declared that “California has a compelling interest in protecting the physical and psychological well-being of minors, including lesbian, gay, bisexual, and transgender youth, and in protecting its minors against exposure to serious harms caused by sexual orientation change efforts.” Cal. Stats. 2012, ch. 835, § 1(n).

## ARGUMENT

### **I. APPELLANTS HAVE NOT DEMONSTRATED GROUNDS TO ENJOIN SB 1172.**

A party seeking an injunction or stay of a state action that the district court has declined to enjoin must demonstrate: (1) a strong showing of likelihood of success on the merits of the appeal; (2) irreparable injury absent a stay; (3) that the issuance of a stay would not substantially injure the other interested parties; and (4) that the stay is in the public interest. *Golden Gate Rest. Ass’n v. City & Cnty. of San Francisco*, 512 F.3d 1112, 1115 (9th Cir. 2008); *see also Hilton v. Braunskill*, 481 U.S. 770, 776 (1987). Appellants cannot meet their burden of establishing any one of these factors, let alone all of them.

**A. Appellants Have Not Met Their Burden to Demonstrate Likelihood of Success on the Merits of the Appeal.**

In order to demonstrate a “strong showing” that they are likely to succeed on the merits of their appeal, Appellants must establish that this Court will overturn Judge Mueller’s Order. *See Lopez v. Heckler*, 713 F.2d 1432, 1436 (9th Cir. 1983). This Court reviews the grant or denial of a preliminary injunction for abuse of discretion. *Am. Trucking Ass’ns v. City of Los Angeles*, 559 F.3d 1046, 1052 (9th Cir. 2009). On review, it must be determined, “whether the court employed the appropriate legal standards governing the issuance of a preliminary injunction and whether the district court correctly apprehended the law with respect to the underlying issues in the case.” *A&M Records, Inc. v. Napster, Inc.*, 239 F.3d 1004, 1013 (9th Cir. 2001). “As long as the district court got the law right, it will not be reversed simply because the appellate court would have arrived at a different result if it had applied the law to the facts of the case.” *Sports Form, Inc. v. United Press, Int’l*, 686 F.2d 750, 752 (9th Cir. 1982).

**1. Judge Mueller Employed the Correct Legal Standard.**

Appellants suggest that Judge Mueller failed to apply the proper standard for preliminary injunctions. Motion at 9-10. Specifically, Appellants contend that Judge Mueller ignored the balancing test set forth in *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1134-35 (9th Cir. 2011), “engaged in a detailed, extra-

record exposition of the merits”<sup>3</sup> of their claims, and did not consider irreparable harm. Motion at 9-10. As an initial matter, and as discussed more fully below, Appellants have not demonstrated any cognizable injury and/or that the balance of hardships in this case tips so strongly in their favor as to justify use of the *Cottrell* standard. *See Cottrell*, 632 F.3d at 1131-35. Moreover, and regardless, because Appellants did not establish either a likelihood of success on the merits or the existence of serious legal questions, it was not necessary to consider the question of irreparable harm. *See* Order at 11-12 (setting forth preliminary injunction standard and stating that a court need not consider remaining factors if “the moving party cannot as a threshold matter demonstrate a ‘fair chance of success on the merits’”) (quoting *Pimentel v. Dreyfus*, 670 F.3d 1096, 1111 (9th Cir. 2012)).

Although Appellants suggest that a preliminary injunction is a routine “device for preserving the status quo” that requires only “limited review” by the district court, Motion at 9, it is settled law that a “preliminary injunction is an extraordinary remedy never awarded as a matter of right.” *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 24 (2008) (internal quotations and

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<sup>3</sup> Appellants do not identify the supposed “extra-record exposition.” In fact, Judge Mueller’s Order considered only the evidence submitted by the parties and judicially noticeable facts, such as dictionary definitions of “psychotherapy,” “sexual orientation,” “practice,” and “treatment.” *See* Fed. R. Evid. 201(b); *Wilshire Westwood Assoc. v. Atlantic Richfield Corp.* 881 F.2d 801, 803 (9th Cir. 1989).

citations omitted). Moreover, an injunction will not preserve the status quo in this case, as the status quo is that the SB 1172 will take effect on January 1, 2013.

*Golden Gate Rest. Ass'n*, 512 F.3d at 1116. To justify a preliminary injunction, the moving party must establish by a “clear showing” “that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.” *Winter*, 555 U.S. at 20, 22. Alternatively, “[a] preliminary injunction is appropriate when a plaintiff demonstrates . . . that serious questions going to the merits were raised and the balance of hardships tips sharply in the plaintiff’s favor.” *Alliance for the Wild Rockies*, 632 F.3d at 1134-35 (internal quotations omitted). Even under the alternative sliding scale test, however, plaintiffs must satisfy all four *Winter* factors. *Id.* at 1135. Thus, where, as here, a party cannot demonstrate even a “fair chance” of prevailing on the merits, a court need not consider the remaining factors. *Pimentel*, 670 F.3d at 1111; *see also* *DISH Network Corp. v. FCC*, 653 F.3d 771, 776-77 (9th Cir. 2011).<sup>4</sup> Accordingly,

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<sup>4</sup> A “serious legal question” must present a “substantial case for relief on the merits” *Leiva-Perez v. Holder*, 640 F.3d 962, 967-68 (9th Cir. 2011). Appellants posit that because the *Welch* court granted an injunction as to the three *Welch* plaintiffs, “serious questions” about the constitutionality of SB 1172 necessarily exist. Motion at 10, 17. Even assuming that it were appropriate to apply the *Cottrell* balancing test here, the fact that another judge came to a different, and erroneous, conclusion regarding SB 1172 does not establish a “substantial, difficult  
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it was proper for Judge Mueller to undertake a comprehensive analysis of the merits of Appellants' claims and not reach their alleged harms.

**2. The District Court Properly Determined That SB 1172 is Rationally Related to the State's Interest in Protecting the Physical and Psychological Well Being of Minors.**

Judge Mueller determined that: (1) SB 1172 is subject to rational basis review because it is a neutral regulation of professional conduct that does not implicate expressive speech protected by the First Amendment or any other constitutional right;<sup>5</sup> and (2) SB 1172 is rationally related to the State's interest in protecting the physical and psychological well being of minors. Order at 42-44. SB 1172 is based on the findings, recommended practices, and opinions of ten professional associations of mental health experts that (1) SOCE is, at a minimum, unproven and potentially harmful; and (2) homosexuality is not a disease or condition that warrants treatment. Order at 42-43; Cal. Stats. 2012, ch. 835, §§ 1(a)-(m). Accordingly, Appellants cannot establish that SB 1172 lacks any conceivable

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and doubtful" issue that could not be "resolved one way or the other at the hearing on the injunction." *Gilder v. PGA Tour, Inc.*, 936 F.2d 417, 422 (9th Cir. 1991).

<sup>5</sup> Appellants' Motion does not address Judge Mueller's decision rejecting their fundamental rights claims. Accordingly, Appellees confine their discussion to the merits of the First Amendment claims.

rational basis, and thus that the order denying the injunction was an abuse of discretion. *See Heller v. Doe*, 509 U.S. 312, 320 (1993).<sup>6</sup>

**a. SB 1172 is a Reasonable Regulation of Professional Conduct**

Judge Mueller held that because SB 1172 regulates professional conduct and implicates speech only incidentally, insofar as speech is used in the practice of SOCE, Appellants are unlikely to succeed on the merits of their First Amendment claims. Order at 16-21. SOCE comprises a variety of psychological treatments and techniques that share the common goal of “curing” homosexuality and changing a patient’s sexual orientation. *See* Declaration of Alexandra Robert Gordon, Exh. A (APA Task Force Report at 21-42). These practices are not expressive speech, but rather professional conduct subject to reasonable regulation by the State. Order at 16-21. Appellants nevertheless insist that psychotherapy and SOCE are “entirely speech,” and thus, entitled to the highest level of protection under the First Amendment. Motion at 19-20. However, this Court already rejected that argument in *National Ass’n for the Advancement of*

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<sup>6</sup> Appellants attempt to discredit the evidence that SOCE causes harm to minors. However, a state need not offer “scientific or epidemiological ‘hard data’ to support a law or regulation affecting public health.” *New York State Ophthalmological Soc’y v. Bowen*, 854 F.2d 1379, 1391 (D.C. Cir. 1987); *Whalen v. Roe*, 429 U.S. 589, 598 n.21 (1977) (“Nothing in the Constitution prohibits a State from reaching . . . a conclusion and acting on it legislatively simply because there is no conclusive evidence or empirical data”). Regardless, as reflected in the Legislature’s findings, SB 1172 is supported by hard data and expert opinion.

*Psychoanalysis v. Cal. Bd. of Psychology*, 228 F.3d 1043 (9th Cir. 2000) (“*NAAP*”). In *NAAP*, plaintiffs challenged California’s licensing scheme for psychoanalysts and argued that “because psychoanalysis is the ‘talking cure,’ it deserves special First Amendment protection because it is ‘pure speech.’” *Id.* at 1054. This Court expressly disagreed and held that “the key component of psychoanalysis is the treatment of emotional suffering and depression, not speech. . . . That psychoanalysts employ speech to treat their clients does not entitle them, or their profession, to special First Amendment protection.” *Id.*; *see also* Order at 17. Accordingly, this Court held that California’s licensing scheme “is a valid exercise of its police power to protect the health and safety of its citizens and does not offend the First Amendment.” 228 F.3d at 1056.

Appellants’ argument ignores well-settled law that the First Amendment distinguishes between the regulation of expressive speech (which must survive strict scrutiny) and the regulation of professional conduct carried out through speech (which need only have a rational basis). This distinction is drawn because regulations that target expressions of opinion and/or “discourse on public matters” implicate the core values protected by the First Amendment. *See Brown v. Entm’t Merchants Ass’n*, 131 S. Ct. 2729, 2733 (2011). In contrast, regulation of professional conduct does not “offend the First Amendment.” *See, e.g., Daly v. Sprague*, 742 F.2d 896, 898 (5th Cir. 1984) (“Limitations on professional conduct

necessarily affect the use of language and association; accordingly, reasonable restraints on the practice of medicine and professional actions cannot be defeated by pointing to the fact that communication is involved.”). While the “First Amendment recognizes no such thing as a ‘false idea,’” *Hustler Magazine v. Falwell*, 485 U.S. 46, 51 (1988), there are “false” and dangerous practices and treatments that the State may regulate or ban to protect the public from harm.<sup>7</sup> *See Washington v. Glucksberg*, 521 U.S. 702, 731 (1997) (states may act to safeguard “the integrity and ethics of the medical profession” and to protect “vulnerable groups . . . from abuse, neglect, and mistakes” at the hands of medical practitioners); *NAAP*, 228 F.3d at 1054 (“it is properly within the state’s police power to regulate and license professions, especially when public health concerns are affected”). Thus, “[i]t has never been deemed an abridgement of freedom of

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<sup>7</sup> Indeed, “without so much as a nod to the First Amendment, doctors are routinely held liable for malpractice for speaking or for failing to speak. Doctors commit malpractice for failing to inform patients in a timely way of an accurate diagnosis, for failing to give patients proper instructions, for failing to ask patients necessary questions, or for failing to refer a patient to an appropriate specialist. In all these contexts, the regulation of professional speech is theoretically and practically inseparable from the regulation of medicine.” Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. Ill. L. Rev. 939, 949 (2007); *see also Ohralik v. Ohio State Bar Ass’n*, 436 U.S. 447, 456 (1978) (noting “numerous” examples of communications “that are regulated without offending the First Amendment”); *cf. Planned Parenthood of Southeastern Penn. v. Casey*, 505 U.S. 833, 884 (1992) (plurality opinion) (stating that a physician’s First Amendment right to speak “as part of the practice of medicine” is “subject to reasonable licensing and regulation by the State”).

speech or press to make a course of conduct illegal merely because the conduct was in part initiated, evidenced, or carried out by means of language, either spoken, written, or printed.” *NAAP*, 228 F.3d at 1053 (quoting *Giboney v. Empire Storage & Ice Co.*, 336 U.S. 490, 502 (1949)).<sup>8</sup>

**b. SB 1172 Does Not Regulate Content or Viewpoint.**

Judge Mueller also rejected Appellants’ contention that SB 1172 unconstitutionally discriminates on the basis of content or viewpoint. Order at 12-16. In their motion and supporting declarations, Appellants repeat their arguments that SB 1172 is content and/or viewpoint-based because it only applies to “conversations about” and prohibits a particular viewpoint regarding sexual orientation. Motion at 18-19. However, SB 1172 only proscribes “practices” and “actions designed to affect a difference [in sexual orientation].” It does not proscribe speech. Order at 15-16. SB 1172 leaves licensed mental health professionals free to express their theories and opinions about sexual orientation and SOCE, including the views that same-sex attractions can be reduced or

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<sup>8</sup> This distinction between professional conduct and expressive speech is in no way contradicted by the statement in *Conant v. Walters*, that “professional speech may be entitled to ‘the strongest protection our Constitution has to offer.’” 309 F.3d 629, 637 (9th Cir. 2002) (quoting *Florida Bar v. Went For It, Inc.*, 515 U.S. 618, 634 (1995)). As discussed below, the speech at issue in *Conant* was not treatment but expressive speech. Similarly, *Florida Bar* noted only that professional speech by attorneys may merit heightened protection when it concerns “public issues and matters of legal representation.” 515 U.S. at 634.

eliminated, that homosexuality is morally wrong, and/or that a minor could seek SOCE from a religious counselor or provider not covered by the challenged law.<sup>9</sup>

For this reason, *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002), on which Appellants rely, is inapposite. *Conant* involved a First Amendment challenge to a federal policy that expressly prohibited doctors from “recommending” the use of medical marijuana to their patients. None of the parties in *Conant* argued that the First Amendment prevented the government from prohibiting doctors from prescribing or dispensing marijuana. The policy enjoined in *Conant* directly restricted protected speech by preventing doctors from offering patients not medical treatment, but information and opinions about medical treatment. In contrast, SB 1172 does not regulate “on the basis of the content of doctor-patient communications.” *Id.* at 637. Instead, it targets mental health treatments that provide no benefits and put patients at risk of serious harms. SB 1172 does not bar therapists from “recommending,” discussing, or providing their clients with information about SOCE; it simply prohibits them from providing SOCE therapy to minors. *See* Order at 15-16 (“SB 1172 does not on its face penalize a mental

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<sup>9</sup> To be clear, telling a client that the therapist believes that being gay is morally wrong or unhealthy and can be changed may well violate applicable ethical standards for mental health providers. Similarly, given the lack of empirical evidence that SOCE works, and the known risks of engaging in SOCE, counseling minors and their families that they should pursue SOCE may violate a mental health provider’s basic duty of competency. Such speech would not, however, violate SB 1172.

health professional's exercise of judgment in simply informing a minor patient that he or she might benefit from SOCE; it also does not prohibit speech necessary to the therapists practice").

Appellants argue that SB 1172 is "content-based" because it restricts therapists from providing one particular type of treatment. Motion at 18. This is incorrect. While a legislative determination that a particular practice is harmful and should be proscribed certainly has content, the law itself is not a "content-based" restriction on speech within the meaning of the First Amendment. "[L]aws that by their terms distinguish favored speech from disfavored speech on the basis of the ideas or views expressed are content-based[.]" as opposed to laws "that confer benefits or impose burdens on speech without reference to the ideas or views expressed are in most instances content-neutral." *Turner Broadcasting Sys., Inc. v. FCC*, 512 U.S. 622, 643 (1994). The Legislature has determined that the "treatment" of SOCE is ineffective and potentially harmful and thus, is per se, "unprofessional conduct" if provided to minors. Because SB 1172 does not suppress protected speech based on its message or viewpoint, but regulates professional practices for the important purpose of protecting public health, safety,

and welfare, it is not a “content-based” regulation of speech. *See NAAP*, 228 F.3d at 1055-56.<sup>10</sup>

Appellants’ suggestion that SB 1172 compels only one viewpoint or message regarding sexual orientation also fails. SB 1172 does not compel *any* viewpoint or force therapists to endorse messages about sexual orientation with which they disagree. As discussed above, therapists will still be free to express any viewpoint regarding the morality or changeability of sexual orientation. The statute makes clear that “[s]exual orientation change efforts” “does not include psychotherapies that provide acceptance, support, and understanding of clients or the facilitation of clients’ coping, social support, and identity exploration and development.” Cal. Stats. 2012, ch. 835, § 2 (to be codified at Cal. Bus. & Prof. Code § 865(b)(2)). However, the fact that these therapies are not prohibited, does not mean that any therapist has to offer them.<sup>11</sup>

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<sup>10</sup> Appellants rely on dicta in *NAAP* for the proposition that because SB 1172 dictates what can be said in therapy, it is not content-neutral. Motion at 18-19. However, as discussed above, SB 1172 does not “dictate the content of what is said in therapy,” except to the extent it prohibits *treatments* deemed ineffective and harmful, which the *NAAP* court’s holding makes clear is constitutionally permissible. *See NAAP*, 228 F.3d at 1050, 1055-56. Indeed, in order to protect the public safety from “incompetent practice,” the State can and does regulate and proscribe treatments and conduct, most of which are conducted through speech. *See, e.g.*, Cal. Bus. & Prof. Code § 2960 (setting forth grounds for denial, suspension, and revocation of psychology license).

<sup>11</sup> Moreover, “affirming” therapy does not mean encouraging same-sex attractions or behaviors. It simply means assisting and affirming the client without  
(continued...)

**B. Appellants Have Not Shown That They Will Suffer Irreparable Harm in the Absence of an Injunction.**

In addition to failing to show a likelihood of success on the merits of their appeal, Appellants also have not met their burden to demonstrate irreparable injury absent an injunction. *See Preminger v. Principi*, 422 F.3d 815, 826 (9th Cir. 2005) (“The smaller the probability of a plaintiff’s success, the greater must be the showing of irreparable harm.”). Much of the injury that Appellants allege is merely a repackaging of their meritless First Amendment claims. Appellants’ motion and supporting declarations contain a litany of unsupported legal conclusions, including that the counselors will be unable to determine what SB 1172 prohibits,<sup>12</sup> that their speech will be suppressed and/or chilled, that they cannot discuss or recommend SOCE, and that they will risk their licenses if they offer the “banned viewpoint.” Bare assertions that SOCE is unconstitutional do not amount to irreparable injury. *See Goldie’s Bookstore, Inc. v. Superior Ct.*, 739

---

(...continued)

any *a priori* treatment goal concerning how clients identify or live out their sexual orientation. APA Report p. 14. In fact, this is therapy that all of the Appellant mental health professionals have claimed that they already provide.

<sup>12</sup> Given that Appellants-therapists all practice SOCE, they cannot argue plausibly that they do not know what SB 1172 prohibits. As Judge Mueller properly determined, the statute is not facially vague. “[I]t is clear what the statute proscribes in the vast majority of its intended applications,’ namely therapy intended to alter a patient’s sexual orientation.” Order at 28 (quoting *Cal. Teachers Ass’n v. State Bd. of Educ.*, 271 F.3d 1141, 1151 (9th Cir. 2001)).

F.2d 466, 472 (9th Cir. 1984); *see also Dex Media West, Inc. v. City of Seattle*, 790 F. Supp.2d 1276, 1289 (W.D. Wash. 2011).<sup>13</sup>

Appellants' remaining assertions of injury are equally unfounded. Although they contend that minor clients will suffer harm (regression, damage to the therapeutic relationship, depression, and even suicidality) if they are not able to continue in SOCE therapy, Appellants do not identify any facts to support this conclusion, and given the complete lack of evidence of SOCE's efficacy, it is unlikely that they could. To the extent the Appellant-therapists insist that if SB 1172 is not enjoined they will abruptly stop counseling their clients, this is a harm that they are threatening to create, and thus cannot form the basis for injunctive relief. SB 1172 prohibits SOCE for minors. It does not require the sudden cessation of counseling or rupture of the therapeutic alliance. There are many other accepted therapies with which to treat emotional distress caused by sexual abuse, family discord, and conflicts between sexual orientation and religious and moral beliefs. These therapies provide all the "generic" benefits of SOCE without

---

<sup>13</sup> Appellants rely on *Sammartano v. First Judicial Dist. Court*, 303 F.3d 959, 973 (9th Cir. 2003) for the proposition that "the fact that a case raises serious First Amendment questions compels a finding that there exists the potential for irreparable injury," but this authority has been abrogated by subsequent law. *Winter* requires that plaintiffs demonstrate that irreparable injury is *likely* in the absence of an injunction. *See Winter*, 555 U.S. at 22; *see also Cottrell*, 632 F.3d at 1135.

any of the attendant harms. *See* APA Report pp. 3, 51-54. SB 1172 does not stop Appellants from continuing to counsel their clients using these methods.<sup>14</sup>

Appellants' remaining claims that failing to enjoin SB 1172 pending appeal will cause irreparable harm to therapists by somehow forcing them to violate their ethical obligations or lose their livelihood all fail. With respect to ethics, Appellants-therapists, who are obligated to provide competent care, plainly have no professional ethical obligation to offer SOCE, which has been disavowed by every mainstream association of mental health experts, to minors. The assertion that the enforcement of SB 1172 will endanger careers and livelihoods is also baseless. While Appellants put forth a variety of declarations in this Court to establish prospective financial ruin, these conflict with the evidence they submitted to the district court. *Compare, e.g.,* Vazzo Decl. (Dkt.3-8), ¶ 3 *with* Vazzo Decl. (Dkt. 3-16), ¶ 5. Moreover, these counselors can still practice their profession; they just cannot provide SOCE to minors. Accordingly, Appellants have not

---

<sup>14</sup> The notion that it is preferable for minors to receive SOCE from licensed mental health professionals rather than religious and unlicensed practitioners is misguided. Unlike valid medical treatments, there is no benefit to receiving SOCE from a licensed professional, but there is a greater harm from doing so. SOCE does not work, and may be damaging, no matter who performs it, but there is a particular harm in giving the imprimatur of a state license to a scientifically invalidated practice. It is this harm of minors receiving SOCE from a licensed mental health professional that SB 1172 seeks to eliminate.

established sufficient injury to warrant an injunction of SB 1172 pending appeal.

*See Goldie's Bookstore, Inc.*, 739 F.2d at 472.

**C. The Balance of Harms and the Public Interest Weigh Heavily Against an Injunction Pending Appeal.**

Appellants cannot establish sufficient harm to outweigh the fact that “[a]ny time a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury.” *Maryland v. King*, --- S. Ct. ---, No. 12A48, 2012 WL 3064878 at \*2 (U.S. July 30, 2012) (citation omitted). Moreover, allowing mental health providers to engage in SOCE with minors pending appeal could cause these minors irreparable harm, including severe depression and suicidal thoughts. Cal. Stats. 2012, ch. 835, § 1(b)-(m). None of this damage could be undone if the injunction were subsequently vacated. These harms to the State and the public interest far outweigh the alleged harm to Appellants. *See Golden Gate Rest. Ass’n*, 512 F.3d at 1126-27 (“The public interest may be declared in the form of a statute”) (citation omitted); *See Fed. Trade Comm’n v. Affordable Media, LLC*, 179 F.3d 1228, 1236 (9th Cir. 1999) (“[W]hen a district court balances the hardships of the public interest against a private interest, the public interest should receive greater weight.”) (citation omitted).

## CONCLUSION

The Court should deny the emergency motion for an injunction pending the preliminary injunction appeal.

Dated: December 14, 2012

Respectfully submitted,

KAMALA D. HARRIS  
Attorney General of California  
DOUGLAS J. WOODS  
Senior Assistant Attorney General  
TAMAR PACHTER  
Supervising Deputy Attorney General

*/s/ Alexandra Robert Gordon*  
ALEXANDRA ROBERT GORDON  
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12-17681

IN THE UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT

<p><b>DAVID H. PICKUP; et al. ,</b> Plaintiffs-Appellants,</p> <p>v.</p> <p><b>EDMUND G. BROWN, Jr. Governor of the State of California, in his official capacity; et al.,</b> Defendants-Appellees.</p>
--

**STATEMENT OF RELATED CASES**

To the best of our knowledge, there are no related cases.

Dated: December 14, 2012      Respectfully Submitted,

KAMALA D. HARRIS  
Attorney General of California  
DOUGLAS J. WOODS  
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*/s/ Alexandra Robert Gordon*  
ALEXANDRA ROBERT GORDON  
Deputy Attorney General  
*Attorneys for Defendants-Appellees*

**CERTIFICATE OF COMPLIANCE  
PURSUANT TO FED.R.APP.P 32(a)(7)(C) AND CIRCUIT RULE 32-1  
FOR 12-17681**

I certify that: (check (x) appropriate option(s))

1. Pursuant to Fed.R.App.P. 32(a)(7)(C) and Ninth Circuit Rule 32-1, the attached **opening/answering/reply/cross-appeal** brief is

Proportionately spaced, has a typeface of 14 points or more and contains \_\_\_\_\_ words (opening, answering and the second and third briefs filed in cross-appeals must not exceed 14,000 words; reply briefs must not exceed 7,000 words

or is

Monospaced, has 10.5 or fewer characters per inch and contains \_\_\_\_ words or \_\_\_\_ lines of text (opening, answering, and the second and third briefs filed in cross-appeals must not exceed 14,000 words or 1,300 lines of text; reply briefs must not exceed 7,000 words or 650 lines of text).

2. The attached brief is **not** subject to the type-volume limitations of Fed.R.App.P. 32(a)(7)(B) because this brief complies with Fed.R.App.P. 27(d)(2) and is no more than 20 pages, exclusive of the signature page and the accompanying documents authorized by Fed.R.App.P. 27(a)(2)(B).

This brief complies with Fed.R.App.P 32(a)(1)-(7) and is a principal brief of no more than 30 pages or a reply brief of no more than 15 pages.

or

This brief complies with a page or size-volume limitation established by separate court order dated \_\_\_\_\_ and is

Proportionately spaced, has a typeface of 14 points or more and contains \_\_\_\_\_ words,

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3. Briefs in **Capital Cases**.  
This brief is being filed in a capital case pursuant to the type-volume limitations set forth at Circuit Rule 32-4 and is

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or is

Monospaced, has 10.5 or fewer characters per inch and contains \_\_\_\_ words or \_\_\_\_ lines of text (opening, answering, and the second and third briefs filed in cross-appeals must not exceed 75 pages or 1,950 lines of text; reply briefs must not exceed 35 pages or 910 lines of text).

4. **Amicus Briefs.**

Pursuant to Fed.R.App.P 29(d) and 9th Cir.R. 32-1, the attached amicus brief is proportionally spaced, has a typeface of 14 points or more and contains 7,000 words or less,

or is

Monospaced, has 10.5 or few characters per inch and contains not more than either 7,000 words or 650 lines of text,

or is

Not subject to the type-volume limitations because it is an amicus brief of no more than 15 pages and complies with Fed.R.App.P. 32 (a)(1)(5).

December 14, 2012

---

Dated

*/s/ Alexandra Robert Gordon*

---

Alexandra Robert Gordon  
Deputy Attorney General

## CERTIFICATE OF SERVICE

Case Name: Pickup, David, et al. v. Brown, et al. No. 12-17681

I hereby certify that on December 14, 2012, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

**OPPOSITION TO EMERGENCY MOTION FOR TEMPORARY INJUNCTION  
PENDING APPEAL (CIRCUIT RULE 27-3)**

**DECLARATION OF ALEXANDRA ROBERT GORDON IN SUPPORT OF  
OPPOSITION TO EMERGENCY MOTION FOR TEMPORARY INJUNCTION  
PENDING APPEAL**

I certify that **all** participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on December 14, 2012, at San Francisco, California.

N. Newlin  
Declarant

/s/ N. Newlin  
Signature

12-17681

IN THE UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT

**DAVID H. PICKUP; et al. ,**

Plaintiffs-Appellants,

v.

**EDMUND G. BROWN, Jr. Governor of the  
State of California, in his official capacity;  
et al.,**

Defendants-Appellees.

On Appeal from the United States District Court  
for the Eastern District of California

No. 2:12-cv-02497-KJM-EFB  
The Honorable Kimberly J. Mueller, Judge

**DECLARATION OF ALEXANDRA ROBERT  
GORDON IN SUPPORT OF OPPOSITION TO  
EMERGENCY MOTION FOR TEMPORARY  
INJUNCTION PENDING APPEAL**

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*Attorneys for Defendants-Appellees*

I, Alexandra Robert Gordon, declare as follows:

1. I am a Deputy Attorney General at the California Department of Justice and serve as counsel to Defendants-Appellees in the above-entitled matter.

2. Except as otherwise stated, I have personal knowledge of the facts set forth in this declaration, and if called upon as a witness I could testify competently as to those facts.

3. I make this declaration to transmit to this Court, for its convenience, true and correct copies of documents submitted to the District Court in support of Defendants' opposition to the motion for preliminary injunction in *Pickup et al. v. Brown et al.*, E.D. Cal. Case no. 12-02497-KJM-EFB.

4. Attached hereto as **Exhibit A** is a true and correct copy of the Declaration of Paul Stein in Support of Defendants' Opposition to Plaintiffs' Motion for a Preliminary Injunction, filed November 9, 2012.

5. Attached hereto as **Exhibit B** is a true and correct copy of the Declaration of Gregory M. Herek in Support of Defendants' Opposition to Plaintiffs' Motion for a Preliminary Injunction, filed November 9, 2012.

6. Attached hereto as **Exhibit C** is a true and correct copy of the Declaration of A. Lee Beckstead in Support of Defendants' Opposition to Plaintiffs' Motion for a Preliminary Injunction, filed November 9, 2012.

7. Attached hereto as **Exhibit D** is a true and correct copy of Senate Bill 1172 (2012).

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: December 14, 2012

Respectfully submitted,

KAMALA D. HARRIS  
Attorney General of California  
DOUGLAS J. WOODS  
Senior Assistant Attorney General  
TAMAR PACHTER  
Supervising Deputy Attorney General

*/s/ Alexandra Robert Gordon*  
ALEXANDRA ROBERT GORDON  
Deputy Attorney General  
*Attorneys for Defendants-Appellees*

# **EXHIBIT A**

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9 IN THE UNITED STATES DISTRICT COURT  
10 FOR THE EASTERN DISTRICT OF CALIFORNIA  
11 SACRAMENTO DIVISION  
12

13 **DAVID PICKUP, ET AL.,**  
14  
15 Plaintiff,  
16  
17 v.  
18 **EDMUND G. BROWN JR., GOVERNOR**  
**OF THE STATE OF CALIFORNIA, IN**  
**HIS OFFICIAL CAPACITY, ET AL.,**  
19 Defendant.  
20  
21

2:12-cv-02497  
**DECLARATION OF PAUL STEIN IN**  
**SUPPORT OF DEFENDANTS'**  
**OPPOSITION TO PLAINTIFFS'**  
**MOTION FOR PRELIMINARY**  
**INJUNCTION**  
Date: November 30, 2012  
Time: 10:00 a.m.  
Courtroom: 3, 15th Floor  
Judge: The Honorable Kimberly J.  
Mueller  
Trial Date: None set  
Action Filed: Oct. 4, 2012

22 I, PAUL STEIN, declare as follows:

23 1. I am a deputy attorney general for the State of California and a counsel of record for  
24 the defendants in this case. I base this declaration on my personal knowledge and, if called upon,  
25 could and would testify as to the accuracy of the facts stated herein.

26 2. On November 6, 2012, I visited the American Psychological Association's website at  
27 <http://www.apa.org/pi/lgbt/resources/sexual-orientation.aspx> and downloaded a copy of the  
28 Report of the American Psychological Association Task Force on Appropriate Therapeutic

1 Responses to Sexual Orientation. A true and correct copy of the report I downloaded is attached  
2 as Exhibit 1 to this declaration.

3 3. Attached as Exhibit 2 to this declaration is a true and correct copy of an excerpt from  
4 Reparative Therapy of Male Homosexuality (1997) by Joseph Nicolosi, Ph.D., published by  
5 Jason Aronson, Inc.

6 I declare under penalty of perjury under the laws of the United States of America that the  
7 foregoing is true and correct.

8 Dated: November 9, 2012

*/s/ Paul Stein*

9

PAUL STEIN

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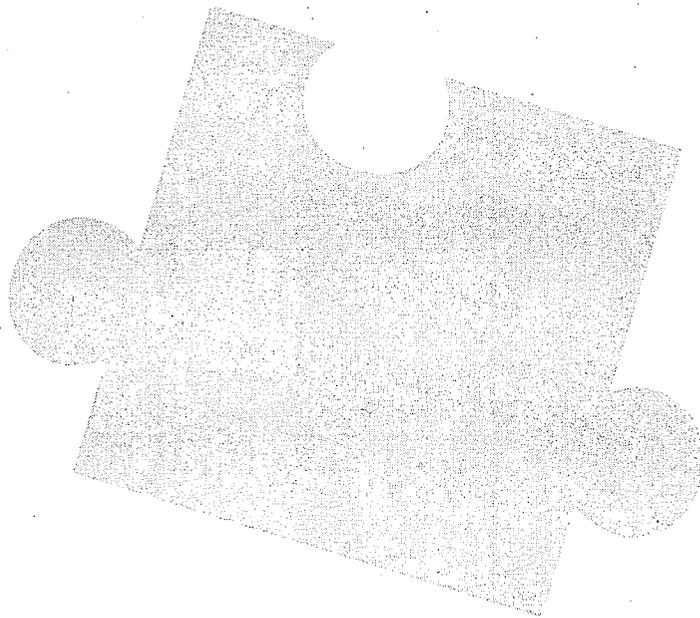
AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

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





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



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Judith M. Glassgold, PsyD, Chair

Lee Beckstead, PhD

Jack Drescher, MD

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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 [www.apa.org/pi/lgbc/publications/](http://www.apa.org/pi/lgbc/publications/)

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*Suggested bibliographic reference:*

APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Washington, DC: American Psychological Association.

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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  
Printed in the USA

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## ABSTRACT

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



## EXECUTIVE SUMMARY

In February 2007, the American Psychological Association (APA) established the Task Force on Appropriate Therapeutic Responses to Sexual Orientation with a charge that included three major tasks:

1. Review and update the 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

*Note.* We use the term *sexual minority* (cf. Blumenfeld, 1992; McCann & 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 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 (e.g., 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 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 and included 83 studies. Most studies in this area were conducted before 1978, and only a few studies have been conducted in the last 10 years. We found serious methodological problems in this area of research, such that 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 (i.e., 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) and aid in an understanding of the population that undergoes sexual orientation change but 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 would be the outcome of valid interventions. These studies show that 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 all 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 drop 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 SOCE participants 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, 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. For instance, in some research, individuals, through participating in SOCE, became skilled in ignoring or tolerating their same-sex attractions. Some individuals report 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

As part of the fulfillment of our 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) assessment, (c) active coping, (d) social support, and (e) identity exploration and development. Acceptance and support include unconditional acceptance 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. 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. 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 (EBPP) 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 felt 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, and respected and potentially re woven 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, assessment, active coping, social support, and identity exploration and development) is also relevant—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.

Research indicates that family interventions that reduce rejection and increase acceptance of their child

*LMHP can provide to parents who are concerned or distressed by their child's sexual orientation accurate information about sexual orientation and sexual orientation identity and can offer anticipatory guidance and psychotherapy that support family reconciliation.*

and adolescent are helpful. Licensed mental health providers (LMHP) can provide to parents who are concerned or distressed by their child's sexual orientation 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 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 and, 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.

Licensed mental health providers 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 B (Benefit and Harm), 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 Judgment). 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*). 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 licensed mental health practitioners 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 about 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 and 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. In addition, we recommend that researchers and practitioners provide such treatments to those who are distressed by their sexual orientation but not aim to alter sexual orientation. For such individuals, the focus would be on frameworks that include acceptance and support, assessment, active coping, social support, and identity exploration, development, and integration 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; and (e) 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.

Finally, the task force recommends that the 1997 APA Resolution on Appropriate Responses to Sexual Orientation be retained. This resolution 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, we recommend that APA adopt a new resolution, the Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts, to address these issues (see Appendix A).

## PREFACE

In February 2007, the American Psychological Association (APA) established the Task Force on Appropriate Therapeutic Responses to Sexual Orientation with the following charge:

1. Review and update the 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.

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 ATLA Religion Database, LexisNexis, Social Work Abstracts, and Sociological Abstracts, to review evidence regarding harm and benefit from sexual orientation change efforts (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 APA task force, the 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 the task force 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, the task force 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 to the task force. 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 invaluable to the accomplishment of our charge: Clinton W. Anderson, PhD, and Charlene DeLong, who supported the task force. 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. Mary Campbell also provided editorial advice on the report, and Stephanie Liotta provided assistance in preparing the final manuscript.

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 invaluable 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; Isiaah Crawford, PhD; June W. J. Ching, PhD; David Michael Corey, 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.<sup>1</sup> 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], 2003) but also acted on the basis of those positions to advocate for legal and policy changes (APA, 2003, 2005a, 2008b; NASW, 2003). On the basis of growing scientific evidence (Gonsiorek, 1991), licensed mental health providers

(LMHP)<sup>2</sup> of all professions increasingly took the perspective throughout this period that homosexuality per se is a normal variant<sup>3</sup> of human sexuality and that lesbian, gay, and bisexual (LGB) people deserve to be affirmed and supported in their sexual orientation,<sup>4</sup> 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; 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; Martin, 2003).

<sup>2</sup> 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.

<sup>3</sup> 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.

<sup>4</sup> 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).

<sup>1</sup> We use the term *sexual minority* (cf. Blumenfeld, 1992; McCarn & Fassinger, 1996; Ullerstam, 1966) to designate only those 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 a lesbian, gay, or bisexual identity.

In the early 1990s, some APA members began to express concerns about the resurgence of individuals and organizations that actively promoted the idea of homosexuality as a developmental defect or a spiritual and moral failing and that advocated psychotherapy and religious ministry to alter homosexual feelings and behaviors, because these practices seemed to be an attempt to repathologize sexual minorities (Drescher & Zucker, 2006; Haldeman, 1994; S. L. Morrow & Beckstead, 2004). Many of the individuals and organizations appeared to be embedded within conservative political and religious movements that supported the stigmatization of homosexuality (Drescher, 2003; Drescher & Zucker, 2006; Southern Poverty Law Center, 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, 1997; 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<sup>5</sup> (SOCE) 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

<sup>5</sup> In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods that aim to change a same-sex sexual orientation (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) 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.

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; Mustanski, 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<sup>6</sup> wanted APA to take a clearer stand and to clarify the conflicting media reports about the likelihood of sexual orientation change (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 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

<sup>6</sup> 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 for APA adoption 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 recommends for APA's adoption is 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 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 (Paul, Weinrich, Gonsiorek, & Hotvedt, 1982; Malyon, 1982), and its meaning has evolved over the last 25 years to include more diversity and complexity (Bieschke, Perez, & DeBord, 2007; Herek & Garnets, 2007; Perez, DeBord, & Bieschke, 2000; Ritter & Terndrup, 2002).

The affirmative approach grew out of a perception that sexual minorities benefit when the sexual stigma<sup>7</sup> they experience is addressed in psychotherapy with interventions that address the impacts of stigma (APA, 2000; Brown, 2006; Browning, Reynolds, & Dworkin, 1991; Davison, 1978; Malyon, 1982; 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 discrimination to guide treatment for sexual minority clients and help these clients overcome negative attitudes about themselves.

<sup>7</sup> See p. 15 for the definition of sexual stigma.

The most recent literature in the field (e.g., APA, 2000, 2002c, 2004, 2005b, 2007b; Bartoli & Gillem, 2008; Brown, 2006; Herek & Garnets, 2007) places affirmative therapeutic interventions within the larger domain of cultural competence, consistent with general multicultural approaches. Multicultural approaches recognize that individuals, families, and communities exist in social, political, historical, and economic contexts (cf. APA, 2002b) and that human diversity is multifaceted and includes age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. Understanding and incorporating these aspects of diversity are important to any intervention (APA, 2000, 2002c, 2004, 2005b, 2007b).

The task force takes the perspective that a multiculturally competent and affirmative approach with sexual minorities is based on the scientific knowledge in key areas: (a) homosexuality and bisexuality are stigmatized, and this stigma can have a variety of negative consequences throughout the life span (D'Augelli & Patterson, 1995, 2001); (b) same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality and are not indicators of either mental or developmental disorders (American Psychiatric Association, 1973; APA, 2000; Gonsiorek, 1991); (c) same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientation identities (Klein, Sepekoff, & Wolf, 1985; McConaghy, 1999; Diamond, 2006, 2008); 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

*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.*

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;<sup>8</sup> (e) the sex<sup>9</sup> and gender of their partner; and (f) the forms of their relationships.

## EVIDENCE-BASED PRACTICE AND EMPIRICALLY SUPPORTED TREATMENTS

Interest in the efficacy,<sup>10</sup> 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 that have been demonstrated as effective through rigorously controlled trials (Levant & Hasan, 2009). EBPP is, as defined by APA's Policy Statement on Evidence-Based Practice in Psychology<sup>11</sup> (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). 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

<sup>8</sup> *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 our gender identity to others, such as clothing, hairstyles, mannerisms, way of speaking, and social roles.

<sup>9</sup> We define *sex* as biological maleness and femaleness in contrast to gender, defined above.

<sup>10</sup> *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).

<sup>11</sup> 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).

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 (Cochran & Mays, 2006; Mays & Cochran, 2001; Meyer, 1995, 2003; Pachankis, 2007; Pachankis & Goldfried, 2004; Pachankis, Goldfried, & Ramrattan, 2008; Safren & Heimberg, 1999).
- 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). 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*:<sup>12</sup> "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 at 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

*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.*

this population (Drescher, 1998a; 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-sex behaviors (Katz, 1995). In the late modern period, the medical and mental health professions added a new type of stigmatization and discrimination

<sup>12</sup> 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*.

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.<sup>13</sup> 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, 1998a; Malyon, 1982; Pachankis, 2007; Pachankis, Goldfried, & Ramrattan, 2008; Troiden, 1993).

In Herek's (2009) model, *internalized stigma*<sup>14</sup> is the adoption of the social stigma applied to sexual

<sup>13</sup> 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 4 states permit same-sex couples to marry, 7 permit civil unions or domestic partnerships, and 5 have some limited form of recognition. For more examples, see National Gay and Lesbian Task Force, n.d.).

<sup>14</sup> 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*

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 that each human being is a part of (D'Augelli, 1994). This hypothesis appears to be confirmed 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 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

(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, n.d.).

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 (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 the goals of affirmative psychotherapy (Beckstead & Israel, 2007; Bieschke, 2008; Frost & Meyer, 2009; Glassgold, 2007; Rostosky, Riggle, Horne, & Miller, 2009; Martell et al., 2004; Russell & Bohan, 2007). Some authors propose that lesbians, gay men, and bisexual 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*)<sup>15</sup> 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,

<sup>15</sup> 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.

community participation, and identity confusion predicted coping with sexual stigma.

## Psychology, Religion, and Homosexuality

Most of the recent studies on SOCE focus on populations with strong religious beliefs (e.g., Beckstead & Morrow, 2004; Nicolosi et al., 2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Ponticelli, 1999; 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; Southern Poverty Law Center, 2005; Pew Forum on Religion and Public Life, 2003; Olyam & Nussbaum, 1998). One of the issues in SOCE is the expansion of religiously based SOCE. 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 in 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; Hebrew Union College, n.d.; Olyam & Nussbaum, 1998; Ontario Consultants on Religious Tolerance, n.d.). 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; Hebrew Union College, n.d.; Olyam & Nussbaum, 1998; Ontario Consultants on Religious Tolerance, n.d.). 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) (Ontario Consultants on Religious Tolerance, n.d.). 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) (Ontario Consultants on Religious Tolerance, n.d.)).

Several professional publications (e.g., *Journal of Gay and Lesbian Psychotherapy*, 2001, 5[3/4]; *Professional Psychology*, 2002, 33[3]; *Archives of Sexual Behavior*,

*Some difficulties arise because the professional psychological community considers same-sex sexual attractions and behaviors to be a positive variant of human sexuality, while some traditional faiths continue to consider it a sin, moral failing, or disorder that needs to be changed.*

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, moral failing, or 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<sup>16</sup>) (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<sup>17</sup>) (W. Hathaway, personal

<sup>16</sup> 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; Schwartz, 2000).

<sup>17</sup> Such naturalistic and empirically based models stress the

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), and the telic worldview can be aware of sexual stigma and respectful of sexual orientation (Throckmorton & Yarhouse, 2006; Tan, 2008; 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 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; 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,

organization, unity, and integration of human beings expressed through each individual's inherent growth or developmental tendency (see, e.g., Rogers, 1961; Ryan, 1995).

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, 2008b) 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 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 (2008b). This resolution

*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.*

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 (2008b) states, psychology has no legitimate function in "arbitrating matters of faith and theology" (line 433) or to "adjudicate religious or spiritual tenets," 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" (line 433). Further, the resolution states that faith traditions "have no legitimate place arbitrating behavioral or other sciences" (line 432) or to "adjudicate empirical scientific issues in psychology" (line 432).

The APA (2002b, 2008c) recommends that psychologists acknowledge the importance of religion and spirituality as forms of meaning-making, tradition, culture, identity, community, and diversity. Psychologists do not discriminate against individuals based on those factors. Further, when devising interventions and conducting research, psychologists consider the importance of religious beliefs and cultural values and, where appropriate, consider religiously and culturally sensitive techniques and approaches (APA, 2008c).

## Psychology of Religion

Historically, some in psychology and psychiatry have held negative views of religion (Wulff, 1997). Yet, with the development of more sophisticated methodologies and conceptualizations, the field of the psychology of religion has flourished in the last 30 years (Emmons & Paloutzian, 2003), culminating in new interest in a diverse field (e.g., Koenig & Larson, 2001; Paloutzian & Park, 2005; Pargament, 2002; Pargament & Mahoney, 2005; Richards & Bergin, 2005; Sperry & Shafranske, 2004; Spilka, Hood, Hunsberger, & Gorsuch, 2003).

Many scholars have attempted to elucidate what is significant and unique about religious and spiritual faith, beliefs, and experiences (e.g., George, Larson, Koenig, & McCullough, 2000; McClennon, 1994). Pargament, Maygar-Russell, and Murray-Swank (2005) summarized religion's impact on people's lives as a unique form of motivation regarding how to live one's life and how to respond to self, others, and life events; a source of significance regarding what aspects of life one imbues with meaning and power; a contributor to mortality and health; a form of positive

and negative coping; and a source of fulfillment and distress. Others, such as Fowler (1981, 1991) and colleagues (Oser, 1991; Streib, 2001, 2005) have posited developmental models of religious identity that are helpful in understanding personal faith.

Additionally, there is a growing literature on integrating spirituality into psychotherapy practice (Richards & Bergin, 2000, 2004, 2005; Shafranske, 2000; Sperry & Shafranske, 2004; E. L. Worthington, Kurusu, McCullough, & Sandage, 1996). These approaches include delineating how LMHP can work effectively with individuals from diverse religious traditions (Richards & Bergin, 2000, 2004; Sperry & Shafranske, 2004). Many of these techniques can be effective (McCullough, 1999) and improve outcomes in clinical treatment with religious clients (Probst, Ostrom, Watkins, Dean, & Mashburn, 1992; Richards, Berrett, Hardman, & Eggett, 2006; E. L. Worthington et al., 1996), even for clients in treatment with secular LMHP (Mayers, Leavey, Vallianatou, & Barker, 2007). These innovations point to ways that psychology can explore and understand religious beliefs and faith in an evidence-based and respectful manner.

There have been claims that some LMHP do not address the issues of conservative religious individuals who are distressed by their same-sex sexual attractions (e.g., Yarhouse, 1998a; Throckmorton, 2002; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002). One of the problems in the field has been an either/or perspective in which sexual orientation and religion are seen as incompatible (Phillips, 2004). Certainly, some individuals may perceive their religion and their sexual orientation as incompatible, because in some faiths homosexuality is perceived as sinful and immoral. However, there is a growing body of evidence illustrating that many individuals do integrate their religious and sexual orientation identities (Coyle & Rafalin, 2000; Kerr, 1997; Mahaffy, 1996; Rodriguez, 2006; Rodriguez & Ouellete, 2000; Thumma, 1991; Yip, 2002, 2003, 2005). Thus, this dichotomy may be enabling a discourse that does not fully reflect the evidence and may be hindering progress to find a variety of viable solutions for clients.

Recently, some authors have suggested alternative frameworks, many of which are drawn from a variety of models of psychotherapy, such as multicultural views of psychology and the psychology of religion, that provide 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 & Gosselin, 2004; S. L. Morrow & Beckstead, 2004; Ritter & O'Neill, 1989; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). For instance, a growing number of authors

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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). Based on of these scholarly contributions, we take the perspective that religious faith and psychology do not have to be seen as being opposed to each other. Further, psychotherapy that respects faith can also explore the psychological implications and impacts of such beliefs.

We support affirmative and multi-culturally 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 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, 1998a, 2002). The first treatments attempted to correct or repair the damage done by pathogenic factors or to facilitate maturity (Drescher, 1998a, 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, 1998a).

### Homosexuality and Psychoanalysis

Initial psychotherapeutic approaches to homosexuality of 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, although bisexuality was normative (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 parents. At the end of this case, Freud concluded that attempts to change homosexual sexual orientation were likely to be unsuccessful.<sup>18</sup>

<sup>18</sup> Analyses of this case have focused on Freud's intense negative reactions to this young woman and his attempts to enforce social

In the psychoanalyses 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<sup>19</sup> 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

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conformity—especially with regard to traditional female gender roles and sexuality (e.g., Lesser & Schoenberg, 1999; O'Connor & Ryan, 1993).

<sup>19</sup> 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.

reconditioning, and satiation therapy (Beckstead & Morrow, 2004; S. James, 1978; Langevin, 1983; LeVay, 1996; Katz, 1995; 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 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

*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.*

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 review by Gonsiorek, 1991). Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation (e.g., Bell, Weinberg, & Hammersmith, 1981; Bene, 1965; Freund & Blanchard, 1983; Freund & Pinkava, 1961; Hooker, 1969; McCord, McCord, & Thurber, 1962; D. K. Peters & Cantrell, 1991; Siegelman, 1974, 1981; Townes, Ferguson, & Gillem, 1976). This research was a significant challenge to the model of homosexuality as psychopathology.

## Homosexuality Removed From the Diagnostic and Statistical Manual

In recognition of the legal nexus between psychiatric diagnosis and civil rights discrimination, especially for government employees, activists within the homophile<sup>20</sup> rights movement, including Frank Kameny and the Mattachine Society of Washington, DC, launched a campaign in late 1962 and early 1963 to

<sup>20</sup> *Homophile* is an early term for what would become the gay rights or gay and lesbian rights movement.

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). Upon the recommendation of its committee evaluating the research, the American Psychiatric Association Board of Trustees and general membership voted to remove homosexuality *per se*<sup>21</sup> 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:

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

<sup>21</sup> 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 for delineating a mental disorder (Drescher, Stein, & Byne, 2005).

(ApsaA, 1991, 1992). In 2000, ApsaA adopted a policy against SOCE, attempting to end that practice within the field:

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 NASW 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 SOCE

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 (Davison, 1976, 1978; Davison & Wilson, 1973; M. King, Smith, & Bartlett, 2004; 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 (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

As in all psychoanalytic treatments, the goal of analysis with homosexuals 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.<sup>22</sup>

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 individuals (National Gay and Lesbian Task Force, n.d.). 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,

<sup>22</sup> 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, and the American Psychoanalytic Association maintains its own bibliography: <http://www.apsa.org/APSAAMBERSSECTION/COMMITTEEWORKROOMS/GAYANDESBIANISSUES/tabid/381/Default.aspx>.

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. Among those who provided such services, the number of clients provided SOCE had remained constant over time (cf. M. King et al., 2004).

with charges that professional psychology has not reflected the concerns of religious individuals,<sup>25</sup> 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 conclude 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; in Chapter 4, the results that can be drawn from this literature.

## Sexual Orientation Change Efforts Provided to Religious Individuals

The visibility of SOCE has increased in the last decade (Drescher, 2003; Drescher & Zucker, 2006; Herek, 2003). From our survey of recent publications and research, most SOCE currently seem directed to those holding conservative religious and political beliefs, and recent research on SOCE includes almost exclusively individuals who have strong religious beliefs (e.g., Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Shidlo & Schroeder, 2002; Spitzer, 2003). In an evolution for some religious communities, sexual minorities are not automatically expelled or shunned (Drescher & Zucker, 2006; Sanchez, 2007; SPLC, n.d.). 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 include negative portrayals of homosexuality, religious outreach efforts, and support groups, as well as psychotherapy (Burack & Josephson, 2005; Cianciotto & Cahill, 2006; Wolkomir, 2006).

Debates between those who advocate SOCE and those who oppose it have at times become polemical,

<sup>25</sup> APA has received correspondence from individuals and organizations asserting this point.

### 3. A SYSTEMATIC REVIEW OF RESEARCH ON THE EFFICACY OF SOCE: 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), 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 attempt 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 charged 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<sup>24</sup> 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<sup>25</sup> 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<sup>26</sup> of the research. In the next chapter, we present our review of the outcomes of the research.

<sup>24</sup> A systematic review starts with a clear question to be answered, strives to locate all relevant research, has clear inclusion and exclusion criteria, and carefully assesses study quality and synthesizes study results (Petticrew, 2001).

<sup>25</sup> Grey literature refers to any publication in any format published outside of peer-reviewed scientific journals.

<sup>26</sup> 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 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).

## Overview of the Systematic Review

Our review included peer-reviewed empirical research on treatment outcomes published from 1960 to the present. 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 from these articles to identify refereed publications of original research investigations on treatment of same-sex attraction that had not been identified via the aforementioned procedures. In all, we obtained and reviewed original publications of 83 studies. The reviewed studies are listed in Appendix B.<sup>27</sup>

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

<sup>27</sup> 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 to be 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).

potential harm of SOCE and experiences of those who seek sexual orientation (Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002). A third type is high-quality<sup>28</sup> 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).<sup>29</sup>

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

*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.*

have described methodological concerns regarding the research literature on sexual orientation change efforts (e.g., Cramer, Golom, LoPresto,

& Kirkley, 2008; Haldeman, 1994; S. L. Morrow & Beckstead, 2004; Murphy, 1992; Sandfort, 2003). Overall, we found that the low quality of the research on SOCE is such that claims regarding its effectiveness and widespread applicability must be viewed skeptically.

As shown in Appendix B, few studies on SOCE produced over the past 50 years of research rise to current scientific standards for demonstrating the efficacy of psychological interventions (Chambless & Hollon, 1998; Chambless & Ollendick, 2001; 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<sup>30</sup> procedures. Only one of these experiments (Tanner,

<sup>28</sup> 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).

<sup>29</sup> These studies are discussed more thoroughly in later sections of the report.

<sup>30</sup> 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), usually 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.

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 SOCE

### *Problems in Making Causal Claims*

A principal goal of the available research on SOCE was to demonstrate that SOCE consistently and reliably produce changes in aspects of sexual orientation. Overall, due to weaknesses in the scientific validity of research on SOCE, the empirical research does not provide a sound basis for making compelling causal claims. A detailed analysis of these issues follows.

### INTERNAL VALIDITY CONCERNS

Internally valid research convincingly demonstrates that a cause (such as SOCE) is the only plausible explanation for an observed outcome such as change

*Research on SOCE has rarely used designs that allow for confident conclusions regarding cause-and-effect relationships between exposure to SOCE and outcomes.*

in same-sex sexual attractions. Lack of internal validity limits certainty that observed changes in people's attitudes, beliefs, and behaviors are a function of the

particular interventions to which they were exposed. A major limitation to research on SOCE, both the early and the recent research, stems from the use of weak research designs that are prone to threats to internal

validity. Research on SOCE has rarely used designs that allow for confident conclusions regarding cause-and-effect relationships between exposure to SOCE and outcomes.

As noted previously, true experiments and rigorous quasi-experiments are rare in the SOCE research. There are only a few studies in the early period that are experiments or quasi-experiments, and no true experiments or quasi-experiments exist within the recent research. Thus, none of these recent studies meet current best practice standards for experimental design and cannot establish whether SOCE is efficacious.

In early studies, comparison and no-treatment control groups were uncommon procedures, and early studies rarely employed multiple baseline assessments, randomization to condition, multiple long-term follow-up assessments, or other procedures to aid in making causal inferences. These procedures are widely accepted as providing the most compelling basis for ruling out the possibility that an alternative source is responsible for causing an observed or reported treatment effect.

Common threats to internal validity in early studies include history (i.e., other events occurring over the same time period as the treatment that could produce the results in the absence of the intervention), regression (i.e., extreme scores are typically less extreme on retest in the absence of intervention), and testing (i.e., taking a test once influences future scores on the test in the absence of intervention). Within-subject and patient case studies are the most common designs in the early SOCE research (see Appendix 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, notably threats to internal validity due to sample attrition and retrospective pretests.

### *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 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 (Schwarz & Clore, 1985; Schwartz & Rapkin, 2004). 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; 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) and will seek to justify the time and effort that they have made in treatment to reduce any dissonance they may feel at experiencing no or less change 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. Modern research of 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 aspects.

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; McConaghy, 1999; McConaghy, Buhrich, & Silove, 1994; Storms, 1980; Thompson &

*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.*

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,<sup>31</sup> Sell, 1997; Shively & DeCecco, 1977; Storms,

<sup>31</sup> 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.

1980; R. L. Worthington, 2003; R. L. Worthington & Reynolds, 2009). Models with multiple dimensions that permit the rating of the intensity of an individual's sexual desire or arousal for other-sex individuals separately from the intensity of that individual's sexual desire or arousal for same-sex individuals allow individuals to have simultaneous levels of attractions. Some commentators believe such models allow for greater understanding of sexual diversity and its interactions with other aspects of identity and culture (Mays & Cochran, 1998; R. L. Worthington et al. 2002).

Considered in the context of the conceptual complexities of and debates over the assessment of sexual orientation, much of the SOCE research does not adequately define the construct of sexual orientation, does not differentiate it from sexual orientation identity, or has misleading definitions that do not accurately assess or acknowledge bisexual individuals.

Early research that focuses on sexual arousal may be more precise than that which relies on self-report of behavior. Overall, recent research may actually measure sexual orientation identity (i.e., beliefs about sexual orientation, self-report of identity or group affiliation, self-report of behavior, and self-labeling) rather than sexual orientation.

#### *Study treatments*

In general, what constitutes SOCE in empirical research is quite varied. As we show in Appendix B, early studies tested a variety of interventions that include aversive conditioning techniques (e.g., electric shock, deprivation of food and liquids, smelling salts, chemically induced nausea), biofeedback, hypnosis, masturbation reconditioning, psychotherapy, systematic desensitization, and combinations of these approaches. A small number of early studies compare approaches alone or in combination. The more recent research includes an even wider variety of interventions (e.g., gender role reconditioning, support groups, prayer, psychotherapy) and providers (e.g., licensed and unlicensed LMHP in varied disciplines, pastoral counselors, laypersons). The recent studies were conducted in such a way that it is not possible to attribute results to any particular

intervention component, approach, or provider.

For instance, these interventions were provided simultaneously or sequentially, without specific separate evaluations of each intervention. The recent research and much of the early research cannot provide clarity regarding which specific efforts are associated with which specific outcomes.

#### *Outcome measures*

Regarding assessment mode, outcomes in early studies were assessed by one or more of the following: gauging an individual's physiological responses when presented with sexual stimuli, obtaining the person's self-report of recent sexual behavior and attractions, and using clinical opinion regarding improvement. In men especially, physiological measures are considered more dependable for detecting sexual arousal in men and women than self-report of sexual arousal or attraction (McConaghy, 1999). However, these measures have important limitations when studying sexual orientation. Many men are incapable of sexual arousal to any stimuli in the laboratory and must be excluded from research investigations in which the measure is the sole outcome measure. More recent research indicates that some penile circumference gauges are less consistent than penile volume gauges (Kuban, Barbaree, & Blanchard, 1999; McConaghy, 1999; Quinsey & Lalumiere, 2001; Seto, 2004) and that some men can intentionally produce false readings on the penile circumference gauges by suppressing their standard sexual arousal responses (Castonguay, Proulx, Aubut, McKibben, & Campbell, 1993; Lalumiere & Harris, 1998) or consciously making themselves aroused when presented with female erotic stimuli (Freund, 1971, 1976; Freund, Watson, & Rienzo, 1988; Lalumiere & Earls, 1992; McConaghy, 1999, 2003). The physiological measure used in all the SOCE experiments was the penile circumference gauge. 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). Coupled 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,<sup>32</sup> even though these studies involved larger samples than the early research.

#### *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.

<sup>32</sup> 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 performing the chi-square test such as missing data, and the analyses are 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, however, the problems associated with running so many tests without adjusting for chance associations 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.

Concerns regarding the sample composition in these studies are common in critiques (e.g., Cramer et al., 2008). The studies from the early period are characterized by samples that are narrow in their demographic characteristics, composed almost exclusively of Caucasian males over the age of 18. No investigations are of children and adolescents exclusively, although adolescents are included in a very few study samples. Few SOCE studies in the early period include women. Although more recent research

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

includes women and respondents of diverse ethnic and racial backgrounds (e.g., Moran, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Schaeffer et al., 2000; Spitzer, 2003; Wolkomir, 2001), White men continue to dominate recent study samples. Thus, the research findings from early and recent studies may have limited applicability to non-Whites, youth, or women. The samples in the recent research have been narrowly defined in other respects, focusing on well-educated, middle-class individuals to whom religion is extremely important (e.g., Beckstead & Morrow, 2004; Nicolosi et al., 2000; Pattison & Pattison, 1980; Schaeffer et al., 2000; Spitzer, 2003; Wolkomir, 2001). Same-sex sexual attraction and treatments are confounded with these particular demographic characteristics across the recent literature. These research findings may be most applicable to educated White men who consider themselves highly religious.

The early research sometimes included men who were receiving intervention involuntarily (e.g., Barlow, Agras, Abel, Blanchard, & Young, 1975; Callahan & Leitenberg, 1973; S. James, 1978; MacCulloch & Feldman, 1967; MacCulloch et al., 1965; McConaghy, 1969, 1976; McConaghy, Proctor, & Barr, 1972), usually men who were court referred as a result of convictions on charges related to criminalized acts of homosexual sex.<sup>33</sup> 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,

<sup>33</sup> Shidlo and Schroeder (2002) found that roughly 24% of their respondents perceived that SOCE was imposed on them rather than pursued voluntarily.

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 who may not be 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 et al., 1972, 1981; McConaghy & Barr, 1973; Segal & Sims, 1972; Thorpe

*Including participants with attractions, sexual arousal, and behaviors to both sexes in the research on SOCE makes evaluating change more difficult.*

et al., 1964), so that men who are or have been sexually active with women and men, only women, only men, or neither are 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 subpopulations fared as a result of intervention. The absence of these analyses obscure 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 are 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 of them 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

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

recent research include problems with conclusion validity (the ability to make inferences from the data) due to small or skewed samples,

unreliable measures, and inappropriate selection and performance of statistical tests. Due to these limitations, the recent empirical literature provides little basis for concluding whether SOCE has any effect on sexual orientation. Any reading of the literature on SOCE outcomes must take into account the limited generalizability of the study samples to the population of people who experience same-sex sexual attraction and are distressed by it. Taking into account the weaknesses and limitations of the evidence base, we next summarize the results from research in which same-sex sexual attraction and behavior have been treated.

## 4. A SYSTEMATIC REVIEW OF RESEARCH ON THE EFFICACY OF SOCE: OUTCOMES

In Chapter 3, we provided an overview of our systematic review of research on sexual orientation change efforts<sup>34</sup> (SOCE) 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 different 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).

<sup>34</sup> In this report, we use the term *sexual orientation change efforts* (SOCE) to describe a method that aims to change a same-sex sexual orientation (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) 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.

*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, Proctor, and Barr (1972) found reductions in penile response in the laboratory following treatment. However, 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 change 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 response 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; Hallan & 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, as 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, Blich and Haynes (1972) treated a single female who was heterosexually experienced and whom they described as strongly committed to reducing her same-sex sexual attractions. Using relaxation, rehearsal, and masturbation reconditioning, she was reported to be able to masturbate without female fantasies 2 months after intervention. Curtis and Presly (1972) used covert sensitization to treat a married man who experienced guilt about his attraction to and extramarital engagement with men. After intervention, he showed reduced other-sex and same-sex sexual interest, as measured by questionnaire items. Huff (1970) treated a single male who was interested in becoming sexually attracted to women. Following desensitization, his journal entries showed that his same-sex sexual fantasies continued, though the ratio of other-sex to same-sex sexual fantasies changed by the 6-month follow-up to favor other-sex sexual fantasies. His MMPI scores showed improvement in his self-concept and reductions in his distress.

By contrast, among the 4 men exposed to orgasmic reconditioning by Conrad and Wincze (1976), all reported decreased same-sex sexual attractions immediately following intervention, but only one demonstrated a short-term measurable alteration in physiological responses to male stimuli. Indeed, one subject's sexual arousal to same-sex sexual stimuli

increased rather than decreased, a result that was obtained for some men in the experimental studies. In a study by Barlow and colleagues (1975), among 3 men who were each exposed to unique biofeedback treatment regimens, all maintained same-sex sexual arousal patterns at follow-up, as measured by penile circumference change in response to photos of male stimuli.

Mintz (1966) found that 8 years after initiating group and individual therapy, 5 of his 10 research participants (50%) had dropped out of therapy. Mintz perceived that among those who remained, 20% ( $n = 1$ ) were distressed, 40% ( $n = 2$ ) accepted their same-sex sexual

*Overall, the low degree of scientific rigor in these studies is likely to lead to overestimates of the benefits of these treatments on reductions in same-sex sexual arousal and attraction and may also explain the contradictory results obtained in nonexperimental studies.*

attractions, and 40% ( $n = 2$ ) were free from conflict regarding same-sex sexual attractions. Birk (1974) assessed the impact of behavioral therapy on 66 men, of whom 60% ( $n = 40$ ) had dropped out of intervention by 7 months. Among those

who remained in the study, a majority shifted toward heterosexual scores on the Kinsey scale by 18 months.

Overall, the low degree of scientific rigor in these studies is likely to lead to overestimates of the benefits of these treatments on reductions in same-sex sexual arousal and attraction and may also explain the contradictory results obtained in nonexperimental studies.

## RECENT STUDIES

Recent studies have investigated whether people who have participated in efforts to change their sexual orientation report decreased same-sex sexual attractions (Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003) or how people evaluate their overall experiences of SOCE (Beckstead & Morrow 2004; Pattison & Pattison, 1980; Ponticelli, 1999; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Wolkomir, 2001). These studies all use designs that do not permit cause-and-effect attributions to be made. We conclude that although these studies may be useful in describing people who pursue SOCE and their experiences of SOCE, none of the recent studies can address the efficacy of SOCE or its promise as an intervention. These studies are therefore described elsewhere in the

report in places where they contribute to understanding respondents' motivations for and experiences of SOCE.

picture of the effects of aversive forms of SOCE similar to that painted by H. E. Adams & Sturgis.

## 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.

For instance, in his study comparing aversion and aversion relief therapies,<sup>36</sup> McConaghy (1969) reported that about 20% of men had engaged in same-sex sexual behavior within 2 weeks following treatment. No longer term data are 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, Armstrong, and Blaszczyński (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 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

## *Decreasing Same-Sex Sexual Behavior*

### EARLY STUDIES

Early studies show that SOCE have limited impact on same-sex sexual behavior, even in cases when lab results show some reduction in same-sex sexual arousal.<sup>35</sup>

#### *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

<sup>35</sup> 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.

<sup>36</sup> Aversive therapy is the application of a painful stimuli; aversion relief therapy is the cessation of an aversive stimulus.

EARLY STUDIES

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 is 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.

*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, Proctor, and Barr (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 an 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, Harrison, 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 identifies 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; Smith et al., 2004), just as other recent studies document that there are people who perceive that they have benefited from it (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Pattison & Pattison, 1980; Schaeffer et al., 2000; Spitzer, 2003). Among those studies reporting on the perceptions of harm, the reported negative social and emotional consequences include self-reports of anger, anxiety, confusion, depression, grief, guilt, hopelessness, deteriorated relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation, self-hatred, and sexual dysfunction. These reports of perceptions of harm are countered by accounts of

perceptions of relief, happiness, improved relationships with God, and perceived improvement in mental health status, among other reported benefits. Many participants in studies by Beckstead and Morrow (2004) and Shidlo and Schroeder (2002) described experiencing first the positive effects and then experiencing or acknowledging the negative effects later.

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

## Summary

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

*Studies from both periods indicate that attempts to change sexual orientation may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts. The lack of rigorous research on the safety of SOCE represents a serious concern, as do studies that report perceptions of harm.*

prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE. However, studies from both periods indicate

that attempts to change sexual orientation may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts. The lack of rigorous research on the safety of SOCE represents a serious concern, as do studies that report perceptions of harm (cf. Lilienfeld, 2007).

## Conclusion

The limited number of rigorous early studies and complete lack of rigorous recent prospective research on SOCE limits claims for the efficacy and safety of SOCE. Within the early group of studies, there are a small number of rigorous studies of SOCE, and those focus on the use of aversive treatments. These studies show that

enduring change to an individual's sexual orientation is uncommon and that a very small minority of people in these studies showed any credible evidence of reduced

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

same-sex sexual attraction, though some show lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and increased

attraction to and engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. We found that nonaversive and recent approaches to SOCE have not been rigorously evaluated. Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective.

We found that there was some evidence to indicate that individuals experienced harm from SOCE. Early studies do document iatrogenic effects of aversive forms of SOCE. High dropout rates characterize early aversive treatment studies and may be an indicator that research participants experience these treatments as harmful. Recent research reports indicate that there are individuals who perceive they have been harmed and others who perceive they have benefited from nonaversive SOCE. Across studies, it is unclear what specific individual characteristics and diagnostic criteria would prospectively distinguish those individuals who will later perceive that they have succeeded and benefited from nonaversive SOCE from those who will later perceive that they have failed or been harmed. In the next chapter, we explore the literature on individuals who seek to change their sexual orientation to better understand their concerns.

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## 5. RESEARCH ON ADULTS WHO UNDERGO SEXUAL ORIENTATION CHANGE EFFORTS

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In the three chapters preceding this one, we have focused on sexual orientation change efforts<sup>37</sup> (SOCE), 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 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 polemical 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

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*We hope that an empathic and comprehensive review of the scholarly literature of the population that seeks and participates in SOCE can facilitate an increased understanding of the needs of this population so that an affirmative therapeutic approach may be developed.*

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

We decided to expand our review beyond empirical literature to have a fuller view of the population in question. Because of the lack of empirical research in this area, the conclusions must be viewed as tentative. The studies that are included in this discussion are (a) surveys and studies of individuals who participated in SOCE and their perceptions of change, benefit, and harm (e.g., S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003; Throckmorton & Welton, 2005);<sup>38</sup> (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 where sexual

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

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<sup>37</sup> In this report, we use the term *sexual orientation change efforts* (SOCE) to describe a method that aims to change a same-sex sexual orientation (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) 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.

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<sup>38</sup> As previously noted, these studies, due to their significant methodological issues, cannot assess whether actual sexual orientation change occurred.

orientation or sexual orientation identity change were considered or attempted (e.g., Borowich, 2008; Drescher, 1998a; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Karten, 2006; Mark, 2008; Tan, 2008; Yarhouse et al., 2005; Yarhouse, 2008); and (d) scholarly articles on the concerns of religious individuals who are conflicted by their same-sex sexual attractions, many of whom accept their same-sex sexual orientation (e.g., Coyle & Rafalin, 2000; Horlacher, 2006; Kerr, 1997; Mahaffy, 1996; Moran, 2007; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Smith et al., 2004; Thumma, 1991; 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 (S. James, 1978; McConaghy, 1969, 1976; McConaghy et al., 1972) and whose participation was not voluntary, but more recent research primarily includes 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. 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.

*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.*

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

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

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. The published literature focused on the impact of religiously oriented self-help groups or was performed by those who sought referrals from groups that advocate SOCE. 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 SOCE

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, 1998a; 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; 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; 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, 1998a; 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 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.

Licensed mental health providers' views about 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; Smith et al., 2004). For example, 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 the belief in their Higher Power, with the perception that this Power was punishing or abandoning them—or would if they acted

on their attractions, some expressed feelings of anger at the situation in which their Power had placed them (Beckstead & Morrow, 2004; Glassgold, 2008; cf. Exline, 2002; Pargament, Smith, Koenig, & Perez, 1998, 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

*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.*

religious sexual minorities due to struggling with conservatively religious family, friends, and communities who thought differently than they did. The distress experienced by

religious individuals appeared intense, for not only did they face sexual stigma from society at large but also messages from their faith that they were deficient, sinful, deviant, and possibly unworthy of salvation unless they changed sexual orientation (Beckstead & Morrow, 2004).

These spiritual struggles had mental health consequences. Clinical publications and studies of religious clients (both male and female) (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008) have described individuals who felt culpable, unacceptable, unforgiven, disillusioned, and distressed due to the conflict between their same-sex sexual attractions and religion. The inability to integrate religion and sexual orientation into a religiously sanctioned life (i.e., one that provides an option for positive self-esteem and religiously sanctioned sexuality and family life) has been described as causing great emotional distress (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008; D. F. Morrow, 2003). These spiritual struggles were sometimes associated with anxiety, panic disorders, depression, and suicidality, regardless of the level of religiosity or the perception of religion as a source of comfort and coping (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004). The emotional reactions reported in the literature on SOCE among religious individuals are consistent with the literature in the psychology of religion 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; Haldeman, 2004; Glassgold, 2008; Mark, 2008). Relief came as some sought repentance from their "sins," but others continued to feel isolated and unacceptable in both religious and sexual minority communities (Shidlo & Schroeder, 2002; Yarhouse & Beckstead, 2007). As an alternative, some with strong religious motivations and purpose were willing to make sexual abstinence a goal and to limit sexual and romantic needs in order to achieve congruence with their religious beliefs (S. L. Jones & Yarhouse, 2007; Yarhouse et al., 2005; Yarhouse, 2008). These choices are consistent with the psychology of religion that emphasizes religious motivations and purpose (cf. Emmons, 1999; Emmons & Paloutzian, 2003; Hayduk, Stratkotter, & Rovers, 1997; Roccas, 2005). Success with this choice varied greatly and appeared successful in a minority of participants of studies, although not always in the long term, and both positive and negative mental health effects have been reported (Beckstead & Morrow, 2004; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Shidlo & Schroeder, 2002).

Some conservatively religious individuals felt a need to change their sexual orientation because of the positive benefits that some individuals found from religion (e.g., community, mode of life, values, sense of purpose) (Beckstead & Morrow, 2004; Borowich, 2008; Glassgold, 2008; Haldeman, 2004; Mark, 2008; Nicolosi et al., 2000; Yarhouse, 2008). Others hoped that being heterosexual would permit them to avoid further negative emotions (e.g., self-hatred, unacceptability, isolation, confusion, rejection, and suicidality) and expulsion from their religious community (Beckstead & Morrow, 2004; Borowich, 2008; Glassgold, 2008; Haldeman, 2004; Mark, 2008).

The literature on non-Christian religious denominations is very limited, and no detailed literature was found on most faiths that differed from the descriptions cited previously. There is limited information on the specific concerns of observant and Orthodox Jews<sup>39</sup> (e.g., Blechner, 2008; Borowich,

<sup>39</sup> 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

2008; Glassgold, 2008; Mark, 2008; Wolowick & 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.<sup>40</sup> 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 out 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 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 (Coyle & Rafalin, 2000; Mahaffy, 1996; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Rodriguez & Ouellette, 2000; Rodriguez,

in other denominations (e.g., Conservative, Reform, Reconstructionist) may not face this type of conflict or this degree of conflict.

<sup>40</sup> 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.

2006; 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 some 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 another-sex person was described as based on socialization, religious views that deny same-sex sexual attractions, lack of awareness of alternatives, and hopes that marriage would change them (Gramick, 1984; Higgins, 2006; Isay, 1998; Malcolm, 2000; Ortiz & Scott, 1994; M. W. Ross, 1989). Others did not recognize or become aware of their sexuality, including same-sex sexual attractions, until after marriage, when they became sexually active (Bozett, 1982; Carlsson, 2007; Schneider et al. 2002). Others had attractions to both men and women (Brownfain, 1985; Coleman, 1989; Wyers, 1987).

For those who experienced distress with their other-sex relationship, some were at a loss as to how to decide what to do with their conflicting needs, roles, and responsibilities and experienced considerable guilt, shame, and confusion (Beckstead & Morrow, 2004; Bozett, 1982; Buxton, 1994, 2004, 2007; Gochros, 1989; Hays & Samuels, 1989; Isay, 1998; Shidlo & Schroeder, 2002; Yarhouse & Seymore, 2006). Love for their spouse conflicted with desires to explore or act on same-sex romantic and sexual feelings and relationships or to connect with similar others (Bridges & Croteau, 1994; Coleman, 1981/1982; Yarhouse & Seymore, 2006). However, many individuals wished to maintain their marriage and work at making that relationship last (Buxton, 2007; Glassgold, 2008; Yarhouse, Pawlowski,

& Tan, 2003; Farnhouse & Seymour, 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 they 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 SOCE

### *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; Wolkomir, 2001, 2006; Throckmorton & Welton, 2005).

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 describe that trying and failing to change their same-sex sexual orientation actually allowed them to accept their same-sex attractions (Beckstead & Morrow, 2004; 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 both from conservative churches and from their families, because of their same-sex sexual attractions, and 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

*...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.*

ex-gay groups recast homosexuality as an ordinary sin, and thus salvation was still achievable. Erzen observed that such groups built hope, recovery, and relapse into an ex-

gay identity, thus expecting same-sex sexual behaviors and conceiving them as opportunities for repentance and forgiveness.

Some participants of SOCE reported what they perceived as other positive values and beliefs underlying SOCE treatments and theories, such as supporting celibacy, validating other-sex marriage, and encouraging and supporting other-sex sexual behaviors (Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Throckmorton & Welton, 2005). For instance, many SOCE theories and communities focus on supporting clients' values and views, often linked to religious beliefs and values (Nicolosi et al., 2000; Schaeffer et al., 2000; Throckmorton & Welton, 2005). Ponticelli (1999)

described that 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

*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.*

strongly influenced by their Christian beliefs and convictions were more likely to perceive themselves as having a heterosexual sexual orientation after their efforts. Schaeffer et al. also found that those who were less religious

were more likely to perceive themselves as having an LGB sexual orientation after the intervention. Some of the respondents in Spitzer's (2003) study concluded that they had altered their sexual orientation, although they continued to have same-sex sexual attractions. These findings underscore the importance of the nature and strength of participants' motivations, as well as the importance of religious identity in shaping self-reports of perceived sexual orientation change.

A number of authors (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001; Yarhouse et al., 2005; Yarhouse & Tan, 2004) have found that identity exploration and reinterpretation were important parts of SOCE. Beckstead and Morrow (2004) described the identity development of their research participants who were or had been members of the Church of Jesus Christ of Latter-Day Saints and had undergone therapy to change their sexual orientation to heterosexual. In this research, those who experienced the most satisfaction with their lives seemed to undergo a developmental process that included the following aspects: (a) becoming disillusioned, questioning authorities, and reevaluating outside norms; (b) wavering between ex-gay, "out" gay, heterosexual, or celibate identities that depended on cultural norms and fears rather than on internally self-informed choices; and (c) resolving their conflicts through developing self-acceptance, creating a positive self-concept, and making decisions about their relationships, religion, and community affiliations based on expanded information, self-evaluations, and priorities. The participants had multiple endpoints, including LGB identity, "ex-gay" identity, no sexual

orientation identity, and a unique self-identity. Some individuals chose actively to *disidentify* with a sexual minority identity so the individual's sexual orientation identity and sexual orientation may 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; 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 and blame toward parents due to believing they "caused" their homosexuality; (b) anger at and a sense of betrayal by SOCE providers; (c) loss of LGB friends and potential romantic partners due to beliefs 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); (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.

Licensed mental health providers 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, 1998a).

These individuals identified aspects of SOCE that they 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 (Levine, Perkins, & Perkins, 2004).

Mutual help groups' philosophy 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).

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<sup>41</sup> 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;

<sup>41</sup> 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.

Peck, 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 (Carillo, 2002; Boykin, 1996; Crawford et al., 2002; Harper et al., 2004; Mays, Cochran, & Zamudio, 2004; Miville & Ferguson, 2004; Walters, Evans-Campbell, Simoni, Ronquillo, & Bhuyan, 2006; 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; International Gay & Lesbian Human Rights Commission, n.d.). 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 identifies a population of predominantly White men who are strongly religious and participate in conservative faiths. This contrasts with the early research that included nonreligious individuals who chose SOCE due to the prejudice and discrimination caused by sexual stigma. Additionally, 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.

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

*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.* 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 (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 and can be provided within an affirmative and multiculturally competent framework that 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 SOCE

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 therapeutic interventions for adults is built on three key findings in the research:

- Our systematic review of the research on SOCE 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.
- What appears to shift and evolve in some individuals’ lives is sexual orientation identity, not sexual orientation (Beckstead, 2003; Beckstead & Morrow, 2004; Buchanan, Dzelme, Harris, & Hecker, 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).
- 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, support, and recognition of important values and concerns.

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;

Studies indicated that experiences of felt stigma, such as self-stigma, 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 (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; Coyle & Rafalin, 2000; Glassgold, 2008; Haldeman, 2004; Herek, 2009; Mahaffy, 1996; Mark, 2008; Ponticelli, 1999; Wolkomir, 2001; Yip, 2000, 2002, 2005). Consequently, an essential focus of treatment is mitigating the negative mental health consequences of minority stress from stigma resulting from age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (Brown, 2006; Cochran & Mays, 2006; Herek, 2009; Herek & Garnets, 2007; Mays & Cochran, 2001; Russell & Bohan, 2007). For instance, although many religious individuals' desired 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).

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 re woven 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 client-centered therapeutic environment

## A Framework for the Appropriate Application of Affirmative Therapeutic Interventions

On the basis of the three findings summarized previously 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) 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 (e.g., Astramovich, 2003; Bartoli & Gillem, 2008; Beckstead

*The client-centered 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.*

The client-centered therapeutic environment aspires to be a place of compassionate caring and respect that facilitates development (Bronfenbrenner, 1979; Winnicott, 1965) by exploring issues without criticism or condemnation (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; McMinn, 2005; Throckmorton & Welton, 2005) and reducing distress caused by isolation, stigma, and shame (Drescher, 1998a; Glassgold, 2008; Haldeman, 2004; Isay, 2001).

This approach involves empathizing with the client's desire to change his or her sexual orientation while understanding that this outcome is unlikely (Beckstead & Morrow, 2004; 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 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

*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.*

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).

### 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 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 clients' religious goals (Emons & Paloutzian, 2003) and motivations (e.g., internal, external, quest, fundamentalism) and positive and negative ways of coping within their 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 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 clients' faith identity development (Fowler, 1981, 1991; Oser, 1991; Reich, 1991; Streib, 2005) and its intersection with sexual orientation identity development (Harris, Cook, & Kashubeck-West, 2008; Hoffman et al., 2007; Knight & Hoffman, 2007; Mahaffy, 1996; Yarhouse &

Tan, 2005a; Farhouse et al., 2005), and (f) enhancing with clients, when applicable, the search for meaning, significance, and a relationship with the definitions of the sacred in their lives (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 (D. A. Cook & Wiley, 2000; Zea, Mason, & Muruia, 2000; Trujillo, 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, 1998a; 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). 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, 1998a), 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. Initiating sensitive but open and educated discussions with clients about their views of and experiences with sexuality may be most helpful, especially for those who have never had permission or space 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

*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.*

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 below.

## 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 an either-or 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,

<sup>42</sup> 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).

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 behavior therapy, and acceptance and commitment therapy techniques are especially 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 &

*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, 2007). For instance, using these techniques, Beckstead and Morrow (2004) and Tan (2008) helped conflicted clients cope with their sexual arousal experiences and live with them, rather than negatively judge or fight against them. Male participants in Beckstead and Morrow's (2004) investigation, regardless of their ultimate sexual orientation identity, described their ability to accept, reframe, or "surrender" to their attractions as reducing their distress by decreasing their self-judgments and reducing their fear, anxiety, and shame. However, acceptance of same-sex sexual attractions and sexual orientation may not mean the formation of an LGB sexual orientation identity; alternate identities may develop instead (Beckstead & Morrow, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008; Yarhouse et al., 2005).

For clients with strong values (religious or secular), an LMHP may wish to incorporate techniques that

promote positive meaning-making, an active process through which people revise or reappraise an event or series of events (Baumeister & Vohs, 2002; cf. Taylor, 1983) to resolve issues that arise out of crises, loss, and suffering (cf. Frankl, 1992; Nolen-Hoeksema & Davis, 2002; O'Neill & Ritter, 1992; Pargament et al., 2005; Ritter & O'Neill, 1989, 1995). Such new meanings involve creating a new purpose in life, rebuilding a sense of mastery, and increasing self-worth (Nolen-Hoeksema & Davis, 2002; Pargament & Mahoney, 2002).

## EMOTION-FOCUSED STRATEGIES

For those who seek SOCE, the process of addressing one's sexual orientation can be very emotionally challenging, as the desired identity does not fit the individual's psychological, emotional, or sexual predispositions and needs. The experience of irreconcilability of one's sexual orientation to one's deeply felt values, life situation, and life goals may disrupt one's core sense of meaning, purpose, efficacy, and self-worth (Beckstead & Morrow, 2004; Yarhouse, 2008; cf. Baumeister & Vohs, 2002; L. A. King & Smith, 2004) and result in emotional conflict, loss, and suffering (Glassgold, 2008; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995). Thus, emotion-focused strategies that facilitate grieving and 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, losses, and dissonance between psychological and emotional needs and possible and impossible selves (Bartoli & Gillem, 2008; Drescher, 1998a; 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 positively adapt to the ambiguity, conflict, uncertainty, and multiplicity (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; Buchanan et al., 2001; Corbett, 2001; Drescher, 1998a; Glassgold, 2008; Halbertal & Koren, 2006; Haldeman, 2002; Miville & Ferguson, 2004).

## RELIGIOUS STRATEGIES

Integrated with other active coping strategies, 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, & Poir, 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

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*Connecting the client to core and overarching values and virtues, such as charity, hope, forgiveness, gratitude, kindness, and compassion, may refocus clients on the more accepting elements of their religion, which may provide more self-acceptance, direction, and peace rather than dwelling on their religion's rejection of homosexuality.*

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connecting the client to core and overarching values and virtues, such as charity, hope, forgiveness, gratitude, kindness, and compassion, may refocus clients on the more accepting elements of their religion, which may provide more self-acceptance, direction, and peace, rather than on their religion's rejection of homosexuality (Lease et al., 2005; McMinn, 2005). Exploration of how to integrate religious values and virtues into their sexuality may further development (cf. Helminiak, 2004).

Altering 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 schema 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).

Licensed mental health providers 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.<sup>43</sup> 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

<sup>43</sup> There are growing numbers of communities available that address unique concerns and identities (see, e.g., [www.safraproject.org/](http://www.safraproject.org/) for Muslim women or <http://www.al-fatiha.org/> for LGB Muslims; for Orthodox Jews, see <http://tirtzah.wordpress.com/>).

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 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 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, 1998a; 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; LaFromboise et al., 1993; Marcia, 1966; Meyers et al., 1991; R. L. Worthington et al., 2002). Marcia (1966) generated a model in which identity development is an active process of exploring and assessing one's identity and establishing a commitment to an integrated identity. R. L. Worthington et al. (2002) hypothesized that sexual orientation identity could be conceptualized along these same lines and advanced a model of heterosexual identity development based on the assumption that congruence among the dimensions of individual identity is the most adaptive status, which is achieved by active exploration. There is some empirical research supporting this model (R. L. Worthington, Navarro,

*An affirmative approach is supportive of clients' identity development without an a priori treatment goal for how clients identify or live out their sexual orientation.*

Savoy, & Hampton, 2008). Additionally, there is some research illustrating that resolution of identity development has important mental health benefits

for sexual minorities in the formation of a collective identity that buffers individuals from sexual stigma, increasing self-esteem and identification with a social group (Balsam & Mohr, 2007; Crawford et al., 2002; Herek & Garnets, 2007).

An affirmative approach is supportive of clients' identity development without an a priori treatment goal for how clients identify or live out their sexual orientation. Sexual orientation identity exploration can be helpful for those who eventually accept or reject their same-sex sexual attractions; the treatment does not differ, although the outcome does. For instance, the existing research indicates that possible outcomes of sexual orientation identity exploration for those distressed by their sexual orientation may be:

- LGB identities (Glassgold, 2008; Haldeman, 2004; Mahaffy, 1996; Yarhouse, 2008)

- Heterosexual sexual orientation identity (Beckstead & Morrow, 2004)
- Disidentifying from LGB identities (e.g., ex-gay) (Yarhouse, 2008; Yarhouse & Tan, 2004; Yarhouse et al., 2005)
- Not specifying an identity (Beckstead & Morrow, 2004; Haldeman, 2004; Tan, 2008)

The research literature indicates that there are variations in how individuals express their sexual orientation and label their identities based on ethnicity, culture, age and generation, gender, nationality, acculturation, and religion (Boykin, 1996; Carrillo, 2002; Chan, 1997; Crawford et al., 2002; Denizet-Lewis, 2003; Kimmel & Yi, 2004; Martinez & Hosek, 2005; Miville & Ferguson, 2004; Millett, Malebranche, Mason, & Spikes, 2005; Stokes, Miller, & Mundhenk, 1998; Toro-Alfonso, 2007; Weeks, 1995; Yarhouse, 2008; Yarhouse et al., 2005; Zea et al., 2003). Some authors have provided analyses of identity that take into account diversity in sexual identity development and ethnic identity formation (Helms, 1995; LaFramboise et al., 1993; Myers et al., 1991; Yi & Shorter-Gooden, 1999), religious identity (Fowler, 1981, 1991; Oser, 1991; Strieb, 2001), as well as combinations of religious and sexual orientation identities (Coyle & Rafalin, 2000; Hoffman et al., 2007; Kerr, 1997; Knight & Hoffman, 2007; Ritter & O'Neill, 1989, 1995; Thumma, 1991; Throckmorton & Yarhouse, 2006; Yarhouse & Tan 2004).

In some of the literature on SOCE, religious beliefs and identity are presented as fixed, whereas sexual orientation is considered changeable (cf. Rosik, 2003). Given that there is a likelihood that some individuals will change religious affiliations during their lifetime (Pew Forum on Religion and Public Life, 2008) and that many scholars have found that both religious identity and sexual orientation identity evolve (Beckstead & Morrow, 2004; Fowler, 1981; Glassgold, 2008; Haldeman, 2004; Mahaffy, 1996; Ritter & Terndrup, 2002; Yarhouse & Tan, 2005b), it is important for LMHP to explore the development of religious identity and sexual orientation identity (Bartoli & Gillem, 2008). Some authors hypothesize that developmental awareness or stage of religious or sexual orientation identity may play a role in identity outcomes (Knight & Hoffman, 2007; Mahaffy, 1996; cf. Yarhouse & Tan, 2005a). Other authors have described a developmental process that includes periods of crisis, mourning, reevaluation, identity deconstruction, and growth (Comstock, 1996; O'Neill & Ritter, 1992; Ritter &

O'Neill, 1989, 1995). Others have found that individuals disidentify or reject LGB identities (Ponticelli, 1999; Wolkomir, 2001, 2006; Yarhouse et al., 2005). Thus, LMHP seeking to take an affirmative attitude recognize that individuals will define sexual orientation identities in a variety of ways (Beckstead, as cited in Shidlo, Schroeder, & Drescher, 2002; Diamond, 2003, 2006; 2008; Savin-Williams, 2005; Yarhouse et al., 2005).

Some religious individuals may wish to resolve the tension between values and sexual orientation by choosing celibacy (sexual abstinence), which in some faiths, but not all, may be a virtuous path (Olson, 2007). We found limited empirical research on the mental health consequences of that course of action.<sup>44</sup> 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).

Licensed mental health providers may approach such a situation by neither rejecting nor promoting celibacy but 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

<sup>44</sup> 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; Jones & Yarhouse, 2007).

(Bartoli & Gillem, 2008; Mirville & 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).
- 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 (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), can encourage identity development and synthesis rather than identity conflict, foreclosure, or compartmentalization.

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<sup>45</sup> 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, 1998a; 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

*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.*

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

<sup>45</sup> 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.

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).

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 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.

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 to understanding their concerns; and (c) encouragement of the client's positive self-concept.

Client assessment includes an awareness of the complete person, including mental health concerns that could impact distress about sexual orientation. Active

*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.*

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.

Licensed mental health providers address specific issues for religious clients by integrating aspects of the psychology of religion into their work, including by 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.

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## 7. ETHICAL CONCERNS AND DECISION MAKING IN PSYCHOTHERAPY WITH ADULTS<sup>46</sup>

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Ethical concerns relevant to sexual orientation change efforts (SOCE) 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 sexual orientation change efforts 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. 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.

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<sup>46</sup> Ethical concerns for children and adolescents are considered in Chapter 8.

For a discussion of the resolution's application to clinical situations, readers are referred to Schneider et al. (2002). APA 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,<sup>47</sup> 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 ethical decision making in this area.<sup>48</sup> We build our discussion on the concepts outlined in the 1997

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<sup>47</sup> As the final chapter of this report reveals, we have developed a new resolution that we recommend APA adopt.

<sup>48</sup> 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.

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,<sup>49</sup> 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)<sup>50</sup>
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.

<sup>49</sup> 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 and 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.

<sup>50</sup> Knapp and VandeCreek (2004) proposed that 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.

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

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.

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.<sup>51</sup> Treatments based on such assumptions raise the greatest level of ethical scrutiny by LMHP because they are inconsistent with the scientific and professional consensus that homosexuality per se is not a mental disorder. Instead, we counsel LMHP to consider other treatment options when clients present with requests for sexual orientation change.

The second key finding from our review is that those who participate in SOCE, regardless of the intentions of these treatments, and those who resolve their distress through other means, may evolve during the course of their treatment in such areas as self-awareness, self-concept, and identity. These changes may include (a) sexual orientation identity, including changes in private and public identification, 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. 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, research on the psychology of religion can be integrated into treatment. For instance, individual religious motivations can be

<sup>51</sup> See, e.g., Socarides (1968), Hallman (2008), and Nicolosi (1991); these theories assume homosexuality is always a sign of developmental defect or mental disorder.

examined, positive religious coping increased, and religious identity and sexual orientation identity explored and integrated (Beckstead & Israel, 2007; Fowler, 1981; Glassgold, 2008; Haldeman, 2004; Knight & Hoffman, 2007; O'Neill & Ritter, 1992; Yarhouse & Tan, 2005a, 2005b). This is consistent with advances in the understanding of human diversity that place LGB-affirmative approaches within current multicultural perspectives that include age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (e.g., Bartoli & Gillem, 2008; Brown, 2006; Fowers & Davidov, 2006), consistent with Principle D (Justice) and Principle E (Respect for People's Rights and Dignity).

However, in some of the debates on these issues, there are tensions between conservative religious perspectives and affirmative and scientific perspectives (Haldeman, 2002; Rosik, 2003; Throckmorton & Welton, 2005; Yarhouse, 1998a; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002). Although there are tensions between religious and scientific perspectives, the task force and other scholars do not view these perspectives as mutually exclusive (Bartoli & Gillem, 2008; Haldeman, 2004; S. L. Morrow & Beckstead, 2004; Yarhouse, 2005b). As we noted in the introduction, in its Resolution on Religious, Religion-Related, and/

*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.*

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 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 effective interventions do 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; 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

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...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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relationships and support groups in a number of different contexts (Levine et al., 2004; Norcross, 2002; Norcross & Hill, 2004). Thus, the benefits reported

by participants in SOCE may be achieved through treatment approaches that do not attempt to change sexual orientation.

Perceptions of risks and rewards of certain courses of action influence the individual's decisions, distress, and process of exploration in psychotherapy. The client and LMHP may define these risks and rewards differently, leading to different perceptions of benefit and harm. Recognizing, understanding, and clarifying these different perceptions of risks and rewards are crucial for a thorough ethical analysis of each client's unique situation and are aspects of client-centered approaches. For instance, an LMHP may attempt to provide information to the client to reduce sexual stigma and increase life options by informing the client about the research literature on same-sex couples. Such relationships may be threatening to the client when such a life course is perceived as being inconsistent with existing religious beliefs and motivations and potentially having negative repercussions on existing relationships with religious communities. 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*, n.d.). 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,<sup>52</sup>

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<sup>52</sup> 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, n.d.). In some other countries, homosexual behavior is still illegal and subject to extreme consequences, even death (e.g., Human Rights Watch, 2008; International Gay & Lesbian Human Rights Commission (IGLHRC), n.d.; Wax, 2008). In extremely repressive environments, sexual orientation conversion efforts are

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 and autonomy has become controversial, and some have suggested that SOCE be offered in the spirit of maximizing client autonomy<sup>53</sup> 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).

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provided in a coercive manner and have been the subject of human rights complaints (e.g., IGLHRC, 2001).

<sup>53</sup> The APA Ethics Code does not use the word *autonomy*; rather it uses *self-determination*, which is defined here as "the process by which a person controls their own life" (*Oxford American Dictionary*, n.d.).

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

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*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.*

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of LMHP to provide competent assessment and interventions that have the potential for benefit with a limited risk of harm. We also believe that LMHP are more likely to maximize their clients' self-determination by providing effective psychotherapy that increases a client's abilities to cope, understand, acknowledge, explore, and integrate sexual orientation concerns

into a self-chosen life in which the client determines the ultimate manner in which he or she does or does not express sexual orientation (Bartoli & Gillem, 2008; Beckstead & Israel, 2007; S. L. Morrow & Beckstead, 2004; Haldeman, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008).

### *Relational Issues in Treatment*

Ideal or desired outcomes may not always be possible, and at times, the client may face difficult decisions that 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 & Van de Creek, 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).

and to be aware of the importance of religion to clients' worldviews, LMHP focus on scientific evidence and professional judgment in determining mental health interventions (APA, 2008a; Beckstead, 2001; Glassgold, 2008; Haldeman, 2004; Yarhouse & Burkett, 2002).

## Summary

The principles and standards of the 2002 *Ethical Principles for Psychologists and Code of Conduct* most relevant to working with sexual minorities who seek to alter their sexual orientation are (a) Bases for Scientific and Professional Judgments (Standard 2.04) and Competence (2.01); (b) Beneficence and Nonmaleficence (Principle A); (c) Justice (Principle D); and (d) Respect for People's Rights and Dignity (Principle E). The key scientific findings relevant to the ethical concerns that are important in the area of SOCE are the limited evidence of efficacy or benefit and the potential for harm. LMHP are cautioned against promising sexual orientation change to clients. LMHP are encouraged to consider affirmative treatment options when clients present with requests for sexual orientation change. Such options include the therapeutic approaches included in Chapter 6 and focus on supporting a client's exploration and development of sexual orientation identity, which provide realistic opportunities for maximizing self-determination. 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.

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

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.	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
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religious beliefs and the psychology of religion (Bartoli, 2007; Yarhouse & VanOrman, 1999; Yarhouse & Fisher, 2002). 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

## 8. ISSUES FOR CHILDREN, ADOLESCENTS, AND THEIR FAMILIES

### Task Force Charge and Its Social Context

mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

The task force was asked to report on three issues for children and adolescents:

1. The appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation<sup>54</sup> on their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.
2. The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.<sup>55</sup>
3. Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to

This charge reflects recent events and current social context. Advocacy groups, both for and against sexual orientation change efforts (SOCE), law journals, and the media have reported on involuntary SOCE among adolescents (Goishi, 1997; Morey, 2006; Sanchez, 2007; Weithorn, 1998; Williams, 2005).<sup>56</sup> 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 (Cianciotto & Cahill, 2006; Kennedy & Cianciotto, 2006; Nicolosi & Nicolosi, 2002; Rekers, 1982; 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 that homosexuality is a mental illness or an adverse developmental outcome. These reports further suggest that there has been an increasing 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

<sup>54</sup> 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.

<sup>55</sup> 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.

<sup>56</sup> We define involuntary treatment as that which is performed without the individual's consent or assent and may be contrary to his or her expressed wishes. Unlike coercive treatment, no threats or intimidation are involved.

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; 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; Menveille, 1998; Menveille & Tuerk, 2002; R. Green, 1986, 1987; Zucker & Bradley, 1995).

Childhood interventions to prevent homosexuality have been presented in non-peer-reviewed literature (see Nicolosi & Nicolosi, 2002; Rekers, 1982).<sup>57</sup> 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).

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,

<sup>57</sup> The only peer-reviewed literature is on children who exhibited nonconformity with gender roles or gender identity disorder and did not focus on sexual orientation (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).

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 (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a; Yarhouse et al., 2005) who expressed confusion regarding their sexual orientation and conflicts between religious values and sexual orientation. In some of these cases, the adolescents or their families sought SOCE or considered SOCE (Cates,

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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 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 such distress is most likely to occur among adolescents in families for whom a religion that views homosexuality as sinful and undesirable is important. Yarhouse (1998b) and colleagues (Yarhouse & Tan, 2005a; Yarhouse, Brooke, Pisano, & Tan, 2005) discussed clinical examples of distress caused by conflicts between faith and sexual orientation surrounding the incompatibility between religious beliefs and LGB identities. 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.

In the small samples represented by articles on case studies and clinical papers, parents' religious beliefs appear to be factors in their request of SOCE for their children. For instance, in clinical case discussions and

psychotherapy articles, Cates (2007), Yarhouse (1998b), Yarhouse and Tan (2005a), and Yarhouse et al. (2005) identified a population of parents who have strong conservative religious beliefs that reject LGB identities and perceive homosexuality as sinful.

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 (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

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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).

### 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 sponsored by religious groups, such as Love in Action's program, Refuge,<sup>58</sup> provide religiously based interventions that claim to change sexual orientation, control sexual behavior, or prevent the development of same-sex sexual orientation. The interventions have been marketed to parents in this way (Burack & Josephson, 2005; Sanchez, 2007; Williams, 2005). Because they are religious in nature and are not explicitly mental health facilities,<sup>59</sup> many of these programs 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.<sup>60</sup> 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).

<sup>58</sup> 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.

<sup>59</sup> These programs advertise helping with addiction, "negative self-talk and irrational belief systems," and behavior change (see [www.loveinaction.org/default.aspx?pid=91](http://www.loveinaction.org/default.aspx?pid=91)).

<sup>60</sup> See [www.loveinaction.org/default.aspx?pid=122](http://www.loveinaction.org/default.aspx?pid=122)

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).

Thus, residential and outpatient programs that are involuntary and coercive and provide inaccurate scientific information about sexual orientation or are

*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.*

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 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. Coercive and involuntary treatment present ethical dilemmas for providers working with many clients (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 (Williams, 2005). Given ethical imperatives that stress maximizing autonomous decision making and self-determination (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 Intervention 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; Ryan, Huebner, Diaz, & Sanchez, 2009; Salzburg,

2004, 2007; Yarhouse & Tan, 2005a).<sup>61</sup> 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),
- ameliorating family and peer concerns (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; Martin, 1982; Perrin, 2002; Radkowsky & Siegel, 1997; Ryan, 2001; Ryan et al., 2009; Ryan & Diaz, 2005; 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 prejudice and affirming of sexual orientation diversity

<sup>61</sup> 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.

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, Scrimshaw, & 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 do 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; Ryan & Diaz, 2005; 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 (Ryan, Huebner, Diaz, & Sanchez, 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; Ryan et al., 2009; Savin-Williams, 1994; Wilber et al., 2006). Further, to improve parents' responses, LMHP need to 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 increase of potential benefits of psychotherapy (Morrisey-Kane & Prinz, 1999; Sobocinski, 1990).

Family therapy for families who are distressed by their child's sexual orientation may be helpful in facilitating dialogues, increasing acceptance and support, reducing rejection, and improving management of conflicts or misinformation that may exacerbate an adolescent's distress (Mattison & McWhirter, 1995; 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; Ryan & Diaz, 2005; Ryan & Futterman, 1997; Ryan et al., 2009; Salzburg, 2004, 2007; Yarhouse, 1998b). Ryan and Futterman (1997) termed this *anticipatory guidance*:

the LMHP provides family members with accurate information regarding same-sex sexual orientation and dispels myths regarding the lives, health, and psychological well-being of LGB individuals.

Perrin (2002) recommended that when working with families of preadolescent children, LMHP 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-prong 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, Ryan et al. (2009) recommended that LMHP assess family reactions to LGB youth, specifically the presence of family rejection. Further, the authors advocated attempting to modify highly rejecting behaviors, providing anticipatory guidance to families that includes recommendations for support on the part of the family, and explaining the link between family rejection and negative health problems in children and adolescents.

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 (Yarhouse & Tan, 2005a, p. 534).

Providing anticipatory guidance to parents to address their unique personal concerns can be helpful (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 (McDeville & 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 alternative sources of information, could reduce the distress for parents 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.<sup>62</sup>

## 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

<sup>62</sup> See, e.g., "Family Fellowship" ([www.ldsfamilyfellowship.org/](http://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/](http://www.huc.edu/ijso/).

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.

developmentally appropriate (Perrin, 2002).

Second, we were asked to comment on the presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation. We found that serious questions are raised by involuntary and coercive interventions and residential centers for adolescents due to their advocacy of treatments that have no scientific basis and potential for harm due to coercion, stigmatization, inappropriateness of treatment level and type, and restriction of liberty. Although the prevalence of these treatment centers is unknown, we recommend that some form of oversight be established for such youth facilities, such as licensure and monitoring, especially as a means of reporting abuse or neglect.

States have different requirements and standards for obtaining informed consent to treatment for adolescents; however, it is recognized that adolescents are cognitively able to participate in some health care treatment decisions and that such participation is helpful. We recommend that when it comes to treatment that purports to have an impact on sexual orientation, LMHP assess the adolescent's ability to understand treatment options, provide developmentally appropriate informed consent to treatment that is consistent with the adolescent's level of understanding, and, at a minimum, obtain the youth's assent to treatment. SOCE that focus on negative representations of homosexuality and lack a theoretical or evidence base provide no documented benefits and can pose harm through increasing sexual stigma and providing inaccurate information. We further concluded that involuntary or coercive residential or inpatient programs that provide SOCE to children and adolescents may pose serious risk of harm, are potentially in conflict with ethical imperatives to maximize autonomous decision making and client self-determination, and have no documented benefits. Thus, we recommend that parents, guardians, or youth not consider such treatments.

Finally, we were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to

change their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.

*We recommend that LMHP provide multiculturally competent and client-centered therapies to children, adolescents, and their families rather than SOCE.*

We recommend that LMHP provide multiculturally competent and client-centered therapies to children,

adolescents, and their families rather than SOCE. Such approaches include an awareness of the interrelatedness of multiple identities in individual development as well an understanding of cultural, ethnic, and religious variation in families. Specific approaches can include (a) supporting children and youth in their developmental processes and milestones, (b) reducing internalized stigma in children and sexual stigma in parents, and (c) providing affirmative information and education on LGB identities and lives. These approaches would support children and youth in identity exploration and development without seeking predetermined outcomes. Interventions that incorporate knowledge from the psychology of religion and that increase acceptance, love, and understanding among individuals, families, and communities are recommended for populations for whom religion is important. Family therapy that provides anticipatory guidance to parents to increase their support and reduce rejection of children and youth addressing these issues is essential. School and community interventions are also recommended to reduce societal-level stigma and provide information and social support to children and youth.

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## 9. SUMMARY AND CONCLUSIONS

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APA's charge to the task force included three major tasks that this report addresses. First, the task force was asked to review and update the 1997 resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998). Second, the task force was asked to report on 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.

Third, the task force was asked to inform APA'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 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 effort (SOCE). In Chapter 5 we addressed the nature of distress and identified conflicts in adults that provide the basis of our recommendations for affirmative approaches for psychotherapy practice that are described in Chapter 6. Chapter 7 discusses 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 address those two tasks—one and three—that have not been addressed in the report so far. With regard to the policy, we recommend that the 1997 policy be retained and that a new policy be adopted to complement it. The new policy that we propose is presented in Appendix A. 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. The review is reported in Chapters 3 and 4: Chapter 3 addresses methodological issues in the research and Chapter 4 addresses the outcomes, such as safety, efficacy, benefit, and harm of the 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 among their beliefs and values and 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

<sup>82</sup> 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).

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, 2008a).

## 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? What is the evidence on whether SOCE is 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 disorders or deficits and are based on older discredited psychoanalytic theories (e.g., Socarides, 1968; see American Psychoanalytic Association, 1991, 1992, 2000; Drescher, 1998a; 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, 1998a; Enns, 2008; Heppner & Heppner, 2008; Levant & Silverstein, 2006; Mustanski et al., 2002; O'Neil, 2008; Peplau & Garnets, 2000; Pleck, 1995; Rahman & Wilson, 2005; Wester, 2008).

Other forms of recent SOCE are religious, are not based on theories that can be scientifically evaluated, and have not been subjected to rigorous examination of efficacy and safety. These approaches are based on religious beliefs that homosexuality is sinful and immoral and, consequently, that identities and life paths based on same-sex sexual orientation are not religiously acceptable. The few high-quality studies of SOCE conducted from 1999 to 2004 are qualitative (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; 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., 1973; Tanner, 1974, 1975) shows that enduring change to an individual's sexual orientation

*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.*

is uncommon and that 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 Seek 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 present to LMHP seeking 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 seeks SOCE. The research does reveal something about those individuals who seek SOCE, how they evaluate their experiences, and why they undergo SOCE, even if the research does not indicate whether SOCE has anything to do with the changes some clients perceive themselves to 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 two qualitative studies are exclusively female (i.e., Moran, 2007; 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 with 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 faith beliefs of those in the early studies. As noted previously, the individuals in recent studies indicated that religion is very important to them.

We concluded that some of the controversy surrounding SOCE can be explained by different understandings of the nature of sexual orientation and sexual orientation identity. Recent research in the field of sexual orientation indicates a range of sexual attractions and desires, sexual orientations, and multiple ways of self-labeling and self-identifying (e.g., Carrillo, 2002; Diamond, 1998, 2006, 2008; Fox, 1995; Hoberg et al., 2004; Savin-Williams, 2005). Some researchers have found that distinguishing the constructs of sexual orientation and sexual orientation identity adds clarity to an understanding of the variability inherent 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 has led SOCE research to obscure 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 individuals who reported that they went on to lead outwardly heterosexual lives, including, for some, developing a sexual relationship with another-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. Those who experienced religious interventions and perceived them negatively said that they felt disillusioned with faith and a sense of failure in the eye of divine being (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Indirect harm from the associated costs (time, energy, 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; 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 (Levine et al., 2004). For those in psychotherapy, the positive perceptions described appear to reflect the documented effects of the supportive function of psychotherapy relationships (e.g., Norcross, 2002). For instance, providing emotional support, empathy, support, and compassion can reduce distress.

### *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 is unlikely, and some participants were harmed by the interventions; (b) sexual orientation identity, not sexual orientation, appears to change via psychotherapy, support groups, or life events; and (c) clients benefit from 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:

- 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 to understanding their 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.

Identity exploration is an active process of exploring and assessing one's identity and establishing a commitment to an integrated identity that addresses 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.

Treatments that are based on assumptions that homosexuality or same-sex sexual attractions are, a priori, a mental disorder or psychopathology 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; 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 should 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.

### *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

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*The goal of treatment is for the client to explore possible life paths that address the reality of their sexual orientation while considering the possibilities for a religiously and spiritually meaningful and rewarding life.*

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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 above. The goal of treatment is for the client to explore possible life paths that address the reality of their sexual orientation while considering the possibilities for a religiously and spiritually meaningful and rewarding life. Such psychotherapy can enhance clients' search for meaning, significance, and a relationship with the sacred in their lives (e.g., Pargament & Maloney, 2005). Such an approach would focus on increasing positive religious coping, understanding religious motivations, integrating religious and sexual orientation identities, and reframing sexual orientation identities to reduce or eliminate self-stigma.

### *Ethical Considerations*

LMHP strive to provide interventions that benefit clients and avoid harm, consistent with current professional ethics. Psychologists aspire to provide treatment that is consistent with the APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002b) and relevant APA guidelines and resolutions (e.g., APA, 2000, 2002c, 2004, 2005a, 2007b) with a special focus on ethical principles such as Benefit and Harm; 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*, n.d.). 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.

### *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, King, & Phillips, 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*,<sup>64</sup> 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).

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

<sup>64</sup> These guidelines are being revised, and a new version will be available in 2010.

religion (e.g., Amé & Vasconcelos, 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. For instance, recent publications provide insight into techniques that address negative attitudes toward sexual minorities by focusing on increasing compassionate responses toward or positive attitudes of 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). This research includes exploring the evolution of positive attitudes toward sexual minorities of 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 and 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. Many of the problems in published SOCE research indicate the need for improvement in the journal review process, for instance. Problems included: (a) violations of statistical measures, (b) measures that were not evaluated prior to use, and (c) inappropriate conclusions drawn from data.

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. Whether a higher standard is necessary is not clear; however, research published on SOCE needs to meet current best-practice research standards. 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.<sup>65</sup> 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

<sup>65</sup> A published study that appeared in the grey literature in 2007 (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.

Indeed, some have raised the concern about both research and practice in this area due to the limited examination of safety (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 (Lilienfeld, 2007), 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; 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; Ryan et al., 2009).

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 brought about by 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.

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).

#### *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

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## APPENDIX A: RESOLUTION ON APPROPRIATE AFFIRMATIVE RESPONSES TO SEXUAL ORIENTATION DISTRESS AND CHANGE EFFORTS

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### 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).<sup>41</sup> 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).

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<sup>41</sup> APA uses the term *sexual orientation change efforts* to describe all means to change sexual orientation (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches). This includes those efforts by mental health professionals, lay individuals, including religious professionals, religious leaders, social groups, and other lay networks such as self-help groups.

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,

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 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) 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 non-religious 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

<sup>A2</sup> 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);

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;

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);

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;

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);

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;

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

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;

WHEREAS, Sexual minority children and youth are especially vulnerable populations with unique developmental tasks (Perrin, 2002; Ryan & Futterman, 1997) who lack adequate legal protection from involuntary or coercive treatment (Arriola, 1998; Burack & Josephson, 2005; Molnar, 1997) and whose parents and guardians need accurate information to make informed decisions regarding their development and well-being (Cianciotto & Cahill, 2006; Ryan & Futterman, 1997); and

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);

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;

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;

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 encourages practitioners to consider the ethical concerns outlined in the 1997 APA Resolution on Appropriate Therapeutic Response to Sexual Orientation (APA, 1998), in particular the following standards and principles: scientific bases

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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, policy makers, religious professionals and organizations, and other organizations to seek areas of collaboration that may promote the wellbeing of sexual minorities.

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APPENDIX B: STUDIES REVIEWED  
(*N* = 83) IN THIS REPORT

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Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
<i>Experimental studies</i>							
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 (ns = 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
<i>Quasi-experimental studies</i>							
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
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, & Blaszczyński, 1981	20	100	Clinical	None reported	Nonequivalent 2 treatment group comparison design	Aversive therapy; covert sensitization	Sexual feelings
<i>Nonexperimental studies</i>							
Bancroft, 1969	16	100	Clinical	6 withdrew participation prior to treatment and 1 during treatment	Case study	Aversive shock therapy	Sexual behavior
Barlow & Agras, 1973	3	100	Clinical	None reported	Case study	Fading	Penile circumference; sexual urges; sexual fantasies
Barlow, Agras, Abel, Blanchard, & Young, 1975	3	100	Clinical	None reported	Single case pre-post within-subject	Biofeedback	Penile circumference
Beckstead & Morrow, 2004	50	80	Purposive	None	Qualitative retrospective, grounded theory	Conversion therapy, ex-gay ministries, and/or support groups	Subjective experiences of treatment; subjective appraisal of sexual orientation identity, attraction, & behavior
Birk, 1974	66	100	Clinical	13 withdrew participation	Pre-post within-subject	Psychotherapy	Sexual orientation
Blicht & 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
Comrad & Wineze, 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, 1964	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
James, 1962, 1963	1	100	Clinical	Treatment stopped due to adverse reaction	Case study	Aversion apomorphine therapy	Sexual fantasies; sexual behavior
Kendrick & McCulloch, 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
McCrary, 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
Wolkmir, 2001	n/a		Purposive	None reported	Ethnography	2 Bible study support groups	Subjective experience

**EXHIBIT 2**

**Reparative  
Therapy of  
Male Homosexuality**

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**A New Clinical Approach**

*Joseph Nicolosi, Ph.D.*

*J*

JASON ARONSON INC.  
Northvale, New Jersey  
London

### III

## Psychotherapy

*Every homosexual is a latent heterosexual.*

—Irving Bieber

*Our heterosexuality is buried under a thousand fears.*

—Colin Cook

In relationship with a same-sex therapist, a client can find some of what he missed in the failed father-son bond. This is the way that a man absorbs the masculine—through answering the challenge of nonsexual male friendships characterized by mutuality, intimacy, affirmation, and fellowship. When he eroticizes a male relationship, a man is perpetually frustrated in absorbing the masculine.

BEGINNING OF TREATMENT

In the first session the client often reveals an optimism, even an excitement. He has finally found a therapist who is willing to help him overcome his homosexuality. There is also a happy anticipation about his new relationship with the therapist, a man who he hopes will, perhaps for the first time in his life, intimately understand and accept him.

Although he has hopes, yet he still has doubts. A part of him will resist change. He may have the common anxiety of being made over or undone. Yet his hope is stronger than his skepticism. As one client expressed it: "I have a right to be that man and all those male things that I've spent a lifetime admiring in others. I have a right to my own masculinity."

Treatment will help to put the issues into clear focus and create clarity out of the maze of confusion. Developing healthy male relationships will be one of the first orders of business, as will growth in a general sense of success in meeting life's challenges. Surprisingly, the original issue of sexuality usually falls to the background as issues of per-

sonal power, assertion, and male relationships come to the forefront.

In the early phase of treatment, when there are strong feelings of hope and a sense of mastery, a new and powerful dimension of awareness temporarily supersedes the old sexual patterns. There may be a reduction in homosexual interests and even overall sexual arousal. This is due to the power of hope, whose worth should never be underestimated.

However, this dramatic change in behavior may also be symptomatic of a transference cure, a temporary abatement of symptoms caused not by resolution of conflict, but by a sublimation of the client's feelings in his desire to please the therapist. A transference cure traces back to the client's self-fulfilling fantasy that the therapist holds the power to heal him. On some level, it results from the unconscious collusion of both client and therapist. The impulse to assume the false role of the "good little boy" and to please the therapist by being the "cured" client must be interpreted. Once this dynamic is understood, both therapist and client can go forward in deeper honesty.

Soon after the initial surge of hope, the return of the old sexual feelings brings into perspective the long struggle that lies ahead. But the return of these feelings and patterns should not be cause for despair. The client should be reminded that this is only the first of many natural developmental cycles of hope and disillusionment.

Over time, the sexual intensity will subside once more. As he continues to develop closer mutual relationships with significant men in his life, the client begins to see his sexual attractions from a different perspective. The more he gets to know his male acquaintances on a personal level,

the more unlikely it is they will remain objects of his sexual fantasies. The erotic power of their traits moves to the background as the whole person comes into focus.

SELF-ACCEPTANCE

According to popular gay rhetoric, if a man attempts to resolve his homosexuality, he must be unable to accept himself as he is. Even popular psychotherapies promote this false dichotomy.

Critics of reparative therapy suspect that it is primarily guilt that keeps clients coming to treatment. Although guilt may have been a strong motivator that originally propelled the client into therapy, it is never the foundation for successful treatment. In fact, after some months in therapy, the client typically reports a diminishment of guilt. What has diminished here is not actually valid guilt, but the excessive guilt he has felt so long that it feels natural.

While a welcome relief, this diminishment seems too good to be true; some men then feel guilty about not feeling guilty. They may even blame the therapist for reducing the guilt they felt they needed to keep them from falling back into unwanted habits. Gradually, however, the client will come to realize that with his deepening commitment to healing will come a new support structure to take the place of that oppressive mind-set that earlier "kept him in place."

The best part of surrendering excessive guilt is that it frees the mind to see clearly the natural dissatisfaction that

results when one's behavior is at odds with one's sense of self. This dissatisfaction emphasizes, simply, what valid guilt is—disappointment with oneself for doing something discordant with what one desires to be. This subtle but deeply felt displeasure with oneself is more effective than excessive guilt in fostering lasting change.

Excessive guilt locks a man into the old, self-defeating thought patterns that reinforce a sense of weakness and self-pity. Excessive guilt erodes self-esteem, which is essential to meet the initiatory challenges of reparative therapy. Self-acceptance and a sincere desire for wholeness open the way to growth. It is through self-acceptance that the man gains the ability to stay in the pain in the faith that he will get better.

One client describes how the way to his own growth was opened:

I used to feel overwhelmed and preoccupied by my homosexuality. Homosexuality took my power away. It depressed me. I used to be alarmed, upset; I felt trapped by it. I used to believe that since I'm homosexual and I don't act out my sexuality, then I'm not being true to myself.

Now, it feels familiar; I get hungry, I get crabby, I get the homosexual feelings. I no longer deny them or act out, but understand them. My homosexual feelings are just a "snapshot" of who I am right now. They tell me something about where I am.

Acceptance of my homosexuality does not mean approval, but a familiarity; "Yeah, this is me, that's weird, but it's me." It does not need to mean loneliness and despair. I don't feel trapped by it, but rather I say to myself, "Oh, here I go again, this is what I do."

Homosexual feelings loom larger when I feel the need for deep friendship. I try to act on the knowledge, not the feeling. There's a power in the option of redirecting the energy; of giving new meaning to the feeling. I've gained the personal knowledge of understanding that my homosexuality is an urge toward male intimacy.

Instead of getting all worked up, I ask myself where I am lacking in personal contact. Then I see that the sexual energy will disappear or significantly diminish.

In computer language, you have "default," which is where the program goes if you fail to give a new command. Our default is homosexuality . . . and our new command is male intimacy.

### THE POWER OF GENDER

Gender identity structures every man's and woman's way of being and defines each person's participation in society. Gender identity is the grounding for all personal identity. We are all much more than simply "persons." Yet gay liberation groups, along with radical factions of the women's movement, have exerted pressure on the social sciences to deny inherent gender differences and condemn sex-role concepts. There has been a substitution of "non-sexist" language, which denies even basic human differences. Little by little, modern consciousness has lost its image of healthy masculinity and femininity.

In freeing himself from his bond with mother, the boy needs help in becoming fully male. He needs to know who he is, and only another man can tell him. Mother, by her grounding in human nature, has told him *what* he is. But father—through his grounding in the outside world—can

tell him *who* he is. By bestowing upon the boy a personal identity, he defines his unique relationship to the world.

To be able to identify oneself to oneself is so fundamental a need that we would rather call ourselves anything than have to call ourselves nothing. We can see how young men who grew up without father's support might look for personal identity through a homosexual relationship. He has eroticized the need for his own masculinity. As one 32-year-old client said during his first session: "I've always suspected my problem is not about homosexuality, but about masculinity."

### Androgyny

In the absence of an appreciation for healthy masculinity and femininity, androgyny is now unchallenged in our culture. In popular usage this term has become synonymous with genderlessness, describing a diluted or neutered version of both genders. Yet true androgyny—in its correct sense—implies a complete integration of both the masculine and the feminine within the personality.

Before one can develop aspects of the other sex, one must claim one's primary gender. The young woman who fully identifies with the feminine gender will possess the qualities of gentleness and nurturance; later, she may also grow into assertion and independence. She will develop those masculine traits out of the foundation of her femininity. The same is true for the male. In his fullest masculinity, he may not only be aggressive and risk-taking, but also empathic and sensitive.

The gay-identified man often attempts to minimize the

significance of gender difference as a justification for his own supposedly more highly evolved androgynous style. Yet androgyny in the gay culture is not so much the true assimilation of femininity, as a mockery of it in the form of effeminacy.

The true integration of femininity—if it is ever to be accomplished in a man's lifetime—occurs later in life after full assimilation of his primary masculinity, and evolves through intimacy with the opposite sex. Through integrating aspects of the opposite sex, we grow into full humanity. Full humanity is not acquired by distilling, compromising, or denying characteristics of our original gender.

**Gender Empowerment as Treatment**

Successful treatment of homosexuality is undermined in a culture where androgyny is upheld as the ideal. There must be acknowledgment by society of the existence of sex-linked traits, behaviors, and perceptions, and a respect for their value. As clients progress in reparative therapy, they develop a deep appreciation of gender difference and how it enhances the individual.

Men in treatment typically report that when they are feeling more masculine, mature, strong, or "adult" (each client describes this gender empowerment in his own way), then same-sex attractions are less distracting, less compelling. When they are feeling good about themselves, feeling up, and feeling strong, their homosexual preoccupations markedly diminish.

These clients also report the opposite: if they have

experienced a setback or rejection, then spontaneous homosexual fantasies will increase to a level of preoccupation. Such feelings of disappointment, discouragement, or failure often lead to anonymous sexual encounters.

This clinically observed relationship between negative feelings about oneself and same-sex fantasies and behavior tells us something about the deficit nature of homosexuality. Can we imagine a married man who would say, "When I'm feeling weak and unmasculine, I'm preoccupied with the need to make love to my wife"? And even more bizarre—"When I'm feeling good and strong about myself, I lose most of my desire to make love to my wife"? There is a motivation in the homosexual drive that has nothing to do with the sexual behavior per se, but all to do with a man's sense of himself.

Client testimonies offer strong evidence that in many homosexual men, same-sex eroticism is used as symbolic reparation of a deficit in masculine strength. Several clients have described what they found attractive in other men:

*Client #1:* Certain guys have a sense of freedom about them—that they could do whatever they want and get away with it. Like they don't even care, it's just so natural to them. That's what I'm attracted to—that inner freedom and power. Like my straight roommate, Bill, who used to say, "You can do just anything if you want to," and sometimes he did. I feel so constricted, like "Oh, I could never do that." I admired that, I wanted to have that power.

*Client #2:* I'm attracted to a guy having a lot of control. That power and control—I've always wanted to draw off of that, to be so together.

*Client #3:* The issue for me is disconnectedness from my masculine identity. I feel like an outsider when I'm with men. I don't feel accepted by them, and I have difficulty living out or expressing anything that I see as a masculine trait. Risk-taking is a masculine trait, and goal-setting requires a masculine energy that I feel very intimidated by. I've always had a tremendous craving for the masculine, whether it's a male friend or some activity that is masculine, some kind of sports.

Searching for different ways to reach that masculinity I feel detached from, I realize I don't really want to sexually pursue other men. I see that I'm trying to bond with them so that I can feel a part of them, connected with them, equal to them, and not to feel that I'm less and the other man's more.

*Client #4:* What is it that defines a man? What is it that is essential to men? Right away I blurt it out—power. A sense of power whether it's physical strength, power over others, or a power over oneself in the form of leadership.

I just know what I *really* want and it's not him or his power, it's me—*what I want me to be*. I want to have all the assuredness I need—I don't want to be frightened of anything. I want to have the ability to deal with whatever comes my way and not want to just go into a room and close the door. I want to have the confidence to go ahead and pursue the kinds of friends that I have always wanted.

#### IDENTIFYING MASCULINITY

One of the earliest questions that must be addressed in psychotherapy is: exactly what is the client's perception of

masculinity? And in what ways is he, and is he not, in possession of that masculinity?

Many men beginning treatment report the sense they have somehow never completely grown up. They may have the sense of themselves as children, as boys. For many of these men, masculinity feels similar to, even synonymous with, adulthood. To feel masculine is to feel adult, and vice versa.

Essential for success in treatment is that the client learn to identify when he is feeling more or less masculine. With practice, he discovers that this is a subjective feeling experienced at different times with varying intensity.

Taking stock of his deficits in masculine identity is important because it tells him what he seeks in other men. He may be quite surprised to realize that what he typically seeks in others, he himself feels deficient in. Sometimes he seeks father figures to lean on, or mirror images to bolster his sense of self. There may be a fascination with particular body types, mannerisms, or styles. A number of male clients report that it is a certain style of male strength that is attractive, particularly a confident, outgoing, energetic personal style. Repeatedly, homosexual clients express an admiration for the basic qualities inherent to masculinity: independence, control of one's life, assertion, self-assuredness, and, they will often say, a "physicalness." Within the first few sessions, the client can identify those particular traits he is attracted to, thus beginning the process of de-mystifying these men.

Growth involves not just a behavioral change of giving up homoerotic behavior, but a deeper transformation of personal identification. It will enable him to feel different about himself, relate differently, to see the world

from the perspective of a fully male-identified man. When one is in possession of his gender identity, he inherits along with it a vitalizing power.

#### MAKING PEACE WITH FATHER

I am often amazed to see how adult men can become so upset by the briefest contact with their fathers. A weekend home or a telephone conversation can enrage or depress an otherwise rational 30-year-old man. These painful paternal encounters are often followed by a regressive phase that may impel the man back into anonymous sexual encounters.

There is a particular quality of anger that usually characterizes the homosexual man's relationship to his father. While heterosexual men also report hostile relations with fathers, there is a qualitative difference. The heterosexual man's anger is usually accompanied by a resigned acceptance. But the homosexual man holds a profound grievance, a grudge, and a deep-seated antipathy that blocks acceptance.

A frequent misunderstanding of many a client is that to accomplish resolution with father, he must gain his father's acceptance in the present. This misunderstanding is based upon the unconscious assumption that father has something he needs in order to outgrow his homosexuality. This idea is rooted in the client's early experience of father as having the power to share or withhold his masculinity.

A significant step in the client's treatment is the realization that it is now *he himself* who holds the power of transformation. Central to the attainment of that power is

forgiveness of his father. The realization that healing comes from an attitudinal shift on his own part is particularly important in cases where father will not or cannot change. As one client said: "A lot of us know that our fathers aren't going to change. We will get as close as we can to our fathers and that's going to be it. We can't really change them because they'll always be the same way."

Then, too, the client may also need to be reminded that the true damage was done not by father, *but by his own defensive detachment from him*. Now he is called to give up this defensive attitude toward all men, beginning with his father.

Forgiveness of father is not an easy task because it often means accepting father for who he is, with his limitations, including his limited ability to demonstrate love, affection, and acceptance. It often feels like a death experience for a young man when he realizes that he must bury once and for all the fantasy of receiving his father's love. To understand and forgive and love his father is, paradoxically, to be father to his father—to give him what he, the son, would have desired. Compassion for father is the final step of forgiveness. Often compassion grows out of an understanding of his father's father, and how he treated his own son.

Almost all of my clients report that their fathers have very little to say about their own fathers. Sometimes this "shadow father" can be traced back for two generations. Thus the problem of homosexuality may have had its foundation laid in an earlier generation.

As he grows in the resolution of his homosexuality, the client simultaneously begins to appreciate his father as a person and as a man. During this stage—to his initial

annoyance—he discovers how much like his father he really is. Those same traits of explosive temper, rigid opinion, easy blame, and difficulty in directly expressing feelings may equally belong to him.

It is interesting to note that gay ideology continues to deny the important common denominator of these problems with father. This results in the ignoring of a key piece of evidence that homosexuality is a developmental failure. In fact there is a deep-seated tendency to refuse to concede any importance whatever to the father. Long ago, many gay men made the decision that father would play no role whatsoever in their lives. This defensive disregard for the importance of the father may in fact have contributed to psychoanalysis's early emphasis on mother, as analysts may have been misled by patients who preferred to spend time and money talking about mother.

#### FACTORS AFFECTING PROGNOSIS

Motivation to change has repeatedly been found to be a primary predictor of success in treatment (Harterer 1970, Mayerson and Lief 1965, Monroe and Enelow 1960, Ovesey 1969, Schwartz and Masters 1984, Stekel 1930, van den Aardweg 1985, 1986). Motivation means the client is unambivalent in rejecting a homosexual identity and is striving toward heterosexuality. Other indicators of favorable prognosis are lack of indulgence in self-pity, a positive sense of self, and the ego-strength to tolerate stress and frustration. Heterosexual fantasies and dreams are also

strongly favorable. Also the stronger family relationships the client has, the better his prognosis.

Traditional values and the sense of oneself as a member of heterosexual society are also strongly supportive in providing a framework from which to reflect on the homosexual experience. Clients who enter reparative therapy are strong in the conviction that psychological development does not come from a surrendering of identity into the gay subculture. Other factors in treatment success are the ability to resist impulsive behaviors and to postpone gratification, the ability to set goals, and the capacity to reflect upon, verbalize, and learn from past experiences. Clients who believe they have power in shaping their own destinies have a far greater likelihood of overcoming their homosexuality than do those who submit to a fatalistic attitude or who see life as happening to them. The ability to be honest with oneself and others is significant to treatment success, as is the ability to identify what one is feeling. An appreciation for the value of gender differences also does much to support the treatment plan.

Those men who have been less sexually active have better prognoses. Considering the habit-forming nature of sexual behavior, the more homosexually active the client is, the more difficult the course of treatment.

For this reason, gay-affirmative counseling services situated on high school campuses can be detrimental, because they actively support early homosexual behavior. If that same adolescent desires to grow into heterosexuality in adulthood, he will then have to face not only the burden of breaking a sexual-habit pattern, but also the gay self-identification that his behavioral patterns have fostered.

Two final qualities that are of the utmost value—second only to motivation to change—are *patience* with oneself and an *acceptance* of the ongoing nature of the struggle.

#### Age Factors

The average age for a homosexual client entering reparative therapy is early twenties to early thirties. Many other therapists have made the observation that this is the age group most receptive to treatment (Bieber 1962, Mayerson and Lief 1965, Rubenstein 1958). This is the time of young adulthood, when friends are getting married and family is exerting pressure to do likewise. There is a line from *The Boys in the Band* that after age 30, you can no longer introduce your lover as a roommate.

Social pressure, however, is not the only impetus. This is a time when the natural desire to enter into an exclusive relationship is most intensely felt and when the choice must be made for either Isolation or Adult Intimacy (Erickson, 1958). One must now make a lifelong relational commitment, and one must know what gender that partner will be.

Treatment before the early twenties has its particular difficulties. The teenager is experiencing his sexual drive at its most intense, and after years of secrecy, isolation, and alienation, most young men find the gay world powerfully alluring, with its romantic, sensual, outrageous, and embracing qualities. At the same time that libidinal drive is at its highest, personal identity is at its most fragile. At this time the adolescent wants to experience. Although he may later have a change of heart, to propose a treatment

requiring self-reflection, conviction, and self-denial is almost more than he can bear. My only successful treatment with an adolescent was a 17-year-old whose outstanding advantage was an enthusiastically supportive family and social network, with every significant person in his life committed to helping him change his life direction.

Prognosis is also poorer with older men over 35. For too many, their deeply ingrained sexual patterns have made them cynical about change. However, there is evidence of positive outcomes with highly motivated older men, especially those who have only been sporadically sexually active.

#### CURE

Growth through reparative therapy is in one way like the gay model of coming out of the closet. That is, it is an ongoing process. Usually some homosexual desires will persist or recur during certain times in the life cycle.

Therefore, rather than "cure," we refer to the goal of "change," a meaning shift beginning with a change in identification of self. As one married ex-gay man described it: "For many years I thought I was gay. I finally realized I was not a homosexual, but really a heterosexual man with a homosexual problem."

Within that essential change in view of self are new ways of understanding the nature of homosexual behavior and its motivational basis in unmet early love needs. One client who had been in reparative therapy for about a year described his feelings as follows:

What my homosexual feelings used to be, they aren't now: They're still around, they're still there, but they're not as upsetting. The improvement is in how they affect me emotionally, how much they shake me up, affect my self-esteem—how compulsive they are, how much I am preoccupied by them.

Another man, a former female impersonator, now married with three teenage sons, commented, "Now those homosexual fantasies are more like a gnat buzzing around my ear." Another man explained: "A problem that used to have a capital 'H' now has a small 'h.'"

While some therapies focus directly on heterosexual conversion, reparative therapy takes a wider view of the homosexual condition as it affects issues of personal power, gender identity, and self-image. Reparative therapy views change as a long-term process, and one that is in fact most probably lifelong. One 25-year-old client explained his process of change in the following letter:

I've been in group therapy now for 13 months, and I can say this time has been the most revealing, growthful, and important period in my life.

My love for my Catholic faith originally led me to seek help for my homosexuality, as I felt guilty and unhappy. However, today I continue to come to therapy because I am motivated by my own progress and the progress of the other men in the group.

The therapy has helped me understand a lot about myself, my past, and the things that have contributed to my situation. For example, my father left my mother when I was 3 years old, and I grew up never having a close male figure to identify or bond with. Consequently I never felt a

true sense of maleness about myself, and as I grew up, I never really felt like one of the guys. This eventually led to an exclusive attraction to males, which I remember started around age six.

Therapy has broken down most of the fantasy world I had built up around other males. My self-esteem and sense of masculinity have improved, and this is reflected in my success at work and my newly established male friendships. I have even started dating, and now I definitely see marriage and children in my future. While my relationship with my father is still not so good, I have made him aware of my situation and he has shown compassion.

The attraction to other men has still not gone away completely, but it has certainly diminished. Other men who used to both intimidate and attract me are much less threatening today. While I do not think that my same-sex attraction will disappear 100 percent, I do think I will reach a point where my attraction to the opposite sex prevails, and I will be able to move on with my life. All of this growth comes about, I have found, through the wholesome male friendships which I have learned how to develop through therapy, a prayer life, and the sacraments of my church.

If our use of the word *change* rather than *cure* sounds pessimistic, one should consider the use of the word *cure* as it applies to other psychiatric conditions. Indeed, except for the most elementary behavior-modification programs such as smoking-cessation and treatment of certain phobias, no psychological treatment can be conceptualized in terms of absolute cure. The alcoholic is never fully cured of his desire to drink, but successful treatment does offer him an effective way of dealing with his lifelong condition. The client with low self-esteem is never fully freed of his doubts

and insecurities, but he grows in self-assurance. And are the issues of Adult Children of Alcoholics (ACAs) ever no longer their issues? So rather than "cure" of homosexuality, we should think in terms of growth, by laying the right foundation of healthy nonerotic male relationships. Then for some, celibacy will be the solution; for others, heterosexual marriage is the hoped-for goal.

The validity of any therapy—no matter what the treatment method or goal—is found in its overall effect on the life of the client. Good therapy must do more than alleviate a specific symptom. If the treatment is right for the person, then the freedom and well-being it brings will radiate throughout all aspects of the personality. Most important, the move to health will bring a growing awareness of personal power.

# The Therapeutic Relationship

## TRANSFERENCE

The most critical and often the most painful dimension of psychotherapy is looking honestly at those feelings the client has transferred onto the therapist from previous relationships. During the course of treatment a broad spectrum of unresolved and unconscious conflicts, defenses, and desires from previous significant relationships are transferred onto the therapist. The client sees the therapist through the eyes of the child he once was. Transferred feelings include fear, anger, aggressive-defensive reactions, and sexual desires.

**EXHIBIT B**

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9

10 IN THE UNITED STATES DISTRICT COURT  
11 FOR THE EASTERN DISTRICT OF CALIFORNIA  
12 SACRAMENTO DIVISION  
13

14 **DAVID PICKUP, ET AL.,**

15 Plaintiffs,

16 v.

17  
18 **EDMUND G. BROWN JR. GOVERNOR  
OF THE STATE OF CALIFORNIA, IN  
19 HIS OFFICIAL CAPACITY, ET AL.,**

20 Defendants.  
21  
22

2:12-cv-02497

**DECLARATION OF GREGORY M.  
HEREK IN SUPPORT OF  
DEFENDANTS' OPPOSITION TO  
PLAINTIFFS' MOTION FOR  
PRELIMINARY INJUNCTION**

Date: Nov. 30, 2012  
Time: 10:00 a.m.  
Courtroom: 3, 15th Floor  
Judge: The Honorable Kimberly J.  
Mueller  
Trial Date: None set  
Action Filed: Oct. 4, 2012

1           1. I have been retained by counsel for Plaintiffs as a consultant in connection with the  
2 above-referenced litigation. I have personal knowledge of the contents of this declaration, and if  
3 called upon to testify, I could and would testify competently to the contents of this declaration.

4           2. My background, experience, and scholarly publications are summarized in my  
5 curriculum vitae, which is attached as Exhibit B to this report.

6           3. I am a Professor of Psychology at the University of California at Davis. In 1983, I  
7 received my Ph.D. in Psychology, with an emphasis in Personality and Social Psychology, from  
8 the University of California at Davis. I was a Post-Doctoral Fellow in Social Psychology at Yale  
9 University from 1983 to 1985. I subsequently served as a Lecturer and Visiting Assistant  
10 Professor at Yale University, and then as an Assistant Professor in the graduate program in Social  
11 and Personality Psychology at the City University of New York Graduate Center. I returned to  
12 the University of California at Davis in 1989 as an Associate Research Psychologist, and was  
13 appointed a tenured full Professor in 1999.

14           4. Two principal foci of my original empirical research program are societal stigma  
15 based on sexual orientation and the social psychology of heterosexuals' attitudes towards lesbians,  
16 gay men, and bisexuals. As reflected in my curriculum vitae (Exhibit B), I have published more  
17 than 100 papers and chapters in scholarly journals and books, most of them related to sexual  
18 orientation, HIV/AIDS, or attitudes and prejudice. I also have edited or coedited five books and  
19 two special issues of academic journals on these topics. I have made more than 90 presentations  
20 at professional conferences and meetings, and have given more than 75 invited lectures to  
21 professional, academic, and community groups. I have received numerous grants for my research  
22 from federal, state, and private entities with combined budgets totaling more than \$5 million.

23           5. I am a member and Fellow of the American Psychological Association (APA), the  
24 Association for Psychological Science, and several other professional organizations. On two  
25 occasions, I have testified before the U.S. Congress about issues of sexual orientation on behalf  
26 of the APA and other professional societies. I have received several professional awards and  
27 honors, including the 1996 APA Award for Distinguished Contributions to Psychology in the  
28

1 Public Interest and the 2010 California Psychological Association's Distinguished Humanitarian  
2 Contribution Award.

3 6. I currently serve on the editorial boards of eight professional journals and I routinely  
4 serve as an ad hoc peer reviewer for others. Throughout my professional career, I have peer-  
5 reviewed manuscripts for a large number of scientific and professional journals spanning a variety  
6 of disciplines, including psychology, sociology, political science, sexuality studies, gender  
7 studies, and public health. I am the Executive Editor Emeritus of *Contemporary Perspectives on*  
8 *Lesbian, Gay, and Bisexual Psychology*, a book series published by the American Psychological  
9 Association dedicated to scientific and professional works on sexual orientation and related  
10 topics. I was a member of a peer review panel for the National Institute of Mental Health from  
11 1992 to 1995, and have served as an ad hoc reviewer of grant proposals for NIMH and other  
12 funding agencies on several occasions since completing my three-year term on that committee.  
13 From 1995 to 2007, I served as chairperson of the Scientific Review Committee of the Wayne F.  
14 Placek Award competition, sponsored by the American Psychological Foundation, which  
15 annually funded empirical research in the behavioral and social sciences related to sexual  
16 orientation. I was a member of the Committee on Lesbian, Gay, Bisexual and Transgender  
17 (LGBT) Health Issues and Research Gaps and Opportunities, an expert panel constituted by the  
18 Institute of Medicine of the National Academy of Sciences in 2010 to prepare a book-length  
19 report for the National Institutes of Health on lesbian, gay, bisexual, and transgender health issues  
20 and research gaps and opportunities. At the University of California, Davis, I regularly teach an  
21 upper-division undergraduate course on sexual orientation and also have taught graduate seminars  
22 on this and related topics. My successful service in these varied capacities has required me to  
23 possess a broad, multidisciplinary knowledge of theory and empirical research on a wide variety  
24 of topics related to sexual orientation. Thus, I have expertise on sexual orientation that crosses  
25 academic disciplinary boundaries and extends beyond the specific areas addressed in my own  
26 original empirical research program.

1 7. In the past six years, I have provided expert testimony by deposition in three matters,  
2 (a) *Varnum v. Brien*, Iowa District Court for Polk County, Case No. CV 5965, (b) *Perry v.*  
3 *Schwarzenegger*, United States District Court for the Northern District of California, Case No. C  
4 09-2292 VRW, and (c) *Carlson v. eHarmony, Inc.*, Superior Court of California, Los Angeles  
5 County, Case No. BC 371958. In addition, I submitted an expert affidavit in the related cases of  
6 *Gill v. Office of Personnel Management* and *Commonwealth of Massachusetts v. United States*  
7 *Department of Health and Human Services*, both in the United States District Court for the  
8 District of Massachusetts, Case Nos. 09-10309-JLT and 1:09-11156-JLT, respectively. I also  
9 submitted an expert affidavit in *Jackson et al., v. Abercrombie et al.*, United States District Court  
10 for the District of Hawaii, Case No.11-00734 ACK-KSC. I also testified at trial in the *Perry v.*  
11 *Schwarzenegger* case cited above.

### 12 III. Sexual Orientation

#### 13 A. Definition and Description of Sexual Orientation

14 8. The term *sexual orientation* is commonly used by behavioral scientists and mental health  
15 professionals to refer to an enduring pattern of or disposition to experience sexual, affectional, or  
16 romantic desires for and attractions to men, women, or both sexes. The term is also used to refer  
17 to an individual's sense of identity based on those desires and attractions, behaviors expressing  
18 them, and membership in a community of others who share them. Most social and behavioral  
19 research has assessed sexual orientation in terms of attraction, behavior, identity, or some  
20 combination of these constructs, depending on the specific goals of the study.<sup>1</sup>

21 9. Although sexual orientation ranges along a continuum from exclusively heterosexual  
22 to exclusively homosexual, it is usually discussed in terms of three categories: *heterosexual*  
23 (having attraction primarily or exclusively to members of the other sex), *homosexual* (having  
24 attraction primarily or exclusively to members of one's own sex), and *bisexual* (having a

25 \_\_\_\_\_  
26 <sup>1</sup> For elaboration on the definition of sexual orientation, see the Institute of Medicine,  
27 2011's (2011) report, *The health of lesbian, gay, bisexual, and transgender people: Building a*  
28 *foundation for better understanding*, as well as the entries on "Homosexuality" I authored for *The*  
*Encyclopedia of Psychology* (Herek, 2000) and *The Corsini Encyclopedia of Psychology and*  
*Behavioral Science* (Herek, 2001).

1 significant degree of attraction to both men and women). Most adults in the United States are able  
2 to report their own sexual orientation when asked to do so by researchers.<sup>2</sup> Among the small  
3 percentage of individuals who do not report their sexual orientation in survey studies, some may  
4 be unsure about their orientation or may be uncomfortable labeling it, but many are probably  
5 motivated by concerns about their personal privacy or, for those who are not heterosexual, fear of  
6 stigma (a topic addressed below).

7 10. In this declaration, I use the term *gay* to refer to men and women with a homosexual  
8 orientation. I also use the term *lesbian* to refer to women with a homosexual orientation. I use  
9 the term *sexual minority* to refer to individuals who self-identify as gay, lesbian, or bisexual, or  
10 who do not so identify but nevertheless manifest an ongoing pattern of homosexual attraction or  
11 sexual behaviors with people of the same sex.

12 **B. Homosexuality Is a Normal Expression of Human Sexuality**

13 11. Many early psychological and psychiatric figures who studied sexuality, including  
14 Sigmund Freud and Havelock Ellis, did not consider homosexuality to be pathological. However,  
15 the view that it is a mental illness achieved dominance in the United States in the mid-twentieth  
16 century, especially among psychoanalysts. In 1952, in the first edition of what came to be called  
17 the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the American Psychiatric  
18 Association classified homosexuality as a mental disorder.<sup>3</sup> This classification, however, reflected  
19 untested assumptions based on then-prevalent social norms as well as clinical impressions drawn  
20 from unrepresentative samples of patients seeking therapy and individuals whose conduct brought  
21 them into the criminal justice system. Once researchers began using the scientific method with  
22 samples of non-patient, nonincarcerated individuals to empirically test the belief that  
23 homosexuality is an illness, evidence accumulated that many homosexuals were psychologically  
24  
25

26 <sup>2</sup> Some heterosexual survey respondents are unfamiliar with terms such as "heterosexual"  
27 and "homosexual" but provide responses (e.g., "normal," "straight") that indicate they identify as  
28 heterosexual (e.g., Laumann, et al., 1994).

<sup>3</sup> American Psychiatric Association, 1952.

1 healthy and that homosexuals as a group did not differ substantially from comparable  
2 heterosexuals in their levels of psychological functioning.<sup>4</sup>

3 12. Confronted with empirical evidence that failed to support the illness model of  
4 homosexuality, as well as changing views of sexuality and gender in the larger culture, the mental  
5 health professions reached the conclusion that classifying homosexuality as a mental disorder had  
6 been incorrect. In 1973, the American Psychiatric Association's Board of Directors voted to  
7 remove it from the DSM, stating that "homosexuality *per se* implies no impairment in judgment,  
8 stability, reliability, or general social or vocational capabilities." The American Psychological  
9 Association adopted the same position in 1975, and urged all mental health professionals to help  
10 dispel the stigma of mental illness that had long been associated with homosexual orientation.<sup>5</sup>

11 13. Today, mainstream mental health professionals and researchers recognize that (a)  
12 homosexuality is a normal expression of human sexuality; (b) being gay or lesbian bears no  
13 inherent relation to a person's ability to perform, contribute to, or participate in society; (c) being  
14 gay or lesbian poses no inherent obstacle to leading a happy, healthy, and productive life; and (d)  
15 the vast majority of gay and lesbian people function well in society and in their interpersonal  
16 relationships.

### 17 C. The Origins and Enduring Nature of Sexual Orientation

18 14. The factors that cause an individual to become heterosexual, homosexual, or bisexual  
19 are not currently well understood. Widely differing accounts of the origins of adult sexual  
20 orientation have been proposed but no single theory enjoys unequivocal empirical support. There  
21 may be multiple developmental pathways to adult sexual orientation rather than a single cause.  
22 Given the current lack of definitive knowledge about why some individuals develop a  
23 heterosexual orientation, others become homosexual, and still others become bisexual, many

24 \_\_\_\_\_  
25 <sup>4</sup> See, e.g., Gonsiorek, 1991.

26 <sup>5</sup> The text of the 1975 American Psychological Association resolution can be found at  
27 <http://www.apa.org/about/policy/discrimination.aspx> and in Conger (1975). The Psychological  
28 Association's other resolutions addressing issues related to sexual orientation are posted at  
<http://www.apa.org/pi/lgbt/resources/policy/index.aspx>. The Psychiatric Association's official  
positions on those issues are posted at <http://www.healthyminds.org/More-Info-For/GayLesbianBisexuals.aspx>.

1 social and behavioral scientists regard sexual orientation as being shaped by a complex  
2 interaction of biological, psychological, and social forces. They often differ, however, on the  
3 relative importance they assign to each.

4 15. Irrespective of the origins of sexual orientation, most gay men and lesbians in the  
5 United States report experiencing either no choice or very little choice in their sexual orientation.  
6 In a 2005 survey that I conducted with a national probability sample<sup>6</sup> of more than 650 self-  
7 identified lesbian, gay, and bisexual adults, for example, 88% of the gay men reported that they  
8 experienced "no choice at all" about being gay, and another 7% reported experiencing only "a  
9 small amount of choice." Only 5% said they experienced "a fair amount" or "a great deal" of  
10 choice. Among lesbians, 68% reported that they experienced no choice, and another 15%  
11 reported experiencing only a small amount of choice; only 16% experienced a fair amount or a  
12 great deal of choice.<sup>7</sup> Similarly, in a survey I conducted during the 1990s with a nonprobability  
13 sample of more than 2,200 gay, lesbian, and bisexual adults in the greater Sacramento area, 87%  
14 of the gay men and 70% of the lesbians reported they experienced "no choice at all" or "very little  
15 choice" about their sexual orientation.<sup>8</sup> I am not aware of empirical studies in which heterosexual  
16 men and women were directly asked whether or not they chose to be heterosexual. If such a  
17 study were to be conducted, however, I believe it is likely that most heterosexuals would report  
18 that they do not experience their own heterosexuality as a choice.

#### 19 **IV. Stigma and Sexual Orientation**

##### 20 **A. Definition of Stigma and Sexual Stigma**

21 16. *Stigma* refers generally to the negative regard and inferior status that society  
22 collectively accords to people who possess a particular characteristic or belong to a particular  
23

---

24 <sup>6</sup> Researchers distinguish between probability and nonprobability samples. For purposes  
25 of this declaration, the most relevant difference is that results obtained from probability samples  
26 (which are sometimes referred to as *representative* samples) can be generalized to the larger  
27 population with a level of statistical confidence that can be calculated mathematically. By  
28 contrast, nonprobability samples (which are sometimes referred to as *convenience* samples) do  
not permit such generalization beyond the members of the sample.

<sup>7</sup> Herek, Norton, Allen, & Sims, 2010.

<sup>8</sup> Herek, Gillis, & Cogan, 2009.

1 group or category.<sup>9</sup> It constitutes shared knowledge about which attributes and categories are  
2 valued by society, which ones are denigrated, and how these valuations can vary across situations.  
3 A classic work in this area characterized it as "an undesired differentness."<sup>10</sup> Social scientists  
4 have long recognized that stigma is not inherent in a particular trait or membership in a particular  
5 group; rather, society collectively designates some characteristics and groups as undesirable,  
6 thereby "constructing" stigma. Because stigma is socially constructed, it can change over time as  
7 social norms and mores change.

8 17. *Sexual stigma* is shared knowledge about the negative regard, inferior status, and  
9 relative powerlessness that society collectively accords to nonheterosexual behaviors, attractions,  
10 identity, relationships, and communities.

11 **B. Homosexuality Remains Stigmatized in the United States and Experiencing**  
12 **Stigma Has Negative Consequences for Sexual Minorities**

13 18. Despite a trend in recent years toward less hostility and discrimination against sexual  
14 minorities, sexual stigma persists in the United States. National opinion surveys reveal that  
15 substantial numbers of heterosexual Americans still harbor negative attitudes and feelings toward  
16 sexual minorities, and sexual minority individuals continue to experience rejection, harassment,  
17 discrimination, and violence.<sup>11</sup> For example, in my national survey of lesbian, gay, and bisexual  
18 adults, 21% of the respondents reported having been the target of a physical assault or property  
19 crime because of their sexual orientation since age 18. Gay men were the most likely to report  
20 they had been the targets of such crimes; 38% had experienced an assault or property crime  
21 because of their sexual orientation.<sup>12</sup> In the same survey, 18% of gay men and 16% of lesbians  
22 reported they had experienced discrimination in housing or employment because of their sexual  
23 orientation. Harassment and bullying of children and adolescents because of their perceived  
24 nonheterosexual orientation or gender nonconformity is also widespread.<sup>13</sup> For example, findings

25 \_\_\_\_\_  
26 <sup>9</sup> See, e.g., Goffman, 1963; Herek, 2009; Link & Phelan, 2001.

27 <sup>10</sup> Goffman, 1963, p. 5.

28 <sup>11</sup> E.g., Herek, 2009; Norton & Herek, 2012; Schafer & Shaw, 2009

<sup>12</sup> Herek, 2009.

<sup>13</sup> United States Commission on Civil Rights, 2011

1 from the California Healthy Kids Survey reveal widespread harassment and bullying based on a  
2 child's actual or perceived sexual orientation in California middle and high schools.<sup>14</sup>

3 19. Sexual stigma is a source of stress and experiencing it in its various manifestations  
4 has negative consequences for sexual minorities. These include heightened psychological distress  
5 among both gay and lesbian adults<sup>15</sup> and adolescents.<sup>16</sup> Being the target of extreme enactments of  
6 stigma, such as an antigay criminal assault, is accompanied by greater psychological distress than  
7 is experiencing a similar crime not based on one's sexual orientation.<sup>17</sup>

8 20. Fear of stigma compels some sexual minority individuals to conceal their sexual  
9 orientation from others, which is often associated with heightened psychological distress and has  
10 negative implications for physical health. Like heterosexuals, sexual minorities benefit  
11 psychologically from being able to share their lives with and receive support from their family,  
12 friends, and other people who are important to them. Lesbians and gay men, for example, have  
13 been observed to manifest better mental health to the extent that they hold positive feelings about  
14 their own sexual orientation, have developed a positive sense of identity based on it, and have  
15 integrated it into their lives by disclosing it to others (such disclosure is commonly referred to as  
16 "coming out of the closet" or simply "coming out").<sup>18</sup> By contrast, lesbians and gay men who feel  
17 compelled to conceal their sexual orientation tend to report more frequent mental health concerns  
18 than their openly gay counterparts and are at greater risk for physical health problems.<sup>19</sup>

19 21. To the extent that sexual stigma and other factors<sup>20</sup> subject gay men, lesbians, and  
20 bisexuals to additional stress beyond what is normally experienced by the heterosexual  
21 population, the sexual minority population may, as a group, include a somewhat greater

22 <sup>14</sup> O'Shaughnessy, Russell, Heck, Calhoun, & Laub, 2004.

23 <sup>15</sup> E.g., Meyer, 2003; Mays & Cochran, 2001.

24 <sup>16</sup> O'Shaughnessy, et al., 2004.

25 <sup>17</sup> Herek, Gillis, & Cogan, 1999.

26 <sup>18</sup> Herek & Garnets, 2007; Pachankis, 2007.

27 <sup>19</sup> Cole, 2006; Herek, 1996; Meyer, 2003; Strachan, Bennett, Russo, & Roy-Byrne, 2007.

28 <sup>20</sup> In addition to stigma, lesbian, gay, and bisexual people face other stressors. For example, because the AIDS epidemic has had a disproportionate impact on the gay male community in the United States, many gay and bisexual men have experienced the loss of a life partner, and gay, lesbian, and bisexual people alike have experienced extensive losses in their personal and social networks resulting from the death of close friends and acquaintances; bereavement related to multiple losses is linked to higher levels of depressive symptoms.

1 proportion of individuals who manifest some forms of mental illness or psychological distress.<sup>21</sup>  
2 In this respect, the sexual minority population is comparable to other groups that face unique  
3 stressors due to prejudice and discrimination based on their minority status.<sup>22</sup> Given the unique  
4 social stressors to which they are subjected, the noteworthy fact is that the vast majority of gay  
5 men, lesbians, and bisexuals effectively cope with these challenges and lead happy, healthy and  
6 well-adjusted lives.

7 **C. Self-Stigma**

8 22. Although most or all members of society are aware of which groups are stigmatized,  
9 they may or may not personally agree with or endorse society's negative evaluation of any  
10 particular group. To the extent that they accept society's negative judgment as a part of their own  
11 value system and self-concept, they can be said to have *internalized* that stigma. To internalize  
12 stigma is to embrace society's denigration and discrediting of the stigmatized group. Members of  
13 the nonstigmatized majority can internalize stigma, as can members of the stigmatized minority.  
14 Among the former, internalized stigma is manifested as prejudice toward the minority group;  
15 among the latter, it is manifested as *self-stigma*.<sup>23</sup>

16 23. For a sexual minority individual, self-stigma involves accepting society's negative  
17 evaluation of homosexuality and consequently harboring negative attitudes toward oneself and  
18 one's own homosexual desires. Such attitudes may be manifested as a wish to renounce one's  
19 homosexuality and become heterosexual.<sup>24</sup>

20 24. Because sexual minority individuals are raised in a society where sexual stigma is  
21 widespread, it is not uncommon for them to manifest some degree of self-stigma when they are  
22 first recognizing their sexual orientation and coming out. This often occurs during adolescence or  
23 early adulthood. Overcoming sexual self-stigma, developing positive feelings toward oneself, and

24 <sup>21</sup> Consistent with this observation, several studies suggest that, compared to the  
25 heterosexual population, a somewhat larger proportion of the homosexual and bisexual  
26 population may manifest certain symptoms of psychological distress, such as symptoms of  
27 anxiety or depression (Herek & Garnets, 2007; Meyer, 2003).

26 <sup>22</sup> Meyer (2003).

27 <sup>23</sup> Herek (2009). Sexual self-stigma is also referred to as *internalized homophobia*,  
*internalized heterosexism*, and *internalized homonegativity*.

28 <sup>24</sup> Herek, et al., 2009.

1 integrating one's sexuality with other aspects of the self are widely considered to be important  
2 achievements for a sexual minority individual's healthy development.

3 25. Sexual self-stigma is generally considered maladaptive and often has important  
4 negative consequences for a sexual minority individuals' well-being.<sup>25</sup> For example, in my  
5 previously cited study of Sacramento-area sexual minority adults, I measured self-stigma using a  
6 psychological scale on which respondents reported their level of agreement or disagreement with  
7 statements such as "I wish I weren't lesbian/bisexual" (for male respondents, the wording was "I  
8 wish I weren't gay/bisexual") and "I have tried to stop being attracted to women in general" (for  
9 male respondents: "I have tried to stop being attracted to men in general"). To the extent that  
10 study participants agreed with such statements, they manifested lower levels of self-esteem and  
11 more symptoms of depression and anxiety.<sup>26</sup>

## 12 V. Sexual Orientation Change Efforts (SOCE)

13 26. The phrase *sexual orientation change efforts* (SOCE) encompasses a variety of  
14 methods, including techniques derived from psychoanalysis, behavioral therapy, and religious and  
15 spiritual counseling. These techniques share the common goal of changing an individual's sexual  
16 orientation from homosexual to heterosexual.<sup>27</sup> Such methods have also been referred to by their  
17 practitioners with various other terms, including *conversion therapy* and *reparative therapy*.

### 18 A. Historical background

19 27. When homosexuality was considered an illness, many mental health professionals  
20 sought to "cure" it using a variety of techniques, including psychotherapy, hormone treatments,  
21 aversive conditioning with nausea-inducing drugs, lobotomy, electroshock, and castration.  
22 However, empirical research failed to find that such interventions could reliably change  
23 homosexual individuals into heterosexuals, i.e., individuals who are no longer attracted to their  
24 same sex but instead are attracted to the other sex and function well in a heterosexual relationship.  
25 Rather, only a small proportion of individuals exhibited any change in their sexuality, and it

26 \_\_\_\_\_  
27 <sup>25</sup> E.g., Herek & Garnets, 2007; Meyer, 2003.

<sup>26</sup> Herek, et al., 2009.

<sup>27</sup> American Psychological Association, 2009a

1 generally fell far short of becoming heterosexual. The interventions sometimes produced  
2 suppression of homoerotic response (as indicated by self-report or laboratory observation) or they  
3 reduced or eliminated an individual's homosexual behavior. Some individuals developed the  
4 capacity to engage in heterosexual intercourse after treatment, and some labeled themselves  
5 heterosexual and even married a partner of the other sex. However, these changes were observed  
6 to occur in only a small percentage of the individuals who undertook treatment.

7 28. Once homosexuality was no longer classified as an illness, the rationale for trying to  
8 "cure" it by changing an individual's sexual orientation ceased to exist. Over time, most  
9 practitioners stopped attempting to change sexual orientation and some took strong public stands  
10 against such efforts. With this shift, scientific research on the effectiveness of change  
11 interventions declined dramatically. Thus, most published studies of clinical interventions for  
12 changing sexual orientation appeared in professional journals while homosexuality was still  
13 considered an illness by most professionals.

#### 14 **B. Definitional and methodological considerations**

15 29. For a psychological intervention to be considered effective,<sup>28</sup> it must be both *reliable*  
16 and *safe*. To be reliable, it must be shown to have consistent positive effects, that is, when  
17 correctly administered it must achieve its intended goals all or most of the time. To be considered  
18 safe, the intervention must not cause serious harm to the people who receive it.

19 30. In order to determine that an intervention causes a particular outcome to occur, an  
20 experimental design is necessary. The basic features of such an experiment are: (a) establishment  
21 of clear criteria for assessing participants' eligibility for the study before receiving the  
22 intervention (e.g., their sexual orientation); (b) random assignment of participants to an  
23 experimental group, e.g., assignment to either a group that receives an intervention (referred to as  
24 a treatment group) or a group that receives no intervention (referred to as a control group); (c)

25 \_\_\_\_\_  
26 <sup>28</sup> A distinction is often made in the professional literature between a treatment's *efficacy*  
27 (its ability to achieve its intended outcomes under optimal conditions of delivery, as during  
28 carefully controlled clinical trials) and its *effectiveness* (the ability of an efficacious treatment to  
achieve its intended outcomes under "real world" conditions, which often are not optimal). For  
purposes of this declaration, these terms are used interchangeably.

1 establishment of clear criteria for assessing the outcome (e.g., participants' sexual orientation after  
2 receiving the intervention); such assessments should be conducted in a manner that is free from  
3 potential bias on the part of the experimenter, e.g., they are conducted by researchers who are  
4 unaware of whether any given participant was assigned to the treatment group or the control  
5 group.

6 **C. Evaluating research on SOCE**

7 31. Few published SOCE studies have used this design. After reviewing the research  
8 literature, a 2009 APA Task Force<sup>29</sup> identified only six published studies that used reasonably  
9 rigorous experimental methods, and only one of those studies included a no-treatment control  
10 group. Three additional studies used a reasonably good *quasi-experimental* design (i.e., they  
11 included comparison of different treatment conditions but participants were not randomly  
12 assigned to those conditions). Most of these studies were published during the early or mid-  
13 1970s; all appeared prior to 1982.

14 32. In their review, the APA Task Force noted numerous methodological limitations of  
15 the research in this area. These included problems related to the composition and recruitment of  
16 samples;<sup>30</sup> attrition over the course of the study;<sup>31</sup> inadequate assessment of participants' sexual  
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20 <sup>29</sup> In response to public debates about SOCE, the American Psychological Association  
21 created a Task Force on Appropriate Therapeutic Responses to Sexual Orientation which  
22 reviewed the relevant research literature and issued a report. The Task Force conclusions are  
23 summarized below.

24 <sup>30</sup> Many studies used very small, homogeneous samples, often consisting of well-  
25 educated, White adult males and, in more recent studies, highly religious individuals. In addition,  
26 some studies included participants who were required to undergo the intervention (e.g., because  
27 of an arrest or criminal conviction). Because such individuals' freedom may have depended on the  
28 outcome of the intervention, they would be strongly motivated to "fake" changes in their sexuality  
in order to be released from custody. Many studies have included both homosexuals and bisexuals  
in the sample, a practice that obscures whether sexual orientation change – if any is observed –  
actually occurred among homosexual individuals, or was limited to participants who already had  
some degree of heterosexual attractions or sexual experience before receiving the intervention.

<sup>31</sup> Many studies had high dropout rates that compromised their validity. Such attrition is  
especially problematic when the dropouts are disproportionately individuals for whom the  
intervention was not working.

1 orientation;<sup>32</sup> inadequate description of the intervention procedures;<sup>33</sup> unclear definitions of the  
2 criteria for judging "success" of the intervention;<sup>34</sup> and problems with the timing of measurement  
3 of sexual orientation after the intervention.<sup>35</sup>

4 <sup>32</sup> The Task Force noted that sexual orientation has not been assessed in a uniform way  
5 across studies. Some studies operationally defined it in terms of attraction (using self-reports or  
6 physiological measures), whereas others assessed self-reported sexual behavior, and others  
7 assessed self-labeling or identity. Some research reports did not include any explanation of how  
8 sexual orientation was measured.

9 <sup>33</sup> Many of the early published studies included clear descriptions of the procedures, e.g.,  
10 researchers reported that participants received aversive conditioning over a set number of  
11 treatment sessions. More recent studies, however, have collected questionnaire data from samples  
12 whose members participated in differing types of intervention programs, with some having  
13 undergone multiple interventions. Details about the specific procedures that were followed in  
14 each participant's intervention(s) have not been available. Thus, even if some of the participants  
15 evidenced change, it is not possible to link it with a specific intervention program or technique.

16 <sup>34</sup> Judging whether a homosexual or bisexual person becomes heterosexual after  
17 undergoing an intervention depends on how sexual orientation is operationally defined. A variety  
18 of approaches have been used to assess the outcomes of SOCE, all of which have important  
19 limitations. For example, self-reports of behavior, attraction, and identity after the intervention  
20 may not be valid if participants are highly motivated to detect changes in their sexuality and to  
21 report "success." Intentionally or unintentionally, they may selectively perceive or remember  
22 feelings or behaviors that are consistent with sexual orientation change, while ignoring or  
23 forgetting feelings and behaviors that are inconsistent with change. Obtaining reliable reports  
24 from an objective, third-party observer is generally not feasible, simply because of the private  
25 nature of sexuality. Whereas physiological measures of sexual attraction might appear to be more  
26 reliable than self-reports, they also have problems. Some people can control their level of  
27 physiological arousal, while others are unable to achieve sexual arousal in a clinical setting. Other  
28 factors, such as anxiety, can also influence the results of physiological measures.

<sup>35</sup> Ideally, sexual orientation is assessed prior to the treatment intervention, soon after it  
concludes, and then again at later times with one or more follow-up assessments. However, long-  
term follow-up assessment has often been lacking. Many recently published questionnaire studies  
have not even collected pre-intervention data. Instead, the researchers collected data only after the  
intervention was completed and relied on the participants' recollections of their past sexual  
attractions, behaviors, and psychological states. In some cases, this required respondents to try to  
remember their subjective state more than 10 years earlier. Self-reports of current sexual desires  
and behaviors were then compared to these retrospective reports. An important problem with this  
approach is that memory of one's own past beliefs, attitudes, and behaviors is often unreliable. As  
the APA Task Force report noted, such recollections are affected by many factors, including:  
impression management (people are motivated to present themselves in a favorable light and thus  
report on the current self as "improved" compared to the former self); expectations about change  
(when people expect their behavior or state to have changed, they are likely to report – and  
believe – that it has, even if this perception is not accurate); a need to justify effort (perceiving  
results after expending time and effort in treatment can be a way of justifying to themselves the  
amount of time and effort they expended); and changes in beliefs or goals (people are especially  
likely to distort their recollections when their emotions, goals, or beliefs have changed since the  
time period they are trying to recall). Thus, people who try to remember their past behaviors and  
earlier mental states often make mistakes. This occurs even when they are unaware of the study's  
purpose. In addition, research participants may be motivated to intentionally misrepresent their  
experiences for various reasons, e.g., because they have an ideological stake in its outcome. In  
some questionnaire studies, for example, most participants were activists who were recruited  
through "ex-gay" ministries. Such participants were likely to feel that they had a strong stake in

(continued...)

1 33. In recent years, several studies have been published in professional journals that  
2 report questionnaire data obtained from people who participated in various forms of SOCE.  
3 These studies are not controlled experiments, however, and the data were collected after the  
4 intervention began (in some cases, many years after the participant completed the intervention;  
5 see Note 35). These studies can reveal the demographic characteristics of individuals who have  
6 participated in interventions, the extent to which those people say the intervention was successful,  
7 and the extent to which they say it was harmful. However, they cannot demonstrate a causal  
8 relationship between participation in the intervention and a specific outcome.

9 34. These and related methodological flaws were recently acknowledged by the author of  
10 what is arguably the most well-known questionnaire study purporting to demonstrate that SOCE  
11 can change the sexual orientation of some individuals. In a 2012 letter to the *Archives of Sexual*  
12 *Behavior*, Dr. Robert Spitzer took the unusual step of expressing regret for having published such  
13 a study in that journal in 2003. In the letter he stated:

14 From the beginning, [the basic research question] was: Can some version of  
15 reparative therapy enable individuals to change their sexual orientation from  
16 homosexual to heterosexual? Realizing that the study design made it impossible to  
17 answer this question, I suggested that the study could be viewed as answering the  
18 question: How do individuals undergoing reparative therapy describe changes in  
19 sexual orientation? A not very interesting question.

20 35. Spitzer then went on to discuss what he labeled "The Fatal Flaw in the Study: There  
21 Was No Way to Judge the Credibility of Subject Reports of Change in Sexual Orientation."

22 I offered several (unconvincing) reasons why it was reasonable to assume that the  
23 participants' reports of change were credible and not self-deception or outright lying.  
24 But the simple fact is that there was no way to determine if the participants' accounts  
25 of change were valid.

26 I believe I owe the gay community an apology for my study making unproven claims  
27 of the efficacy of reparative therapy. I also apologize to any gay person who wasted  
28 time and energy undergoing some form of reparative therapy because they believed  
that I had proven that reparative therapy works with some "highly motivated"  
individuals.<sup>36</sup>

(...continued)

the findings of the study, a potential bias that raises questions about the validity of the data.  
Further discussion of the methodological limitations of past studies in this area are available in  
the Task Force report.

<sup>36</sup> Spitzer, 2012.

1 36. The APA Task Force on SOCE reported that it found "serious methodological  
2 problems in this area of research, such that only a few studies met the minimal standards for  
3 evaluating whether psychological treatments, such as efforts to change sexual orientation, are  
4 effective" (American Psychological Association, 2009a, p. 2). Based on its review of the studies  
5 that met these standards, the Task Force concluded:

6 "enduring change to an individual's sexual orientation is uncommon. The participants  
7 in this body of research continued to experience same-sex attractions following  
8 SOCE and did not report significant change to other-sex attractions that could be  
9 empirically validated, though some showed lessened physiological arousal to all  
10 sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and of  
11 engagement in sexual behavior with the other sex was rare. Few studies provided  
12 strong evidence that any changes produced in laboratory conditions translated to daily  
13 life. Thus, the results of scientifically valid research indicate that it is unlikely that  
14 individuals will be able to reduce same-sex attractions or increase other-sex sexual  
15 attractions through SOCE" (pp. 2-3).

16 37. The Task Force found that some individuals who underwent SOCE reported receiving  
17 benefits from it that were distinct from sexual orientation change, e.g., greater social support and  
18 increased opportunities to talk with others about their own struggles related to sexuality. The  
19 Task Force concluded that these same benefits can be realized through non-SOCE therapies.

20 38. In response to the Task Force report, the APA passed a resolution that stated, in part,  
21 "the American Psychological Association concludes that there is insufficient evidence to support  
22 the use of psychological interventions to change sexual orientation" and "the American  
23 Psychological Association concludes that the benefits reported by participants in sexual  
24 orientation change efforts can be gained through approaches that do not attempt to change sexual  
25 orientation" (American Psychological Association, 2009b).

26 **D. Reports of harm related to SOCE**

27 39. Although SOCE interventions have not been shown to reliably change sexual  
28 orientation from homosexual to heterosexual, evidence exists that they may cause harm. The  
APA Task Force found evidence indicating that some individuals experienced harm or believed  
they had been harmed by these interventions.<sup>37</sup> Early studies reported that some individuals

<sup>37</sup> The Task Force report provides a detailed discussion of this topic and an extensive  
review of relevant research. It is available at: <http://www.apa.org/pi/lgbt/resources/therapeutic->  
(continued...)

1 undergoing SOCE lost their capacity for any sexual response. For example, some individuals  
2 who were subjected to electric shocks or nausea-producing drugs while viewing pictures of same-  
3 sex nudes did not display an increase in attraction to the other sex but they subsequently  
4 experienced a significant reduction in their same-sex arousal.

5 40. More recent data from questionnaire studies, as well as reports from therapists,  
6 indicate that patients who "fail" to change their sexual orientation may experience shame, a  
7 general sense of failure, guilt, depression, intimacy avoidance, sexual dysfunction, or even  
8 suicidality.<sup>38</sup> Although these data derive from questionnaire studies, clinical case studies, and  
9 anecdotal reports rather than controlled experiments, they are important because they raise serious  
10 questions about whether SOCE may be harmful to many who undergo it. Individuals who have  
11 suffered these and other negative effects from SOCE are likely to be excluded from or severely  
12 underrepresented in studies relying on samples recruited through "ex-gay" organizations and  
13 SOCE practitioners (as is the case with most recent studies in this area).

14 41. In light of the many reports of harm, the lack of rigorous studies demonstrating  
15 effectiveness, and the fact that homosexuality is not a psychological disorder that requires "cure,"  
16 the major mental health professional associations in the United States have adopted policy  
17 statements warning the profession and the public about treatments that purport to change sexual  
18 orientation.

19 42. For example, the American Psychiatric Association Board of Trustees referred to the  
20 dangers associated with SOCE in its 1998 position statement:

21 "The potential risks of 'reparative therapy' are great, including depression, anxiety and  
22 self-destructive behavior, since therapist alignment with societal prejudices against  
23 homosexuality may reinforce self-hatred already experienced by the patient ...."

24 "Therefore, the American Psychiatric Association opposes any psychiatric treatment,  
25 such as 'reparative' or 'conversion' therapy which is based upon the assumption that  
26 homosexuality per se is a mental disorder or based upon a prior assumption that the  
27 patient should change his/her homosexual orientation." (American Psychiatric  
28 Association, 2000)

(...continued)  
response.pdf

<sup>38</sup>Haldeman, 2001; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002.

1 43. They supplemented this position with a background statement that said, in part:

2 Psychotherapeutic modalities to convert or "repair" homosexuality are based on  
3 developmental theories whose scientific validity is questionable. Furthermore,  
4 anecdotal reports of "cures" are counterbalanced by anecdotal claims of psychological  
5 harm. In the last four decades, "reparative" therapists have not produced any rigorous  
6 scientific research to substantiate their claims of cure. Until there is such research  
7 available, APA recommends that ethical practitioners refrain from attempts to change  
8 individuals' sexual orientation, keeping in mind the medical dictum to First, do no  
9 harm.

10 44. Concerns about harm resulting from SOCE have also informed the positions of the  
11 other major mental health professional associations in the United States, including the American  
12 Psychological Association, American Counseling Association, and National Association of Social  
13 Workers. Their policy statements cautioning the profession and the public about treatments that  
14 purport to change sexual orientation are described in a publication titled *Just the Facts About  
15 Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel*, which  
16 is endorsed as well by the American Academy of Pediatrics, American School Counselor  
17 Association, American School Health Association, National Association of School Psychologists,  
18 and School Social Work Association of America. As summarized in that publication, "the  
19 nation's leading professional medical, health, and mental health organizations do not support  
20 efforts to change young people's sexual orientation through therapy and have raised serious  
21 concerns about the potential harm from such efforts."<sup>39</sup>

22 **V. Conclusion**

23 45. Although homosexuality is a normal expression of human sexuality, it remains widely  
24 stigmatized in the United States. In the course of their upbringing, sexual minority individuals  
25 often internalize this stigma and consequently hold negative attitudes toward themselves and their  
26 homosexuality. Although this self-stigma typically diminishes as individuals come out and  
27 develop positive feelings about their sexual orientation, while it persists it is often associated with  
28 psychological distress and manifested in an expressed desire to stop being attracted to members  
of the same sex and instead to be heterosexual. However, sexual orientation is highly resistant to

<sup>39</sup> p. 19. *Just the Facts About Sexual Orientation and Youth* is available on the American Psychological Association's Web site: <http://www.apa.org/pi/lgbt/resources/just-the-facts.pdf>

1 change through psychotherapy or religious interventions. Interventions aimed at changing an  
2 individual's sexual orientation have not been empirically demonstrated to be effective or safe.  
3 Indeed, such interventions may be psychologically harmful in an unknown number of cases;  
4 clinical observations and self-reports indicate that many individuals who unsuccessfully  
5 attempted to change their sexual orientation have experienced considerable psychological  
6 distress. Moreover, because homosexuality is a normal variant of human sexuality, the major  
7 mental health professional organizations do not encourage individuals to try to change their  
8 sexual orientation from homosexual to heterosexual. Rather, individuals who experience self-  
9 stigma or who desire to change their sexual orientation because it conflicts with other beliefs and  
10 values can benefit from other therapeutic interventions that do not have the goal of making them  
11 heterosexual.

12 I declare under penalty of perjury pursuant to the laws of the State of California that the  
13 foregoing is true and correct.

14 Executed this 8th day of November, 2012, at Berkeley, California.

15 /s/ Gregory M. Herek (original signature retained by attorney)

16 \_\_\_\_\_  
17 GREGORY M. HEREK

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1 EXHIBIT A

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### CURRENT POSITION

Professor of Psychology, University of California at Davis.

### EDUCATION

B.A. University of Nebraska at Omaha, 1977. Majors in Psychology and Sociology (*magna cum laude*).  
M.A. University of California at Davis, 1980. Personality and Social Psychology.  
Ph.D. University of California at Davis, 1983. Personality and Social Psychology.  
Post-Doctoral Fellowship Yale University, 1983-1985. Social Psychology.

### ACADEMIC AND RESEARCH APPOINTMENTS

1999-present Professor, University of California at Davis.  
2000 Distinguished Visiting Scholar, Richard and Rhoda Goldman School of Public Policy, University of California, Berkeley.  
1994-1999 Research Psychologist, University of California at Davis.  
1989-1994 Associate Research Psychologist, University of California at Davis.  
1986-1989 Assistant Professor, Graduate Program in Social and Personality Psychology, Graduate Center of the City University of New York.  
1986 Visiting Assistant Professor, Yale University.  
1985-1986 Lecturer, Yale University.  
1984 Visiting Lecturer, Branford and Ezra Stiles Colleges, Yale University.  
1983-1985 Postdoctoral Fellow in Personality and Social Psychology, Yale University.  
1978-1983 Teaching Assistant, Research Assistant, and Teaching Associate in Psychology, University of California at Davis.

### SCIENTIFIC AND PROFESSIONAL SERVICE

2008-2012 Member, Faculty Advisory Committee, The Williams Institute, University of California Los Angeles School of Law.  
2010-2011 Member, Committee on Lesbian, Gay, Bisexual and Transgender (LGBT) Health Issues and Research Gaps and Opportunities. Institute of Medicine, National Academy of Sciences.  
2010 Invited Participant, *Social and Behavioral HIV Prevention Research Think Tank*. National Institutes of Health and Office of AIDS Research.

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**SCIENTIFIC AND PROFESSIONAL SERVICE (continued)**

- 2009 Ad Hoc Reviewer, National Science Foundation.
- 2009 Ad Hoc Reviewer, Anthony Marchionne Foundation Small Grants Program.
- 2007-2008 Chair, Fellows Committee. Society for the Psychological Study of Social Issues (APA Division 9)
- 1995-2007 Chair, Wayne Placek Award Scientific Review Committee, American Psychological Foundation.
- 2003-2007 Member, Task Force on Sexual Orientation and Military Service, American Psychological Association.
- 2002-2005 Member, Advisory Board for the National Sexuality Resource Center. Sponsored by the Ford Foundation and San Francisco State University.
- 2001-2005 Member, Diversity Committee, Society for Personality and Social Psychology.
- 2004-2005 Member, Policy Task Force, Society for the Psychological Study of Social Issues.
- 2003-2004 Ad Hoc Reviewer, National Institute of Mental Health.
- 2001 Member, Program Committee for "Sexual Orientation and Mental Health: Toward Global Perspectives on Practice and Policy," an international conference cosponsored by the American Psychological Association and professional societies from Europe, Australia, and South America.
- 1996-2001 Ad Hoc Reviewer, National Institute of Mental Health.
- 2000 Member, Public Interest Awards Committee, American Psychological Association.
- 2000 Member, International Review Committee, World Conference on AIDS.
- 2000 Ad Hoc Reviewer, National Science Foundation.
- 1999-2000 Member, Community Advisory Board, Program in Human Sexuality Studies, San Francisco State University.
- 1998 Member, International Review Committee, World Conference on AIDS.
- 1997 Ad Hoc Reviewer, National Science Foundation.
- 1996 Chair of research workshop, *AIDS, Stigma, and Mental Health: Research Issues and Directions*. Sponsored by the Office on AIDS, National Institute of Mental Health.
- 1992-95 Member, National Institute of Mental Health (NIMH) Mental Health, AIDS and Immunology Review Committee.
- 1992-94 Member, International Scientific Program Committee, International Conference on AIDS.
- 1985-94 Convention Program Committee, APA Division 44. (Member, 1985-87, 1989-94; Chair, 1987-88).
- 1991-93 Convention Program Committee, American Psychological Society.
- 1986-92 Ad Hoc Reviewer and Site Visitor, National Institute of Mental Health.
- 1990-91 Consultant, National Academy of Sciences Committee on AIDS Research, for study of the social impact of AIDS.
- 1990 Scientific consultant to Social Science Research Council for proposed National Survey of Health and Sexual Behavior.

(continued)

**SCIENTIFIC AND PROFESSIONAL SERVICE (continued)**

- 1989 Chair of research workshop, *Mental Health Aspects of Violence Toward Lesbians and Gay Men: Research Issues and Directions*. Sponsored by the Antisocial and Violent Behavior Branch, National Institute of Mental Health.
- 1987-89 Member, Task Force on Psychology and AIDS, American Psychological Association (APA).
- 1986-87 Chairperson (1987) and Member (1986), APA Committee on Lesbian and Gay Concerns.
- 1985-87 President (1987) and Steering Committee Member (1985-86), Association of Lesbian and Gay Psychologists.
- 1985-87 Member, APA Task Force on Avoiding Heterosexist Bias in Psychological Research.

**PUBLIC POLICY AND LEGAL SERVICE**

- 2012 Consultant for *amicus curiae* brief by American Psychological Association in *Golinski v. Office of Personnel Management et al.*, summarizing social science research on sexual orientation, stigma, and other topics relevant to the federal Defense of Marriage Act. (U.S. Court of Appeals, 9<sup>th</sup> District)
- 2012 Submitted expert declaration in *Jackson et al., v. Abercrombie et al.*, summarizing social science research relevant to marriage laws and same-sex couples. (U.S. District Court for the District of Hawaii)
- 2011 Consultant for *amicus curiae* brief by American Psychological Association in *Donaldson et al. v. Montana*, summarizing social science research relevant to Montana law concerning civil unions and legal recognition of same-sex couples. (Montana Supreme Court)
- 2011 Provided invited oral and written testimony for the U.S. Commission on Civil Rights on *Federal Enforcement of Civil Rights Laws to Protect Students Against Bullying, Violence and Harassment*. Washington, DC
- 2009-2010 Submitted expert declaration in *Gill et al. v. Office of Personnel Management et al.*, summarizing social science research on sexual orientation, stigma, and other topics relevant to the federal Defense of Marriage Act. (U.S. District Court for the District of Massachusetts)
- 2009-2010 Expert witness in *Perry et al. v. Schwarzenegger et al.*, a case challenging the constitutionality of California's Proposition 8, which bars same-sex couples from marrying. (U.S. District Court for the Northern District of California)
- 2009 Primary consultant for *amicus curiae* brief by American Psychological Association in *Florida Department Of Children And Families vs. In the Matter of Adoption of X.X.G. and N.R.G.*, summarizing social science research relevant to Florida law concerning adoption by gay men and lesbians. (Florida District Court of Appeal)
- 2007 Primary consultant for *amicus curiae* brief by American Psychological Association in *In re Marriage Cases*, summarizing social science research relevant to California law concerning marriage and same-sex couples. (California Supreme Court)
- 2007 Submitted expert affidavit in *Varnum et al., v. Brien*, summarizing social science research relevant to marriage laws and same-sex couples. (Iowa District Court)

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**PUBLIC POLICY AND LEGAL SERVICE (continued)**

- 2007 Primary consultant for *amicus curiae* brief by American Psychological Association in *Kerrigan et al. v. Commissioner of Public Health et al.*, summarizing social science research relevant to a Connecticut law prohibiting the marriage of same-sex couples. (Connecticut Supreme Court)
- 2006 Primary consultant for *amicus curiae* brief by American Psychological Association in *Conaway et al. v. Deane & Polyak et al.*, summarizing social science research relevant to a Maryland law prohibiting the marriage of same-sex couples. (Court of Appeals of Maryland)
- 2006 Primary consultant for *amicus curiae* brief by American Psychological Association for *In re: Adoption of R.A. and M.A.*, summarizing social science research relevant to foster parenting by same-sex couples. (Maine Supreme Judicial Court)
- 2005-06 Primary consultant for *amicus curiae* brief by American Psychological Association in *Department of Human Services et al. v. Matthew Howard et al.*, summarizing social science research relevant to a ruling by the Arkansas Child Welfare Agency Review Board barring gay and lesbian foster parents (Arkansas Supreme Court).
- 2005 Primary consultant for *amicus curiae* brief by American Psychological Association in *Citizens For Equal Protection v. Bruning et al.*, summarizing social science research relevant to a Nebraska state law prohibiting all recognition of same-sex relationships (US Court of Appeals, 8<sup>th</sup> District).
- 2005 Primary consultant for *amicus curiae* briefs by American Psychological Association in *Samuels et al. v. New York, Shields et al. vs. Madigan et al.*, and *Hernandez et al. vs. Robles*, summarizing social science research relevant to a New York state law prohibiting the marriage of same-sex couples. (Supreme Court of New York: First, Second, and Third Judicial Departments)
- 2004 Primary consultant for *amicus curiae* briefs by American Psychological Association in *Li et al. vs. Oregon, Lewis v. Harris, and Andersen et al. vs. Washington*, summarizing social science research relevant to state laws prohibiting the marriage of same-sex couples in Oregon, New Jersey, and Washington. (Oregon Supreme Court, New Jersey Superior Court, Washington Supreme Court)
- 2004 Submitted expert declaration in *San Francisco v. California et al.*, summarizing social science research relevant to marriage laws and same-sex couples. (California Superior Court)
- 2003 Primary consultant for *amicus curiae* brief by American Psychological Association in *Lawrence v. Texas*, summarizing social science research relevant to state sodomy laws (US Supreme Court).
- 2002 Consultant for *amicus curiae* brief by American Psychological Association in *Boy Scouts of America v. District of Columbia Commission on Human Rights*, summarizing social science research relevant to the D.C. Human Rights Commission's enforcement of antidiscrimination legislation against the Boy Scouts (District of Columbia Court of Appeals).
- 2001 Consultant for *amicus curiae* brief by American Psychological Association in *Jegley v. Picado*, summarizing social science research relevant to the Arkansas sodomy law (Arkansas Supreme Court).

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**PUBLIC POLICY AND LEGAL SERVICE (continued)**

- 2000 Member, Advisory Task Force for AB 537, advising the California State Superintendent of Public Instruction on reducing and preventing hate-motivated acts against lesbian, gay, bisexual, and transgendered students in public schools.
- 2000 Consultant for *amicus curiae* brief by American Psychological Association in *Boy Scouts of America v. Dale*, summarizing social science research relevant to antigay discriminatory policy by the Boy Scouts (U.S. Supreme Court).
- 1997 Invited participant, White House Conference on Hate Crimes.
- 1997 Invited speaker, Congressional briefing on hate crimes (sponsored by the American Psychological Association).
- 1995 Submitted expert declarations in *Able et al. v. U.S.* and *Watson v. Perry et al.* (summarizing social science research relevant to Department of Defense revised policy prohibiting service by gay personnel).
- 1995 Consultant for *amicus curiae* brief by American Psychological Association in *Campbell et al. v. Sundquist et al.*, summarizing social science research relevant to Tennessee sodomy law (Tennessee Court of Appeals).
- 1994 Consultant for *amicus curiae* brief by American Psychological Association in *Romer v. Evans*, summarizing social science research relevant to a Colorado statewide initiative prohibiting local statutes to protect people from discrimination on the basis of their sexual orientation (U.S. Supreme Court).
- 1995 Submitted expert declaration summarizing social science research relevant to U.S. Department of Defense policy prohibiting service by gay personnel in administrative discharge proceedings for *Petty Officer Mark A. Philips, USN*, and *A1C Sean Fucci, USAF*.
- 1994 Submitted expert declaration, *Cammermeyer v. Aspin et al.* (summarizing social science research relevant to Department of Defense policy prohibiting service by gay personnel).
- 1994 Consultant for *amicus curiae* brief by American Psychological Association in *Equality Foundation of Greater Cincinnati v. City of Cincinnati*, summarizing social science research relevant to a court ruling that struck down an initiative prohibiting statutes to protect people from discrimination on the basis of their sexual orientation (U.S. District Court, Southern District of Ohio).
- 1994 Submitted expert declarations summarizing social science research relevant to U.S. Department of Defense policy prohibiting service by gay personnel in the following administrative discharge proceedings: *Lt. Paul G. Thomasson, USN*; *Capt. Richard P. Richenberg, USAF*; *LTJG Tracy W.J. Thorne, USNR*; and *LTJG Richard Dirk Selland, USN*.
- 1993 Witness, Committee on Armed Services, U.S. House of Representatives (Hon. Ronald Dellums, Chair). Hearings on *The Policy Implications of Lifting the Ban on Homosexuals in the Military*. Provided expert testimony on behalf of the American Psychological Association, American Psychiatric Association, and four other national professional organizations.
- 1993 Consultant for *amicus curiae* brief by American Academy of Child & Adolescent Psychiatry, American Psychological Association, and others in *Bottoms v. Bottoms*, summarizing social science research relevant to a court ruling that removed a child from the custody of his lesbian mother (Virginia Court of Appeals).

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### **PUBLIC POLICY AND LEGAL SERVICE (continued)**

- 1993 Submitted expert declaration summarizing social science research relevant to U.S. Department of Defense policy prohibiting service by gay personnel in the following administrative discharge proceedings: *HN Berkeley R. Allen Pemberton, USN; Lt. Maria Zoe Dunning, USN; Sgt. Justin Elzie, USMC.*
- 1993 Submitted expert declaration, *Meinhold v. U.S. Department of Defense and U.S. Department of the Navy* (summarizing social science research relevant to Navy policy prohibiting service by gay personnel).
- 1992 Submitted expert declarations summarizing social science research relevant to U.S. Department of Defense policy prohibiting service by gay personnel in the following administrative discharge proceedings: *Sgt. Richard A. Kirton, WAARNG; AWI Volker Keith Meinhold, USN; SSgt. Thomas P. Paniccia, USAF; LTJG Tracy W.J. Thorne, USNR.*
- 1992 Submitted expert declaration in *Evans et al. v. Colorado* (summarizing social science research relevant to Amendment 2, which prohibited passage of legislation to prevent discrimination on the basis of sexual orientation).
- 1992 Submitted expert affidavit, *Douglas v. The Queen* (summarizing social science research relevant to Canadian military policy prohibiting service by gay personnel).
- 1992 Submitted expert declaration, *Woodard v. Gallagher* (summarizing social science research relevant to discriminatory employment policy of Sheriff's Department of Orange County, Florida).
- 1991-92 Member, San Francisco District Attorney's Special Commission on Hate Crimes.
- 1990 Submitted expert affidavit, *Morales et al. v. Texas* (summarizing social science research relevant to Texas state sodomy law).
- 1991 Submitted expert affidavit, *Steffan v. Cheney et al.* (summarizing social science research relevant to Navy policy prohibiting service by gay personnel).
- 1988-92 Consultant for *amicus curiae* briefs by American Psychological Association summarizing social science research relevant to state sodomy laws (including *Kentucky v. Wasson*, Kentucky Supreme Court).
- 1988-89 Consultant for *amicus curiae* brief by American Psychological Association, *Watkins vs. U.S. Army*, summarizing social science research relevant to military ban on gay and lesbian members (U.S. Court of Appeals, Ninth Circuit).
- 1985-86 Consultant for *amicus curiae* brief by American Psychological Association, *Bowers v. Hardwick*, summarizing social science research relevant to Georgia sodomy law (U.S. Supreme Court).
- 1986 Witness, Committee on the Judiciary, Subcommittee on Criminal Justice, U.S. House of Representatives (Hon. John Conyers, Chair). Hearings on *Anti-Gay Violence*. Provided testimony on behalf of American Psychological Association.

### **CURRENT PROFESSIONAL MEMBERSHIPS**

- Association for Psychological Science (Fellow)
- American Psychological Association (Fellow)
- Society for Experimental Social Psychology (Fellow)
- Society for Personality and Social Psychology (APA Division 8, Fellow)
- Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues (APA Division 44, Fellow)
- Society for the Psychological Study of Social Issues (APA Division 9, Fellow)

## SERVICE FOR ACADEMIC JOURNALS AND SERIES

### **Executive Editor**

*Contemporary Perspectives on Lesbian, Gay, and Bisexual Psychology*, book series cosponsored by the Society for the Psychological Study of Lesbian and Gay Issues and APA Books (1999-2008)

### **Editor**

*Psychological Perspectives on Lesbian and Gay Issues*, annual volume sponsored by the Society for the Psychological Study of Lesbian and Gay Issues, APA Division 44 (1992-2000)

### **Consulting Editor, Associate Editor, or Member of Editorial Board or Advisory Board**

#### **Academic Book Series**

*Contemporary Social Issues*. (Society for the Psychological Study of Social Issues) (2007-present)

*Sexuality and Social Policy: Studies In Culture, Development, Citizenship & Social Health*.

(National Sexuality Resource Center, San Francisco State University) (2007-2012)

*Research on Men and Masculinity*. (Sage Publications) (1994-present)

#### **Academic Journals**

*Journal of Social Issues* (2013 - )

*Psychology & Sexuality*, British Psychology Society (2009 - )

*Stigma Research & Action* (2009 - )

*Sexuality Research & Social Policy* (2003 - )

*Basic & Applied Social Psychology* (1997 - )

*Journal of Sex Research* (1995 - )

*Men and Masculinities* (1992 - )

*Journal of Homosexuality* (1984 - )

*Psychology of Sexualities Review*, British Psychology Society (2007-2009)

*Psychology of Men and Masculinity* (1999-2009)

*Personality and Social Psychology Bulletin* (2002-2003)

*Journal of the Gay and Lesbian Medical Association* (1996-2003)

*Journal of Lesbian and Gay Social Work* (1991-2000)

### **Ad Hoc Reviewer (partial list)**

*Aggressive Behavior*

*AIDS & Behavior*

*AIDS Care*

*American J. of Community Psychology*

*American J. of Orthopsychiatry*

*American J. of Public Health*

*American Psychologist*

*Analysis of Social Issues & Public Policy*

*British J. of Social Psychology*

*Comprehensive Psychiatry*

*Culture, Health & Sexuality*

*Emotion*

*European J. of Social Psychology*

*Gender & Society*

*Group Processes & Intergroup Relations*

*Health Psychology*

*J. of Applied Social Psychology*

*J. of Consulting & Clinical Psychology*

*J. of Contemporary Criminal Justice*

*J. of Experimental Social Psychology*

*J. of Interpersonal Violence*

*J. of Law, Medicine & Ethics*

*J. of Lesbian Studies*

*J. of Personality & Social Psychology*

*J. of Politics*

*The Lancet*

*Merrill-Palmer Quarterly*

*Political Psychology*

*Political Research Quarterly*

*Professional Psychology*

*Psychological Bulletin*

*Psychological Review*

*Psychological Science*

*Psychology of Women Quarterly*

*Psychology, Public Policy & Law*

*Public Opinion Quarterly*

*Sex Roles*

*Social & Personality Psychology Compass*

*Social Science & Medicine*

*Sociological Perspectives*

## RESEARCH GRANTS RECEIVED

- 2012-2013 *Sexual Prejudice in the United States: Sources, Consequences, and Interventions.* Tides Foundation/Face Value Project (\$61,896).
- 2004-2006 *The Experience of Stigma in Persons with HIV/AIDS.* Universitywide AIDS Research Program (\$99,876).
- 2005-2006 *Sexual Prejudice and Voters' Attitudes Toward Public Policy Affecting Sexual Minorities in the United States.* The Gill Foundation (\$48,240)
- 1997-2002 *HIV/AIDS-Related Stigma.* Independent Scientist Award, National Institute of Mental Health (\$429,916).
- 1995-1999 *HIV/AIDS-Related Public Attitudes and Beliefs in the US.* National Institute of Mental Health (\$1,173,872).
- 1993-1996 *Mental Health Consequences of Anti-Gay/-Lesbian Violence.* National Institute of Mental Health (\$736,095).
- 1992-1996 *Gay/Bisexual Identity and Community In The AIDS Era.* National Institute of Mental Health (\$540,295).
- 1988-1997 *Public Education About AIDS: A Social Psychological Approach.* National Institute of Mental Health (\$1,432,963).
- 1989-1993 *Public Reactions to AIDS: Knowledge, Attitudes, and Behavior.* National Institute of Mental Health (\$674,080).
- 1990-1992 *Cultural Differences in AIDS-Related Attitudes and Behaviors Among Californians.* Universitywide AIDS Research Program (\$70,092).
- 1987-1989 *Public Knowledge, Attitudes, and Behavior Concerning AIDS: A National Survey.* National Institute of Mental Health (\$121,391).
- 1987-1988 *Public Education About AIDS.* PSC/CUNY Foundation (\$6068).
- 1986-1988 *A Neofunctional Theory of Attitudes.* National Institute of Mental Health. (\$15,000)
- 1985-1986 *Anti-Gay Prejudice and Public Reactions to AIDS.* Society for the Psychological Study of Social Issues, Grants-in-Aid Program. (\$1000)
- 1982 Dissertation research grant. National Gay Academic Union (\$1000).
- 1982 Dissertation research grant. UC Davis Psychology Department (\$600).
- 1979-1981 Annual Graduate Research Awards, University of California at Davis. (\$1400 total)

## OTHER AWARDS AND HONORS

- 2012 8th Annual Dr. Evelyn Lee Visiting Scholar Lectureship in Cultural Competence and Diversity, University of California, San Francisco.
- 2010 Distinguished Scholarly Public Service Award. Academic Senate, University of California, Davis.
- 2010 Distinguished Humanitarian Contribution Award. California Psychological Association.
- 2009 Distinguished Service Award. Society for the Psychological Study of Lesbian, Gay, Bisexual, and Transgender Issues (APA Division 44). Presented at the annual meeting of the American Psychological Association, Toronto.
- 2006 Kurt Lewin Memorial Award for "outstanding contributions to the development and integration of psychological research and social action." Society for the Psychological Study of Social Issues (APA Division 9).
- 2005 William Bevan Memorial Lecture on Psychology and Public Policy. American Psychological Foundation. Presented at the annual meeting of the American Psychological Association, Washington, DC.
- 2005 Elected Fellow, Society for Personality and Social Psychology, Division 8 of the American Psychological Association.
- 2003 Certificate of Appreciation for presenting psychological science to the courts in *Lawrence v. Texas* and other cases related to sexual orientation. Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues, APA Division 44. Presented at the annual meeting of the American Psychological Association, Toronto.
- 2001 Recognized for contributions to research and public policy by the Society for the Psychological Study of Men and Masculinity, APA Division 51. Presented at the annual meeting of the American Psychological Association, San Francisco.
- 2000 Elected Fellow, Society for the Psychological Study of Social Issues, Division 9 of the American Psychological Association.
- 2000 Monette/Horwitz Trust Award, "in recognition of distinguished achievement in combating homophobia through research and writing." Presented at the Lambda Literary Awards banquet, Chicago.
- 2000 Elected Fellow, Society for Experimental Social Psychology.
- 1999 1999 Award for Distinguished Scientific Contribution. Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues (APA Division 44). Presented at the annual meeting of the American Psychological Association, Boston.
- 1996 Distinguished Contribution to Psychology in the Public Interest. American Psychological Association. (Early Career Award)
- 1994 Frederick Howell Lewis Distinguished Lecturer. Psi Chi Honor Society.
- 1993 Myers Center Award for the Study of Human Rights in the United States, presented to *Hate Crimes: Confronting Violence Against Lesbians And Gay Men* (Herek & Berrill, editors). Gustavus Myers Center for the Study of Human Rights in North America, Fayetteville, AR.

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**OTHER AWARDS AND HONORS (continued)**

- 1992 Outstanding Achievement Award. Committee on Lesbian and Gay Concerns, American Psychological Association.
- 1992 *Hate Crimes: Confronting Violence Against Lesbians And Gay Men* (Herek & Berrill, editors) named an Outstanding Academic Book of 1992 by Choice Magazine, American Library Association.
- 1991 Elected Fellow, American Psychological Association and the Society for the Psychological Study of Gay and Lesbian Issues, APA Division 44.
- 1989 Award for "Best Contribution to Empirical Research in Peace Psychology," from Psychologists for Social Responsibility. Presented at the annual meeting of the American Psychological Association, New Orleans. [Shared with Irving L. Janis and Paul Huth for Herek, Janis, & Huth (1987)]
- 1989 Recipient of first annual award for "Distinguished Scientific Contributions to Lesbian and Gay Psychology." Society for the Psychological Study of Lesbian and Gay Issues (APA Division 44). Presented at the annual meeting of the American Psychological Association, New Orleans.
- 1989 Master Lecturer. American Psychological Association.
- 1984 Mark Freedman Memorial Research Award. Association of Lesbian and Gay Psychologists. Presented at the annual meeting of the American Psychological Association, Toronto.
- 1983 Postdoctoral Fellowship. Yale University.
- 1982 Teaching Award for Outstanding Graduate Student. University of California at Davis.
- 1979-82 Regents' Fellowships (three annual awards). University of California at Davis.
- 1977 First Prize, J.P. Guilford National Undergraduate Research Competition sponsored by Psi Chi Honor Society. Presented at the annual meeting of the American Psychological Association, San Francisco.
- 1977 First Prize, Nebraska Psychological Association Undergraduate Research Competition.

## BIBLIOGRAPHY

### *Books and Edited Volumes*

1. Herek, G.M., & Berrill, K. (Eds.) (1990). *Violence against lesbians and gay men: Issues for research, practice, and policy* [Special issue]. *Journal of Interpersonal Violence*, 5 (3).
2. Herek, G.M., & Berrill, K. (Eds.) (1992). *Hate crimes: Confronting violence against lesbians and gay men*. Thousand Oaks, CA: Sage. [Named an Outstanding Academic Book of 1992 by *Choice Magazine*, American Library Association; recipient of a 1993 Myers Center Award for the Study of Human Rights in the United States.]
3. Greene, B., & Herek, G.M. (Eds.) (1994). *Lesbian and gay psychology: Theory, research, and clinical applications*. Thousand Oaks, CA: Sage Publications. [Translated into Croatian as *Psihologija ženske i muške homoseksualnosti*, published by Jesenski i Turk D.O.O., Zagreb, Croatia, 1999.]
4. Herek, G.M., & Greene, B. (Eds.) (1995). *AIDS, identity, and community: The HIV epidemic and lesbians and gay men*. Thousand Oaks, CA: Sage Publications.
5. Herek, G.M., Jobe, J.B., & Carney, R. (Eds.) (1996). *Out in force: Sexual orientation and the military*. Chicago: University of Chicago Press.
6. Herek, G.M. (Ed.) (1998). *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals*. Thousand Oaks, CA: Sage Publications. [Translated into Russian by The State Municipal Enterprise Book Advertising Agency, Kharkov, Ukraine, 2002.]
7. Herek, G.M. (Ed.) (1999). *AIDS and stigma in the United States* [Special issue]. *American Behavioral Scientist*, 42 (7).
8. Berkowitz, B. A., Blum, R., Bockting, W. O., Bradford, J., De Vries, B., Garofalo, R., Graham, R., Herek, G., Howell, E. A., Kasprzyk, D., Makadon, H. J., Patterson, C. J., Peterson, J. L., Ryan, C. C., Schuster, M. A., Taylor, Lowell J., & Zambrana, R. E. (Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities). (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*, National Academy Press, Washington, DC. [Authors listed alphabetically]
9. Herek, G.M. (in preparation). *Beyond homophobia: Understanding sexual stigma and prejudice*. Chicago: University of Chicago Press.

### *Papers in Academic Journals*

1. Barbatsis, G., Wong, M., & Herek, G.M. (1983). A struggle for dominance: Relational communication patterns in television drama. *Communication Quarterly*, 31, 148-155.
2. Herek, G.M. (1984). Beyond "homophobia": A social psychological perspective on attitudes toward lesbians and gay men. *Journal of Homosexuality*, 10(1/2), 1-21. [Reprinted in J.P. DeCecco (Ed.), *Bashers, baiters, and bigots: Homophobia in American society*. New York: Harrington Park Press, 1985. Reprinted and translated as "Et sosialpsykologisk synspunkt på folks holdninger til homofile" in Vera H. Føllesdal (Ed.), *Homofili: Fordommer og fakta*. Oslo, Norway: Solum Forlag, 1990.]
3. Herek, G.M. (1984). Attitudes toward lesbians and gay men: A factor-analytic study. *Journal of Homosexuality*, 10(1/2), 39-51. [Reprinted in J.P. DeCecco (Ed.), *Bashers, baiters, and bigots: Homophobia in American society*. New York: Harrington Park Press, 1985.]
4. Herek, G.M. (1986). On heterosexual masculinity: Some psychical consequences of the social construction of gender and sexuality. *American Behavioral Scientist*, 29, 563-577. [Reprinted in: (a) M.S. Kimmel (Ed.), *Changing men: New directions in research on men and masculinity*. Thousand Oaks, CA: Sage. (b) L.D. Garnets & D.C. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male experiences*. New York: Columbia University Press.]

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*Papers (continued)*

5. Herek, G.M. (1986). The instrumentality of attitudes: Toward a neofunctional theory. *Journal of Social Issues*, 42(2), 99-114.
6. Crosby, F.J., & Herek, G.M. (1986). Male sympathy with the situation of women: Does personal experience make a difference? *Journal of Social Issues*, 42(2), 55-66.
7. Herek, G.M. (1986). The social psychology of homophobia: Toward a practical theory. *Review of Law and Social Change*, 14, 923-934.
8. Herek, G.M. (1987). Religious orientation and prejudice: A comparison of racial and sexual attitudes. *Personality and Social Psychology Bulletin*, 13, 56-65.
9. Herek, G.M., Janis, I.L., & Huth, P. (1987). Decision-making during international crises: Is quality of process related to outcome? *Journal of Conflict Resolution*, 31, 203-226
10. Herek, G.M. (1987). Can functions be measured? A new perspective on the functional approach to attitudes. *Social Psychology Quarterly*, 50, 285-303.
11. Herek, G.M., & Glunt, E.K. (1988). An epidemic of stigma: Public reactions to AIDS. *American Psychologist*, 43, 886-891.
12. Herek, G.M. (1988). Heterosexuals' attitudes toward lesbians and gay men: Correlates and gender differences. *The Journal of Sex Research*, 25, 451-477.
13. Herek, G.M. (1989). Hate crimes against lesbians and gay men: Issues for research and policy. *American Psychologist*, 44, 948-955. [Reprinted in W.R. Dynes & S. Donaldson (Eds.), *Homosexuality: Discrimination, criminology, and the law*. New York: Garland, 1992.]
14. Herek, G.M., Janis, I.L., & Huth, P. (1989). Quality of U.S. decisionmaking during the Cuban missile crisis: Major errors in Welch's reassessment. *Journal of Conflict Resolution*, 33, 446-459.
15. Herek, G.M. (1990). Gay people and government security clearances: A social science perspective. *American Psychologist*, 45, 1035-1042. [Reprinted in J. Duntley & L. Shaffer (Eds.), *Human development across the life span*. Acton, MA: Copley, 1993.]
16. Herek, G.M. (1990). The context of anti-gay violence: Notes on cultural and psychological heterosexism. *Journal of Interpersonal Violence*, 5, 316-333. [Reprinted in: (a) R. Cleaver & P. Myers (Eds.), *A certain terror: Heterosexism, militarism, violence and change*. Chicago: American Friends Service Committee, 1993. (b) L.D. Garnets & D.C. Kimmel (Eds). *Psychological perspectives on lesbian and gay male experiences*. New York: Columbia University Press. (c) S.L. Ellyson & A.G. Halberstadt (Eds.) (1995). *Explorations in social psychology: Readings and research*. New York: McGraw-Hill.]
17. Herek, G.M., & Berrill, K. (1990). Documenting the victimization of lesbians and gay men: Methodological issues. *Journal of Interpersonal Violence*, 5, 301-315. [Reprinted in G. Herek & K. Berrill (Eds.) (1992). *Hate crimes: Understanding and responding to anti-gay violence* (pp. 270-286). Thousand Oaks, CA: Sage.]
18. Herek, G.M., & Berrill, K. (1990). Anti-gay violence and mental health: Setting an agenda for research. *Journal of Interpersonal Violence*, 5, 414-423.
19. Garnets, L., Herek, G.M., & Levy, B. (1990). Violence and victimization of lesbians and gay men: Mental health consequences. *Journal of Interpersonal Violence*, 5, 366-383. [Reprinted in: (a) G. Herek & K. Berrill (Eds.) (1992). *Hate crimes: Confronting violence against lesbians and gay men* (pp. 207-226). Thousand Oaks, CA: Sage. (b) L.D. Garnets & D.C. Kimmel (Eds). *Psychological perspectives on lesbian and gay male experiences*. New York: Columbia University Press.]
20. Berrill, K.T., & Herek, G.M. (1990). Primary and secondary victimization in anti-gay hate crimes: Official response and public policy. *Journal of Interpersonal Violence*, 5, 401-413. [Revised and reprinted in G. Herek & K. Berrill (Eds.) (1992). *Hate crimes: Confronting violence against lesbians and gay men* (pp. 289-305). Thousand Oaks, CA: Sage.]

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*Papers (continued)*

21. Herek, G.M., & Glunt, E.K. (1991). AIDS-related attitudes in the United States: A preliminary conceptualization. *The Journal of Sex Research, 28*, 99-123.
22. Herek, G.M., Kimmel, D.C., Amaro, H., & Melton, G.B. (1991). Avoiding heterosexist bias in psychological research. *American Psychologist, 46*, 957-963. [Reprinted in *Bioethics News, 12* (5), Special Supplement, 2-19. (Published by the Centre for Human Bioethics at Monash University, Australia)]
23. Herek, G.M. (1991). Myths about sexual orientation: A lawyer's guide to social science research. *Law and Sexuality, 1*(1), 133-172.
24. Herek, G.M., & Capitanio, J.P. (1993). Public reactions to AIDS in the United States: A second decade of stigma. *American Journal of Public Health, 83*, 574-577.
25. Herek, G.M. (1993). Sexual orientation and military service: A social science perspective. *American Psychologist, 48*, 538-547.
26. Herek, G.M., & Glunt, E.K. (1993). Interpersonal contact and heterosexuals' attitudes toward gay men: Results from a national survey. *The Journal of Sex Research, 30*, 239-244.
27. Herek, G.M. (1993). Documenting prejudice against lesbians and gay men on campus: The Yale Sexual Orientation Survey. *Journal of Homosexuality, 25*(4), 15-30.
28. Herek, G.M., & Capitanio, J.P. (1994). Conspiracies, contagion, and compassion: Trust and public reactions to AIDS. *AIDS Education and Prevention, 6*, 367-377.
29. Herek, G.M., & Capitanio, J.P. (1995). Black heterosexuals' attitudes toward lesbians and gay men in the United States. *The Journal of Sex Research, 32*, 95-105.
30. Herek, G.M., & Capitanio, J.P. (1996). "Some of my best friends": Intergroup contact, concealable stigma, and heterosexuals' attitudes toward gay men and lesbians. *Personality and Social Psychology Bulletin, 22*, 412-424.
31. Herek, G.M., Gillis, J.R., Cogan, J.C., & Glunt, E.K. (1997). Hate crime victimization among lesbian, gay, and bisexual adults: Prevalence, psychological correlates, and methodological issues. *Journal of Interpersonal Violence, 12*, 195-215.
32. Herek, G.M., & Capitanio, J.P. (1997). AIDS stigma and contact with persons with AIDS: Effects of direct and vicarious contact. *Journal of Applied Social Psychology, 27*, 1-36.
33. Herek, G.M., Cogan, J.C., Gillis, J.R., & Glunt, E.K. (1998). Correlates of internalized homophobia in a community sample of lesbians and gay men. *Journal of the Gay and Lesbian Medical Association, 2*(1), 15-23.
34. Herek, G.M., Mitnick, L., Burris, S., Chesney, M., Devine, P., Fullilove, M.T., Fullilove, R., Gunther, H.C., Levi, J., Michaels, S., Novick, A., Pryor, J., Snyder, M., & Sweeney, T. (1998). AIDS and stigma: A conceptual framework and research agenda. *AIDS and Public Policy Journal, 13*, 36-47.
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11. Herek, G.M. (1988). *The social psychology of violence against lesbians and gay men*. In K. Hancock (Chair), *Violence against lesbians and gay men: Toward a research agenda*. American Psychological Association, Atlanta, GA. (Symposium)
12. Herek, G.M. (1988). *The meaning of AIDS for individuals and society*. In S. Morin (Chair), *Critical psychological aspects of AIDS*. American Psychological Association, Atlanta, GA. (Invited Symposium)
13. Herek, G.M., & Glunt, E.K. (1989). *AIDS-stigma and anti-gay prejudice: Public reactions to AIDS-related policies and gay men in the U.S.A.* Fifth International Conference on AIDS, Montreal, Canada. (Poster)
14. Herek, G.M. (1989). *Illness, stigma and AIDS*. Invited Master Lecture, American Psychological Association, New Orleans.
15. Herek, G.M. (1989). *Lesbians, gay men, and government security clearances*. American Psychological Association, New Orleans. (Symposium)
16. Herek, G.M. (1989). *The context of anti-gay violence: Psychological, social, and cultural issues*. "Mental Health Aspects of Violence Toward Lesbians and Gay Men: Research Issues and Directions." Workshop sponsored by the Antisocial and Violent Behavior Branch, National Institute of Mental Health, Bethesda, MD.
17. Herek, G.M. (1990). *The psychological dimensions of public reactions to AIDS*. In J. Martin (Chair). *Public reactions to AIDS in the United States*. American Psychological Association, Boston. (Symposium)
18. Herek, G.M., Bat-Chava, Y., Capitanio, J., Araba-Owoyele, L., & Castañeda, D. (1991). *A social psychological evaluation of AIDS-educational videos*. Seventh International Conference on AIDS, Florence, Italy. (Poster)

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*Presentations at Professional Meetings (continued)*

19. Herek, G.M., & Capitanio, J.P. (1991). *AIDS-related attitudes and beliefs among Black Californians: A preliminary methodological discussion*. Investigators' Conference, UC Universitywide AIDS Research Program. (Poster)
20. Herek, G.M. (1991). *Violence against lesbians and gay men: A research agenda for the 1990s*. In G. Herek (Chair), *Violence against lesbians and gay men: Challenges for psychologists in the 1990s*. American Psychological Association, San Francisco. (Invited Symposium)
21. Herek, G.M. (1991). *Is homosexuality incompatible with military service?: A review of social science data*. In S. Morin (Chair), "Homosexuality is incompatible with military service." Psychological evaluation of DoD policy. American Psychological Association, San Francisco. (Symposium)
22. Herek, G.M. (1991). *Violence against lesbians and gay men: Challenges for action research*. Invited presentation for a research luncheon sponsored by the American Psychological Association with the National Institute of Mental Health. San Francisco.
23. Herek, G.M., & Capitanio, J.P. (1991). *Reactions to AIDS in the United States: A social psychological analysis*. Paper presented at the First International Conference on Biopsychosocial Aspects of HIV Infection. Amsterdam, The Netherlands.
24. Herek, G.M., & Capitanio, J.P. (1992). *AIDS-related attitudes and beliefs among African Americans in California*. Investigators' Conference, UC Universitywide AIDS Research Program. (Poster)
25. Herek, G.M., & Capitanio, J.P. (1992). *Intergroup contact predicts heterosexuals' attitudes toward gay men*. American Psychological Society, San Diego. (Poster)
26. Capitanio, J.P., & Herek, G.M. (1992). *Racial differences in attitudes toward persons with AIDS and AIDS policies*. American Psychological Society, San Diego. (Poster)
27. Herek, G.M., & Capitanio, J.P. (1992). *AIDS-related stigma persists in the United States*. Eighth International Conference on AIDS, Amsterdam, The Netherlands. (Poster)
28. Herek, G.M. (1993). *Violence against lesbians and gay men: Heterosexism, hate crimes, and the law*. Tenth Annual Claremont Symposium on Applied Social Psychology, Claremont, CA. (Invited Paper)
29. Herek, G.M. (1993). *Hatred and heterosexism: Prejudice and violence against lesbians and gay men in the United States*. Casassas Conference on "The Persistence of Hatred," Loyola Marymount University, Los Angeles, CA. (Invited Paper)
30. Herek, G.M., & Capitanio, J.P. (1993). *The relationship of trust to public reactions to AIDS in the United States*. Ninth International Conference on AIDS, Berlin, Germany. (Poster)
31. Herek, G.M., & Capitanio, J.C. (1993). *The National Survey on AIDS and Stigma*. Paper presented at the annual meeting of the American Psychological Association, Toronto.
32. Herek, G.M. (1993). *Psychologists, bigotry, and the ballot box: Using scientific data to counter attacks on gay/lesbian rights*. In M. Biaggio (Chair), *Countering attacks on gay/lesbian rights: State movements and referenda*. American Psychological Association, Toronto. (Symposium)
33. Herek, G.M. (1993). *A social psychological perspective on implementing a nondiscriminatory military policy*. In C. Anderson (Chair), *Integrating lesbians and gay men into the U.S. military*. American Psychological Association, Toronto. (Invited Symposium)
34. Herek, G.M., Gillis, J.R., Glunt, E.K., Lewis, J.L., & Welton, D.A. (1994). *Improving the credibility of AIDS education among African Americans: An experimental evaluation*. AIDS Impact: Biopsychosocial Aspects of HIV Infection, Second International Conference. Brighton, England. (Poster)

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*Presentations at Professional Meetings (continued)*

35. Herek, G.M. (1994). *Sexual orientation and the U.S. military: Putting the new policy in context*. In J. Jobe, G. Herek, & R. Carney (Chairs), *Gays and lesbians in the military: Psychological perspectives on implementing the new policy*. American Psychological Association, Los Angeles. (Pre-convention workshop)
36. Herek, G.M. (1994). *Interpersonal contact and heterosexuals' attitudes toward lesbians and gay men*. In I. Meyer & F. Wong (Chairs), *Gays and lesbians in the 21st century: Setting a research agenda*. American Psychological Association, Los Angeles. (Invited Symposium)
37. Herek, G.M. (1994). *Victimization experiences among lesbians and gay men in Sacramento*. In G. Herek (Chair), *Mental health and anti-lesbian/-gay victimization: The Sacramento Hate Crimes Study*. American Psychological Association, Los Angeles. (Symposium)
38. Glunt, E.K., Herek, G.M., Fead, F.B., Gillis, R.J., & Webb, D. (1994). *Gay/bisexual identity, community, and HIV/AIDS risk reduction*. Paper presented at the annual meeting of the American Psychological Association, Los Angeles.
39. Gillis, R.J., Herek, G.M., Lewis, J.L., Glunt, E.K., Sullivan, C.S., & Barber, A.C. (1994). *AIDS risk, knowledge, and stigma of Northern California African Americans*. American Psychological Association, Los Angeles. (Poster)
40. Herek, G.M. (1994). *Philadelphia* (Discussant). In E. Donnerstein (Chair), *Film Discussion: Philadelphia*. Sponsored by APA Ad Hoc Committee on Films and Other Media at the annual meeting of the American Psychological Association, Los Angeles. (Film/discussion)
41. Herek, G.M. (1995). *Hate crimes: Confronting violence against lesbians and gay men*. Pacific Sociological Association, San Francisco. (Panel discussion of Herek & Berrill [1992])
42. Herek, G.M. (1995). *Mental health consequences of antigay and anti-lesbian victimization*. In G. Herek (Chair), *The Sacramento Hate Crimes Study: Psychological impact of anti-lesbian and anti-gay victimization*. American Psychological Association, New York. (Symposium)
43. Glunt, E.K., & Herek, G.M. (1995). *HIV and AIDS risk reduction and psychological functioning among gay and bisexual men*. American Psychological Association, New York. (Poster)
44. Gonzalez, M., Herek, G.M., Welton, D., Fead, F., & Medina, G. (1995). *Gay-/bisexual- and Latino-/Latina-targeted AIDS educational videos: A content analysis*. American Psychological Association, New York. (Poster)
45. Gillis, J.R., Herek, G.M., Cogan, J.C., & Glunt, E.K. (1995). *Forcing open the closet door: Attitudes toward outing*. American Psychological Association, New York. (Poster)
46. Cogan, J.C., Herek, G.M., Gillis, J.R., & Glunt, E.K. (1995). *Lesbian and gay perceptions of body image: An empirical understanding*. American Psychological Association, New York. (Poster)
47. Herek, G.M. (1995). *Prejudice and violence against lesbians and gay men*. Arizona Psychological Association, Phoenix. (Invited workshop)
48. Herek, G.M., Cogan, J.C., & Gillis, J.R. (1996). *Psychological correlates of hate crime victimization among gay men, lesbians, and bisexuals*. American Psychological Society, San Francisco. (Poster)
49. Herek, G.M., Gillis, J.R., & Cogan, J.C. (1996). *Hate crimes against gay men, lesbians, and bisexuals: Psychological consequences*. American Psychological Association, Toronto. (Symposium)
50. Herek, G.M. (1997). *AIDS stigma: A psychosocial perspective*. AIDS Impact: Biopsychosocial Aspects of HIV Infection, Third International Conference. Melbourne, Australia. (Invited paper)
51. Herek, G.M. (1997). *Homophobia: A barrier to AIDS prevention*. Sexuality and HIV/AIDS in Cuba, Latin America, and the Caribbean: Building bridges, crossing borders. Havana, Cuba. (Invited address)

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*Presentations at Professional Meetings (continued)*

52. Herek, G.M. (1997). *Sexual orientation and public policy*. American Psychological Association, Chicago. (Invited award address, Distinguished Contribution to Psychology in the Public Interest, Early Career Award).
53. Herek, G.M. (1997). *Sexual prejudice: Understanding heterosexuals' attitudes toward lesbians and gay men*. "Homosexuell I Dag" Conference [*Homosexuality Today*], Stockholm University, Stockholm, Sweden. (Invited address)
54. Herek, G.M. (1997). *Hate crimes in the USA: The psychological impact of violence against lesbians and gay men*. "Homosexuell I Dag" Conference [*Homosexuality Today*], Stockholm University, Stockholm, Sweden. (Invited address)
55. Herek, G.M., & Capitanio, J.P. (1998). *AIDS stigma and HIV-related beliefs in the United States: Results from a national telephone survey*. World AIDS Conference, Geneva, Switzerland. (Oral presentation and poster)
56. Herek, G.M. (1998). *Sexual prejudice: The social psychology of homophobias and heterosexisms*. American Psychological Association, San Francisco. (Invited address, Society for the Psychological Study of Social Issues, APA Division 9)
57. Herek, G.M. (1999). *Sexual prejudice*. "Beyond Homophobia" International Conference, San Francisco. (Invited keynote address)
58. Herek, G.M. (1999). *AIDS and stigma in the United States*. Workshop on HIV/AIDS Stigma in Developing Countries. US Agency for International Development, Horizons Project, San Francisco. (Invited presentation)
59. Herek, G.M. (1999). *AIDS and stigma in the United States*. Conference on "HIV-AIDS: Issues in treatment, stigma, and policy." University of Nebraska, Lincoln. (Invited address)
60. Herek, G.M. (1999). *Interpersonal contact and sexual prejudice*. In G. M. Herek (Chair), *The psychology of prejudice*. American Psychological Society, Denver, Colorado. (Invited symposium)
61. Herek, G.M. (1999). *Sexual prejudice: Survey research on heterosexuals' attitudes toward lesbians and gay men*. Conference on "New approaches to research on sexual orientation, mental health, and substance abuse." National Institute of Mental Health, Bethesda, Maryland. (Invited presentation)
62. Herek, G.M. (1999). *Hate crimes: A framework for empirical research*. Hate Crimes: Research, Policy, and Action. Conference sponsored by the Society for the Psychological Study of Social Issues, Los Angeles, California. (Invited keynote remarks)
63. Herek, G.M. (1999). *Criminal victimization and sexual orientation: The Sacramento Hate Crimes Study*. Hate Crimes: Research, Policy, and Action. Conference sponsored by the Society for the Psychological Study of Social Issues, Los Angeles, California. (Invited presentation)
64. Herek, G.M. (2000). *Gender gaps in heterosexuals' attitudes toward gay men and lesbians*. Paper presented at the annual conference of the American Association for Public Opinion Research, Portland, OR.
65. Herek, G.M., Cogan, J.C., & Gillis, J.R. (2000) *Psychological well-being and commitment to lesbian, gay, and bisexual identities*. Paper presented in G.M. Herek (Chair), *Identity, community, and well-being among lesbians, gay men, and bisexuals*. American Psychological Association, Washington, DC.
66. Herek, G.M. (2001). *Heterosexual masculinity and the dynamics of sexual prejudice*. American Psychological Association, San Francisco. (Invited address, Society for the Psychological Study of Men and Masculinity, APA Division 51).

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*Presentations at Professional Meetings (continued)*

67. Herek, G.M. (2001). *The social psychology of stigma*. Invited address, conference on "Health, law, and human rights: Exploring the connections," sponsored by the American Society of Law, Medicine, and Ethics. Philadelphia, September 30, 2001.
68. Herek, G.M. (2002). *Heterosexism: Characteristics, causes, and consequences*. American Psychological Association, Chicago. (Symposium Chair and Discussant)
69. Herek, G.M. (2003). *Gender differences in sexual prejudice*. Paper presented in T. K. Vescio (Chair), Sexual prejudice and heterosexism: Critical considerations on perpetrators and targets. Society for Personality and Social Psychology, Los Angeles. (Invited symposium)
70. Herek, G.M. (2003). *Why is sexual prejudice declining in the United States? The role of heterosexuals' interpersonal contact with lesbians and gay men*. Paper presented at the annual conference of the American Association for Public Opinion Research, Nashville, TN.
71. Herek, G.M. (2003). *Beyond "homophobia": Thinking about sexual stigma and prejudice in the twenty-first century*. Invited paper presented at the conference, "Critical Issues in American Sexuality," sponsored by the San Francisco State University National Sexuality Resource Center, San Francisco.
72. Herek, G.M. (2005). *Marriage equality*. Conference of the International Association for the Study of Sexuality, Culture, and Society, San Francisco, CA. (Plenary panel: Invited discussant)
73. Herek, G.M. (2005). *Recognition of same-sex relationships: Politics, policy, and public opinion*. Paper presented in A. Omioto (Chair), Public policy and same sex relationships: Scientific perspectives. American Psychological Association, Washington, DC. (Invited paper)
74. Herek, G.M. (2005). *From sodomy laws to marriage equality: Psychology's role in public policy related to sexual orientation*. William Bevan Lecture on Psychology and Public Policy, presented at the annual meeting of the American Psychological Association, Washington, DC. (Invited address)
75. Herek, G.M. (2006). *The relationship of stigma to psychological and physical well-being in people with HIV/AIDS*. Paper presented at the Universitywide AIDS Research Program Investigators' Conference, San Mateo, CA.
76. Herek, G.M. (2006). *Sexual prejudice and stigma in the United States*. Nebraska Symposium on Motivation, University of Nebraska at Lincoln. (Invited lecture)
77. Steward W.T., Ramakrishna J., Herek G.M., Bharat S., Chandy S., Wrubel J., Huebner D.M., Singh G., & Ekstrand M.L. (2006) *Developing culturally-specific AIDS stigma scales for use in India*. XVI International AIDS Conference, Toronto, Canada (Poster)
78. Herek, G.M. (2006). *Eradicating sexual stigma and prejudice: Roles for psychologists*. Paper presented at the biennial convention of the Society for the Psychological Study of Social Issues, Long Beach, CA. (Invited award address)
79. Herek, G.M. (2006). *Understanding public opinion about same-sex relationships in the United States*. Paper presented in J. Mohr (Chair), Psychological research on legal recognition of same-sex romantic relationships. American Psychological Association, New Orleans, LA.
80. Herek, G.M. (2006). *Stigma, coping, and psychological and physical well-being in people with HIV/AIDS*. Paper presented in J. Stone (Chair), Relationship between stigma and well-being: New factors in coping and change. American Psychological Association, New Orleans, LA.
81. Herek, G.M. (2007). *Sexual prejudice and intergroup contact: The moderating effects of disclosure and communication*. Paper presented in Mark Snyder (Chair), Sexual prejudice: Continuities and discontinuities with other forms of prejudice. Society for Personality and Social Psychology, Memphis, TN.

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*Presentations at Professional Meetings (continued)*

82. Norton, A.T., & Herek, G.M. (2007). *Exploring the gender(ed) divide: Attitudes toward transgender people in a national probability sample of US adults*. Society for Personality and Social Psychology, Memphis, TN. (Poster)
83. Herek, G.M. (2007). *Sexualities, science, and stigma*. Paper presented in Morton Ann Gernsbacher (Chair), *Stigma from science: Group differences, not group deficits*. Association for Psychological Science, Washington, DC. (Presidential Symposium: Invited participant)
84. Herek, G.M. (2007). *Confronting sexual prejudice: Theory and practice*. American Psychological Association, San Francisco, CA. (Invited address, Society for Personality and Social Psychology, APA Division 8)
85. Herek, G.M. (2007). Discussant in A. Lott (Chair), *Sexual orientation and military service: Current evidence and APA policy*. Presidential Symposium, American Psychological Association, San Francisco.
86. Herek, G.M., & Allen, T.J. (2007). *When does heterosexuals' contact with sexual minorities reduce sexual prejudice?* Paper presented in L. Garnets (Chair), *Sexual prejudice and intergroup contact*. American Psychological Association, San Francisco.
87. Allen, T.J., Sherman, J., & Herek, G.M. (2008). *Levels of self-representation determine the target of defense-based prejudice*. Society for the Psychological Study of Social Issues, Chicago, IL. (Poster)
88. Herek, G.M. (2008). *Beyond "homophobia": Thinking about sexual prejudice and stigma*. International Lesbian, Gay, Bisexual, and Transgender Psychology Summer Institute, University of Michigan, Ann Arbor. (Invited lecture)
89. Steward, W. T., Herek, G. M., Chandy, S., Singh, G., Panicker, S., Osmand, T., & Ekstrand, M. L. (2008). *Avoiding disclosure of HIV status results leads to greater isolation and depression among HIV-infected individuals in Southern India*. XVII International AIDS Conference, Mexico City. (Poster)
90. Herek, G.M. (2009). *Sexual orientation, science, and the law: How social and behavioral research can inform public policy*. World on Fire Graduate Student Research Conference, Claremont Graduate University, Claremont, CA. (Keynote lecture)
91. Herek, G.M. (2010). *Sexual orientation, stigma, and legal recognition of same-sex relationships*. Paper presented in C. Goodheart & B. Strickland (Chairs), *Marriage equality for same-sex couples: Science and the legal debate*. American Psychological Association, San Diego, CA. (Invited presidential symposium)
92. Herek, G.M. (2010). Participant in J. Tobias (Chair), *Intersection of law, policy, and scholarship in gay rights debates*. Conversation Hour, American Psychological Association, San Diego, CA.
93. Herek, G.M. (2011). *LGBT health and the 2011 Institute of Medicine report*. Williams Institute 2011 Annual Update Conference, University of California, Los Angeles. (Invited panel presentation)

## INVITED LECTURES AND COLLOQUIA

1. *Why prejudice, why tolerance? The social psychology of attitudes toward lesbians and gay men.* University of California, Davis. July 23, 1984. (Invited colloquium)
2. *Homophobias, heterosexisms, and the psychological functions of prejudice.* AIDS Project New Haven (CT). February 7, 1985. (Invited lecture)
3. *The psychological functions of prejudice and tolerance.* Barnard College of Columbia University, New York. March 6, 1985. (Invited colloquium)
4. *Homophobias and heterosexisms: The psychology of prejudice and sexuality.* Connecticut College, New London, CT. May 1, 1985. (Invited lecture)
5. *Making better decisions: A psychologist's perspective.* Conference of Maine, New Hampshire, and Vermont Superior Court Justices. May 10, 1985. (Invited address)
6. *Straight talk about homophobia and health care.* Grand Rounds, Yale Student Health Center, New Haven, CT. May 21, 1985. (Invited lecture)
7. *Straight talk about homophobia and health care.* Fair Haven (CT) Community Health Clinic. June 14, 1985. (Invited lecture)
8. *Bioethical problems associated with AIDS.* Symposium on Bioethical Issues, Sponsored by Department of Biology, Yale University, New Haven. December 12, 1985. (Discussant).
9. *AIDS, prejudice, and politics.* Connecticut Jungian Society, Guilford, CT. February 8, 1986. (Invited panel discussion)
10. *The social psychology of homophobia: Toward a practical theory.* Conference on Sex, Politics, and the Law. New York University Law School. February 22, 1986. (Invited address)
11. *The psychology of homophobia and the politics of AIDS.* Yale University Summer Lecture Series, New Haven. July 17, 1986. (Invited lecture)
12. *Attitudes toward lesbians and gay men: A social psychological approach.* Smith College, Northampton, MA. October 23, 1986. (Invited lecture)
13. *Sexuality and civil rights.* Yale University, New Haven. November 12, 1986. (Invited lecture and panel discussion)
14. *The social psychology of homophobia.* Pennsylvania State University, University Park, PA. February 12, 1987. (Invited lecture)
15. *Public education about AIDS: A functional approach.* Yale University, New Haven. April 1, 1987. (Invited colloquium)
16. *A functional approach to attitudes: The case of prejudice against lesbians and gay men.* University of Nebraska at Omaha. April 15, 1987. (Invited colloquium)
17. *AIDS and homophobia: Psychosocial and political dimensions of the epidemic.* University of Texas Medical Center, Dallas, TX. September 18, 1987. (Invited lecture)
18. *The psychology of homophobia and the politics of AIDS.* Haverford College, PA. November 7, 1987. (Invited lecture)
19. *Homophobia and the politics of discrimination.* 92nd Street YMHA, New York. November 14, 1987. (Invited public lecture)
20. *Public reactions to AIDS.* Teachers College of Columbia University, New York. December 1, 1987. (Invited lecture)
21. *The social psychology of homophobia and anti-gay/anti-lesbian violence.* California State University, Fresno. April 7, 1988. (Invited lecture)

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*Invited Lectures and Colloquia (continued)*

22. *Attitudes toward lesbians and gay men.* Second Tuesdays Lecture Series of the New York Lesbian and Gay Community Center. April 12, 1988. (Invited public lecture)
23. *Attitudes toward lesbians and gay men: A social psychological approach.* Midwest Association for the Psychological Study of Lesbian and Gay Issues, Chicago. June 25, 1988. (Invited lecture)
24. *Assessing attitude functions: Theoretical and methodological issues.* Institute for Personality Assessment and Research, University of California, Berkeley. November 8, 1988. (Invited colloquium)
25. *AIDS and public opinion.* Center for AIDS Prevention Studies, University of California at San Francisco. April 28, 1989. (Invited colloquium)
26. *The psychology of prejudice and the politics of AIDS and AIDS-prevention.* James Madison University, Harrisonburg, VA. October 2, 1989. (Invited lecture)
27. *Invisible victims of crime: The lesbian and gay community.* Governor's Conference on Victim Services and Public Safety, Anaheim, CA. May 29, 1990. (Invited address)
28. *The social psychology of public reactions to AIDS.* California Office of AIDS, Sacramento, CA. December 11, 1990. (Invited colloquium)
29. *The psychology of prejudice and the politics of AIDS.* Marquette University, Milwaukee WI. April 17, 1991. (Invited lecture)
30. *Anti-gay prejudice: A social science perspective.* University of Wisconsin, Milwaukee. April 18, 1991. (Invited public lecture)
31. *The psychology of heterosexism: Prejudice and violence in the era of AIDS.* Stanford University. April 26, 1991. (Invited lecture)
32. *Hate crimes against lesbians and gay men.* Stanford University Law School Conference on Bias Crimes. April 8, 1992. (Invited address and panel discussion)
33. *Hetero/Sexism: Prejudice and violence against lesbians and gay men.* Oregon State University, Corvallis. October 30, 1992. (Invited lecture)
34. *Hate crimes and heterosexism: The social psychology of violence against lesbians and gay men.* Pennsylvania State University. November 7, 1992. (Invited lecture)
35. *Sexual orientation and the U.S. military: A social science perspective on current policy.* Meeting of national organizations on the U.S. military policy on homosexuality and military service, sponsored by the American Psychological Association. December 7, 1992. (Invited address)
36. *Research on Gay, Lesbian, and Bisexual Issues at the University of California* (Panel discussion). "U.C. us everywhere: A U.C. systemwide conference on gay, lesbian, and bisexual issues." University of California, Davis. February 13, 1993. (Invited address and panel discussion)
37. *Hetero/Sexism: Prejudice and violence against lesbians and gay men.* California State University, Long Beach. February 19, 1993. (Invited lecture)
38. *U.S. military personnel policy and gay people: A social science perspective on implementing a nondiscriminatory policy.* The Rand Corporation, Santa Monica, CA. May 12, 1993. (Invited lecture and briefing)
39. *Sex, lies, and factoids: The uses and misuses of social science research in the fight for lesbian and gay civil rights.* Symposium cosponsored by the American Psychological Association, National Gay & Lesbian Task Force, and Human Rights Campaign Fund. Washington, DC. November 5, 1993. (Invited lecture)

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*Invited Lectures and Colloquia (continued)*

40. *Heterosexuals' attitudes toward lesbians and gay men: The contact hypothesis reconsidered.* "At The Frontier: Homosexuality and the Social Sciences." Conference sponsored by the Center for Lesbian and Gay Studies, City University of New York. December 3, 1993. (Invited lecture)
41. *Homophobia.* Gay, lesbian, and bisexual studies seminar for psychiatry residents and fellows, UCSF Langley Porter Institute. December 14, 1993. (Invited lecture)
42. *Heterosexuals' attitudes toward lesbians and gay men.* Grand Rounds, Department of Psychiatry, University of California Medical Center, Sacramento, CA. April 6, 1994. (Invited lecture)
43. *Prejudice, public policy, and sexual orientation: A psychologist's perspective.* Frederick Howell Lewis Distinguished Lecture, Psi Chi. American Psychological Association, Los Angeles. August, 1994. (Invited award lecture)
44. *Mental health and anti-lesbian/anti-gay victimization: The Sacramento Hate Crimes Study.* Bay Area Hate Crimes Investigators' Association, San Francisco. September 21, 1994. (Invited lecture)
45. *Heterosexuals' attitudes toward lesbians and gay men: The contact hypothesis reconsidered.* Conference on "Health Sciences, Heterosexism, and Homophobia." University of California, San Francisco. April 22, 1995. (Invited address)
46. *Heterosexuals' attitudes toward lesbians and gay men: Does coming out make a difference?* Lawrence Berkeley National Laboratories, University of California, Berkeley. October 10, 1995. (Invited lecture)
47. *Hate crimes: Confronting violence against lesbians and gay men.* Phoenix College, Phoenix, AZ. October 14, 1995. (Invited public lecture)
48. *Hate crimes: Psychological responses to violence against lesbians and gay men.* Yale University. April 29, 1996. (Invited lecture)
49. *Homophobia and public health.* National Lesbian and Gay Journalists Association, Miami. September 6, 1996. (Invited address)
50. *Hate crimes and homophobia in the USA.* Sydney Anti-Violence Project, Sydney, Australia. June 26, 1997. (Invited public lecture)
51. *Sexual prejudice: Understanding heterosexuals' attitudes toward lesbians and gay men.* Schorer Institute and University of Utrecht, Amsterdam, The Netherlands. October 27, 1997. (Invited public lecture)
52. *The impact of victimization: Why hate crimes are a special case.* Congressional briefing sponsored by the American Psychological Association, Washington, DC. November 7, 1997. (Invited lecture)
53. *Sexual prejudice: Understanding homophobias and heterosexisms.* Department of Psychology, University of California, Davis. January 21, 1998. (Invited lecture)
54. *Sexual prejudice: The psychology of homophobias and heterosexisms.* Oberlin College. December 5, 1998. (Invited lecture)
55. *Hate crimes against lesbians and gay men.* Columbia University HIV Center. May 20, 1999. (Grand Rounds) (Invited lecture)
56. *Hate crimes based on sexual orientation: An overview.* American Civil Liberties Union Biennial Conference, San Diego. June 25, 1999. (Invited address)
57. *Sexual prejudice in the United States.* San Francisco Public Library. October 16, 1999. (Invited public lecture and panel discussion)
58. *Sexual prejudice.* Department of Psychology, University of California, Santa Cruz. April 19, 2000. (Invited colloquium)
59. *AIDS and stigma in the United States.* Centers for Disease Control and Prevention. Atlanta, June 9, 2000. (Invited address)

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*Invited Lectures and Colloquia (continued)*

60. *AIDS and stigma in the United States*. Forum on "Stigma: Breaking Through the Misinformation," sponsored by AIDS Action and the Centers for Disease Control and Prevention, Washington DC. January 26, 2001. (Invited address)
61. *The roots of sexual prejudice*. Invited lecture for the series, "Homosexuality and Christian Faith: New Visions for the New Century," sponsored by an inter-denominational group of 24 churches in the San Francisco Bay Area. San Francisco. March 22, 2001.
62. *Survey methods for studying stigma and prejudice*. Summer Institute on Sexuality, Society and Health. Program in Sexuality Studies, San Francisco State University. June 28, 2001. (Invited lecture)
63. *"Live and Let Live."* Sacramento and Yolo Counties World AIDS Day Commemoration. December 5, 2002. (Invited keynote address)
64. *Sexual prejudice*. Summer Institute on Sexuality, Society and Health. Program in Sexuality Studies, San Francisco State University. July 22, 2003. (Invited lecture)
65. *Sexual orientation, science, and the law: How social and behavioral research can inform public policy*. Jeanne Herberger Lecture Series on "Communication, Culture, and Conflict," Hugh Downs School of Human Communication, Arizona State University. October 9, 2003. (Invited lecture)
66. *Fitness for priesthood? Shifting Vatican teachings on homosexuality*. National Sexuality Resource Center, San Francisco State University, February 23, 2006. (Invited address and panel discussion)
67. *Beyond "homophobia": What social science tells us about sexual prejudice*. Marquette University. April 20, 2006. (Invited lecture)
68. *Deconstructing "LGB": Social, psychological, and demographic differences and similarities among lesbians, gay men, bisexual women, and bisexual men in a US national probability sample*. Department of Psychology, University of California, Los Angeles. May 4, 2006. (Invited colloquium)
69. *Deconstructing "LGB": Findings from a nationally representative sample of sexual minority adults*. Department of Psychology, University of California, Berkeley. April 3, 2007. (Invited colloquium sponsored by the Diversity Student Alliance)
70. *Deconstructing "LGB": Findings from a nationally representative sample of sexual minority adults*. Bay Area Sexuality Research Seminar Series, San Francisco State University. April 26, 2007. (Invited lecture)
71. *Identity, relationships, and stigma among U.S. sexual minority adults*. Sexual Minority Action Research Team, San Francisco. May 1, 2007. (Invited lecture)
72. *Stigma, prejudice, and sexual orientation*. Continuing Medical Education conference on Sexual Orientation and Gender Identity in Primary Care, General Medicine and Mental Health, UC Davis Medical Center, January 17, 2009. (Keynote lecture)
73. *Beyond "homophobia": What social science tells us about sexual prejudice*. Stauffer Colloquium Series on Applied Psychology, Claremont Graduate University, March 5, 2009. (Invited lecture)
74. *Moral intuition and the emotion of disgust*. Expert Roundtable, Williams Institute, UCLA School of Law, June 4-5, 2009. (Invited speaker and roundtable participant)
75. *Beyond "homophobia": Thinking about sexual stigma and prejudice*. International Human Rights Funders Group, San Francisco. January 26, 2010. (Invited symposium presentation)
76. *Beyond "homophobia": Thinking more clearly about stigma, prejudice, and sexual orientation*. Grand Rounds, Langley Porter Psychiatric Institute, University of California, San Francisco. October 16, 2012.
77. *Stigma and sexual minority health*. Grand Rounds, San Francisco General Hospital. October 16, 2012.

# **EXHIBIT C**

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10 IN THE UNITED STATES DISTRICT COURT  
11 FOR THE EASTERN DISTRICT OF CALIFORNIA  
12 SACRAMENTO DIVISION  
13

14 **DAVID PICKUP, ET AL.,**

15 Plaintiffs,

16 v.

17  
18 **EDMUND G. BROWN JR. GOVERNOR  
OF THE STATE OF CALIFORNIA, IN HS  
19 OFFICIAL CAPACITY, ET AL.,**

20 Defendants.

2:12-cv-02497

**DECLARATION OF A. LEE  
BECKSTEAD IN SUPPORT OF  
DEFENDANTS' OPPOSITION TO  
PLAINTIFFS' MOTION FOR  
PRELIMINARY INJUNCTION**

Date: Nov. 30, 2012  
Time: 10:00 a.m.  
Dept: 3, 15th Floor  
Judge: The Honorable Kimberly J.  
Mueller  
Trial Date: None set  
Action Filed: Oct. 4, 2012

1 I, A. Lee Beckstead, declare as follows:

2 1. I have been retained by Defendants as an expert in connection with the above-  
3 referenced litigation. I have personal knowledge of the contents of this declaration, and if called  
4 upon to testify, I could and would testify competently to the contents of this declaration.

5 **EXPERT BACKGROUND AND QUALIFICATIONS**

6 2. My background and experience are summarized in my curriculum vitae, which is  
7 attached as Exhibit B to this report. My curriculum vitae also includes a list of publications I  
8 have authored in the last twelve years.

9 3. I am a licensed psychologist in Utah, where the majority of my full-time clinical  
10 practice involves individual, couple, family, and group counseling to those distressed about their  
11 or someone else's sexual orientation due to religious and/or social circumstances.

12 4. I am currently a member of the International Academy of Sex Research, which allows  
13 me to engage in dialogue with the top sex researchers and clinicians about current research and  
14 best practices regarding homosexuality, heterosexuality, bisexuality, transgender issues, as well  
15 as pedophilia, paraphilias, sexual trauma, and healthy and unhealthy sexuality. I am also a co-  
16 facilitator of weekend retreats for men who have been sexually abused and have worked  
17 extensively with individuals who have been conflicted and confused about their sexuality due to  
18 trauma.

19 5. I was selected to be part of the American Psychological Association's (APA) task  
20 force in 2007 to evaluate the clinical practice of trying to change sexual orientation and make  
21 therapeutic recommendations for those desiring such a change.

22 6. I have conducted research to understand the experiences of Mormon individuals who  
23 underwent sexual orientation change efforts (SOCE) and who reported being heterosexual or  
24 adopting a lesbian, gay, or bisexual (LGB) identity after these efforts. My research focused on  
25 understanding why such highly religious participants reported benefit and/or harm and what they  
26 described as influencing these outcomes. Prior to this research, I underwent a similar type of  
27 therapy, at the age of 21, to stop being gay and be heterosexual. Although I remained in treatment  
28 for only 6 months, the beliefs and promises of these interventions stuck with me and I continued

1 to try to change until age 27 when I decided to see what it would be like to accept being gay.  
2 Based on my research and personal experiences, I developed a treatment approach that sought to  
3 help clients find individualized but realistic solutions to their struggles (Beckstead & Morrow,  
4 2004; Beckstead & Israel, 2009).

5 7. In preparing to write this declaration, I reviewed the declarations filed by the  
6 plaintiffs in this matter.

### 7 **SEXUAL ORIENTATION CHANGE EFFORTS**

8 8. A review of the literature in the field of Sexual Orientation Change Efforts (SOCE)  
9 reveals that the premise underlying SOCE is that homosexuality is a mental disorder, and that it is  
10 counter to some practitioners' religious and/or personal beliefs. Practitioners of SOCE believe  
11 that the only way to manage the potential harm from this "disorder" is to try and reduce or  
12 eliminate same-sex feelings and hope to develop heterosexual ones. Mental-health professionals  
13 have tried for at least a century to cure the distress of those experiencing unwanted same-sex  
14 attractions who do not want to be lesbian, gay, or bisexual (LGB). Clients throughout the century  
15 have been willing to put themselves through a wide range of treatments from the aversive to the  
16 benign.

17 9. Current SOCE practice tend to utilize psychodynamic principles and define  
18 homosexuality as a developmental disorder that results when a child does not receive sufficient  
19 love through the attachment to the same-sex parent, thereby creating an estrangement toward  
20 same-sex others. Interventions tend to involve telling clients that everyone is inherently  
21 heterosexual, but those who desire to be sexually intimate with same-sex others have experienced  
22 an incompleteness in their gender identity, due to some trauma, and have been conditioned to  
23 sexualize their normal same-sex emotional needs.

24 10. SOCE involve helping clients talk about these difficult childhood experiences,  
25 teaching them traditional gender roles, and helping them develop nonsexual relationships with  
26 same-sex others. Homosexuality is reinforced directly or indirectly as something to avoid.  
27 Heterosexuality is encouraged and assumed to be developed when the child has the support of  
28 heterosexual parents and dis-identifies from the other-sex parent and identifies more with the

1 same-sex parent. Attempts to change sexual orientation can require concerted efforts to avoid,  
2 suppress, overcome, break down, remake, or extinguish deeply felt needs and patterns of feelings  
3 and behaviors and then try to create long-lasting erotic desires not previously experienced.

4 **SCIENTIFIC STUDIES HAVE FOUND SEXUAL ORIENTATION**  
5 **EFFORTS ARE CONTRAINDICATED**

6 11. The Report of the American Psychological Association Task Force on Appropriate  
7 Therapeutic Responses to Sexual Orientation (APA (2009a)) explained how the assumptions  
8 underlying SOCE practices are either unfounded or have been discredited through scientific  
9 methods. Research in the last five decades has been able to investigate a variety of hypotheses  
10 related to the etiology of homosexuality. Freund and Blanchard (1983), for example, found a  
11 consistent pattern of results that suggested that the emotionally distant relationships of fathers and  
12 homosexual sons relate to the sons' atypical childhood gender identity (or observed gender-role  
13 behavior) rather than to the sons' sexual attractions to males. Although male homosexuals overall  
14 may report poorer relationships with their fathers, scientific methods show that family patterns do  
15 not implicate homosexuality in men or women. Similarly, sexual trauma may affect a person's  
16 sexuality (e.g., by reenacting the abuse dynamics and causing confusion about sexual and gender  
17 identity), but research does not conclude that sexual trauma causes a person's sexual orientation.  
18 Correlation does not justify an inference of causation.

19 12. Furthermore, a range of biological correlations continues to persist as valid markers  
20 that differentiate sexual and gender minorities from the general population. Evidence from a  
21 variety of experimental approaches validates the conclusion that biological mechanisms are the  
22 ones operating in the etiology of a homosexual orientation. The current scientific hypothesis  
23 involves interactions between genes, levels of sex hormones, and the cells of the developing body  
24 and brain during different critical periods of fetal development (LeVay, 2011).

25 13. The assumption that homosexuality is due to gender inferiority caused by rejection of  
26 same-sex parents and/or peers ignores the fact that well-established theories of universal  
27 attachment styles can account for much of the distress found in LGB individuals. In theory, both  
28 non-heterosexuals and heterosexuals who are rejected, ignored, and/or abused by their parents,

1 peers, and/or communities may become distressed and preoccupied with distrust, experience  
2 anxiety about belonging, and attempt to gain validation and support. That is, the distress  
3 experienced by LGB individuals is not caused by their sexual orientation, but rather because of  
4 the lack of attachment, which would likely cause distress in heterosexual individuals who suffer a  
5 similar detachment from their parents, peers, and/or communities.

6 14. Research confirms this hypothesis that the stress seen in LGB individuals can be due  
7 to rejection (the “rejection-sensitive hypothesis”), especially as it relates to gender nonconformity  
8 and its effect on gay men and lesbian women’s relationships and health. Thus, the more universal  
9 attachment theory explains why SOCE psychotherapists see distress about gender inferiority and  
10 sexuality within their clinical populations.

11 15. The belief that homosexuality is a mental illness and developmental disorder became  
12 increasingly challenged, starting in the late 1950s, by studies that investigated other causes to  
13 why homosexual individuals felt distressed other than being due to their attractions. A large body  
14 of research currently exists that demonstrates how minority stress and the false assumptions  
15 embedded in homophobia, heterosexism, and sexism can be significant reasons for the anxiety,  
16 shame, depression, despair, isolation, and addictions found within LGB populations. Beliefs that  
17 being LGB ultimately leads one to a life of unhappiness, disease, and promiscuity are false and  
18 restricting and can be manipulative if those beliefs are used to directly or indirectly control an  
19 LGB individual’s behavior and choices. Research shows that sexual and gender minorities are  
20 equally as capable of living satisfying and fulfilling lives and forming healthy and long-term  
21 relationships as heterosexuals, especially when they are provided affirming information about  
22 their attractions and their options. Given these realities, all major mental-health institutions have  
23 taken a stand that homosexuality per se does not indicate a mental illness.

24 16. Current research regarding the psychology of gender also indicates that reinforcing  
25 traditional gender roles and heterosexism can be harmful by increasing guilt, shame, intimacy  
26 problems, depression, and difficulties expressing emotions. Best therapeutic practice involves a  
27 more complex theory of gender that accounts for and affirms gender diversity and uses  
28 interventions to relieve the pain of growing up with the stigma of gender nonconformity. Instead

1 of helping same-sex attracted individuals fit in and act more traditionally heterosexual, the  
2 rejection-sensitive hypothesis informs the need to counteract societal and parental rejection by  
3 affirming sexual and gender diversity. SOCE's emphasis on reinforcing traditional gender roles  
4 therefore is contraindicated in the professional scientific literature.

5 17. The APA (2009a) Report found that SOCE interventions have no scientific basis. The  
6 studies used to support such interventions have serious methodological and conceptual flaws that  
7 make their results unreliable. For instance, the APA Report outlined the significant statistical  
8 errors made in the two studies by Nicolosi (Byrd & Nicolosi, 2002; Nicolosi, Byrd, & Potts,  
9 2000) on SOCE benefits. Alternate hypotheses are available for why an individual would report  
10 positive outcomes from such interventions besides a change in their sexual orientation. For  
11 instance, a variety of qualitative studies depicts how SOCE consumers may change their sexual  
12 identity and behaviors but not necessarily their sexual orientation. These studies demonstrate how  
13 some SOCE consumers may also experience an initial "honeymoon stage" by benefiting from the  
14 validation and hope of meeting supportive psychotherapists and similar others and talking about  
15 their attractions, after a lifetime of secrets and shame. Although some SOCE consumers may  
16 continue their therapy because of these benefits, they may not be aware of how SOCE can  
17 implicitly cause harm during treatment due to its failure to correct prejudices and explore with  
18 clients the option of living openly with their attractions.

19 18. After a peer review of the conclusions of the APA (2009a) task force, the APA passed  
20 a resolution (APA, 2009b) declaring that SOCE's benefits are unreliable and SOCE represent an  
21 incomplete and potentially harmful practice. In addition, the resolution clarifies that the benefits  
22 reported (e.g., validation, support, congruence with religion and sexuality) can be found in other  
23 approaches that do not have the intrinsically harmful aspects of SOCE. Therefore, APA, along  
24 with all the other major mental-health organizations, remains resolved that SOCE are unnecessary  
25 and potentially harmful, and should not be promoted or offered.

26 **APPROPRIATE INTERVENTIONS FOR SAME-SEX ATTRACTED INDIVIDUALS**

27 19. APA (2009a) reemphasized the importance of respecting a client's right to self-  
28 determination. Licensed Mental Health Practitioners (LMHPs) should not have an a priori

1 assumption or expectation of how the client will or should identify or live out her or his sexual  
2 orientation, gender, religion/spirituality, and other aspects of diversity. Rather, the APA Report  
3 encouraged LMHPs to empower all sexual and gender minorities to determine the behavioral  
4 expression of their sexual orientation; their public and private social roles; their gender roles,  
5 identities, and expression; the sex and gender of their partner; and the forms of their relationships.  
6 This Report highlighted a variety of interventions found in the literature to facilitate this identity  
7 development by providing support, informed consent, accurate information, and a comprehensive  
8 assessment of distress and sexuality, and facilitating the client's ability to explore and reevaluate  
9 beliefs and options, develop self-acceptance, and enhance active coping skills.

10 20. Instead of trying to change sexual orientation, the focus for treatment can involve (a)  
11 changes in self-awareness, including increased knowledge, coping, self-efficacy, self-concept,  
12 relationships, and identity; (b) changes in sexual orientation identity (i.e., the label a person uses  
13 to refer to her or his sexual orientation), including private and public identification, sexual stigma,  
14 group membership and affiliation; (c) changes in emotional adjustment, including self-stigma,  
15 shame, and ability to grieve losses and face discrimination; and (d) changes in personal beliefs,  
16 values, and norms (e.g., reevaluating what is necessary, true, and important for the individual),  
17 including religious and sexual beliefs, behaviors, self-expression, and motivations. The Report  
18 highlighted several approaches found in the literature that would apply for adolescent, individual,  
19 couples, and family counseling. Any claims that SOCE clients and their therapists will be left  
20 with no treatment modalities or interventions if SOCE is banned misrepresent the existing  
21 scholarly literature.

22 21. Rather than being contrary to a client's autonomy, interventions that affirm sexual  
23 and gender diversity actually serve client autonomy since informed decisions and true self-  
24 determination are accomplished when a client's false assumptions are corrected and when  
25 individuals have the ability to explore the many ways to live positively being a sexual or gender  
26 minority (i.e., LGB-affirmative interventions). The scholarly literature since the 1970s has  
27 evolved in instructing LMHPs in how to help those desiring a change in their sexual orientation  
28 by countering minority stress and stigma instead of reinforcing society's false or restrictive

1 beliefs. LGB-affirmative interventions are based on a similar premise of best practice for other  
2 populations that experience societal oppression, such as racial minorities and women, of helping  
3 these populations develop competence in managing stigma and discrimination proactively rather  
4 than be left with the option of trying to conform to societal norms to relieve distress.

5 **SOCE CARRIES A SIGNIFICANT RISK OF HARM**

6 22. Serious harms have been reported from those who have experienced these practices.  
7 For example, several studies illustrate how initial hopes can turn into long-term despair when  
8 some SOCE consumers continue to desire same-sex intimacy and cannot meet societal  
9 expectations. The long-term consequences of trying to change attractions have been described as  
10 setting up an addictive cycle in which individuals try to distract themselves from their attractions  
11 but then feel compelled to act on them impulsively due to their needs for authenticity and  
12 connection, and then repress the desires again out of guilt and shame. The distress they initially  
13 felt about their “unwanted attractions” is then increased.

14 23. SOCE harms have been described as the result of the client (a) being misinformed  
15 about realistic outcomes, (b) being misled with unsubstantiated theories and treatments, (c)  
16 blaming him or herself for not changing or trying hard enough and thus internalizing treatment  
17 failure, (d) being reinforced that being LGB is shameful and must be avoided, (e) being restricted  
18 from accurate information and exploration of options, and (f) feeling pressured to be “one way or  
19 another” and reject/suppress core aspects of self. Such actions were described as increasing  
20 despair, self-hatred, confusion, anxiety, depression, guilt, shame, hopelessness, resentment,  
21 loneliness, intimacy difficulties, addictions, risk for HIV, and suicidality, including the loss of  
22 valuable time, money, resources, and trust. In addition, some SOCE consumers reported  
23 experiencing significant distress and aversion when they were sexual with their spouse, despite  
24 their feelings of love, similar to how exclusively heterosexual individuals would experience harm  
25 if made to be sexual with their non-preferred sex.

26 24. No alternate hypotheses have been provided for why a client would report a negative  
27 outcome from SOCE besides the inherently harmful aspects of the interventions.  
28

1 25. Above all, ethical practitioners take seriously reports of harms more than they do  
2 reports of benefit due to our adherence to the professional standard of “first, do no harm.” SOCE  
3 literature, on the other hand, focuses solely on positive self-reports and neglects any detail of the  
4 short- or long-term risks described in the literature. This is similar to the harm of providing  
5 medication without informing patients in detail of the potential negative side effects associated  
6 with the treatment and the lack of science in determining benefits.

7 26. Indeed, reports of SOCE benefits are inherently suspect. As several studies and  
8 personal accounts have noted (e.g., Beckstead, 2003; Beckstead & Morrow, 2004; Duberman,  
9 2001; Ford, 2001; Moor, 2001; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002), some who  
10 underwent SOCE have lied to their psychotherapists and others (e.g., parents, spouse, religious  
11 authorities) about changing their sexual orientation because they anticipated disapproval, wanted  
12 to please them, felt embarrassed, and believed their psychotherapist and others could not handle  
13 the disclosure. This need for impression management regarding treatment failure seems to be  
14 unaccounted for by SOCE psychotherapists.

15 27. Adults who have not had a chance to explore or know their sexuality due to living  
16 with a concealed identity in restricted and prejudicial environments can be harmed by the bias and  
17 lack of accurate information inherent in SOCE. This vulnerability is especially relevant for  
18 minors who require a period of exploration and evaluation to consolidate their sexual and gender  
19 identity rather than to try and fit themselves into the false and/or unfounded ideology of SOCE.

20 28. Further, parents themselves are being misinformed and unjustly blamed when they  
21 are told that their behaviors make homosexual or effeminate children. Absent or angry fathers  
22 may affect their homosexual or gender nonconforming son’s life, especially as it relates to  
23 attachment and developmental issues, but while these behaviors may cause a child stress, this  
24 does not suggest that such behaviors cause an LGB individual’s sexual orientation.

25 **SB 1172 IS CONSISTENT WITH THE ETHNICAL DUTIES**  
26 **OF LICENSED MENTAL HEALTH PROFESSIONALS**

27 29. California LMHPs are not placed in an ethical dilemma due to SB 1172. LMHPs are  
28 not ethically bound to always respect the wishes of their clients or to allow parents to decide the

1 course of treatment for minors. Rather, a LMHP's responsibility is to spend time understanding a  
2 client's requests in the light of their professional expertise and current scientific knowledge.  
3 Ethical practice does not prioritize one standard of care over another, except for doing no harm,  
4 and depends on understanding how ethical principles and standards are interrelated. To increase  
5 the likelihood of a benefit, a LMHP must first reduce the likelihood of harm. Moreover, positive  
6 outcomes depend upon the psychotherapist's competence (e.g., ability to assess, intervene, and  
7 resolve the problem) and such competence is increased by using scientific knowledge to guide  
8 treatments and assessment.

9 30. In order to further a client's self-determination, a psychotherapist must fully  
10 understand the client's cultural background, including the societal oppression faced by LGB  
11 individuals. These cultural influences may limit a client's perceived choices, and only by  
12 understanding that fact can an LMHP provide appropriate interventions that truly support a  
13 client's autonomy. An LMHP develops this cultural competence by increasing awareness of her  
14 or his biases, including any negative views of homosexuality, and does the work to correct these  
15 biases so that they do not interfere with a client's self determination (Lyons, Bieschke, Dendy,  
16 Worthington, & Georgemiller, 2010). A client might state with some certainty that her decision  
17 to enter treatment is fully autonomous but then later disclose developmental, cultural, or family  
18 issues that impinge on her choice. A youth who feels vulnerable to discrimination cannot make a  
19 choice to face discrimination. If a client says he does not want to be gay, a LHMP's fiduciary  
20 responsibility is to assess the reasons for that request and offer interventions that realistically  
21 provide benefit and avoid harm.

22 31. Any LHMP practicing in this area has an ethical obligation to familiarize themselves  
23 with the literature in this field that describes how those seeking SOCE can be negatively  
24 influenced by wrong and negating information, lack of accurate and affirming information, lack  
25 of awareness of options, pressures to live societal and familial norms, and the internalization,  
26 conformity, needs for acceptance, opposing needs, repression, confusion, fears, shame,  
27 rationalization, lack of exploration, and compliance that may occur. This literature explains how  
28 parental dynamics, trauma, peer abuse, role modeling, culture, developmental issues, and stigma

1 can influence how a person thinks and feels about their erotic desires and how they live out their  
2 sexual orientation.

3 32. It is not the responsibility of the public or client to know which interventions work  
4 and which do not, or to understand the current state of the scientific literature. Rather, it is the  
5 responsibility of LMHPs to develop their competence so that they can offer interventions that  
6 align with science. LMHPs are not ethically bound to provide a particular treatment simply  
7 because a client desires it, but must use his or her professional judgment to provide treatment that  
8 is scientifically indicated to help the client, and above all to avoid treatment that poses a  
9 substantial risk of harm.

10 33. SOCE proponents' concern that SB 1172 will harm their religious clients because no  
11 religious counseling will be available also misrepresents the current psychology of religion. The  
12 APA (2009a) Report highlighted this broad scholarly literature that emphasizes how a LMHP can  
13 respect and honor religious beliefs while being aware of the effects of these beliefs and knowing  
14 how to evaluate them and outcomes with clients. It is clear from studies that investigate the  
15 experiences of highly religious, same-sex attracted individuals that religion can both positively  
16 and negatively influence their health and well-being. In addition, one major problem found in  
17 SOCE literature is reinforcement of the (false) assumption that resolving conflicts between  
18 religion and sexual orientation only allows for an "either-or" solution. Scholarly literature,  
19 however, describes various therapeutic ways of how one can transcend this bind by helping  
20 clients explore, evaluate, and possibly integrate these aspects of their lives and develop both their  
21 religious and sexual identities, and thus have the option of living positively being both same-sex  
22 attracted and religious/spiritual. Regardless of a client's religious goals, the overarching goal for a  
23 LMHP is the client's mental health.

#### 24 **EFFECT OF SOCE ON MINORS**

25  
26 34. Minors in particular are especially vulnerable to harm from SOCE because they are in  
27 the initial stages of exploring and acquiring information to enhance their understanding and skills  
28 associated with their sexuality and choices. The problem with offering SOCE to minors is that

1 youth may not realize their long-term needs and may overestimate their ability to cope in the  
2 long-term with distracting and not acting on their sexual and romantic desires, especially if they  
3 are focused on meeting the needs of their parents and society.

4 35. Similarly, sexual and gender minority youth who are not affirmed for their attractions  
5 may miss out on important milestones and be at risk for serious harm. For example, at a time  
6 when heterosexual adolescents are learning to socialize, sexual and gender minority youth who  
7 undergo SOCE may be left at a disadvantage with learning how to hide, conflicted about those  
8 they cannot date, and dating those they do not romantically or erotically prefer (Hetrick & Martin,  
9 1987; Lasser & Gottlieb, 2004; Ream & Savin-Williams, 2005). The APA (2012) Practice  
10 Guidelines for LGB clients indicate that these attempts to mask or deny sexual identity put sexual  
11 and gender minority youth at risk for unwanted pregnancy, unsafe sex, interpersonal violence,  
12 substance abuse, and suicide attempts.

13 36. Although some SOCE youth consumers may feel supported by their SOCE provider,  
14 at its core, SOCE reinforce a message that their sexual desires are wrong and something to  
15 extinguish. Healthy sexuality on the other hand depends on developing an integrated awareness  
16 and acceptance of one's needs and values, which can provide meaning, authenticity, wholeness,  
17 and satisfaction as it orients the individual toward intimacy, love, and companionship. Sexual  
18 development therefore requires periods of exploration without bias and learning how to live  
19 positively with one's attractions, regardless of one's sexual identity and life choices. As  
20 summarized in the APA (2009a) Report,

21 Children and adolescents are often unable to anticipate the future consequences of a  
22 course of action and are emotionally and financially dependent on adults. Further,  
23 they are in the midst of developmental processes in which the ultimate outcome is  
24 unknown. Efforts to alter that developmental path may have unanticipated  
25 consequences. (p. 77).

26 37. Research on sexual and gender minority youth demonstrate that some behaviors that  
27 parents may use to protect their child from harm actually puts the child at high risk for suicide,  
28 depression, and other major health problems. These behaviors include trying to change their  
29 child's sexual orientation and blocking access to positive LGB influences. This research  
30 demonstrates how sexual and gender minority youth may only feel acceptable if they can get rid

1 of their romantic and sexual feelings and learn to enjoy sex with their non-preferred sex.  
2 Additionally, SOCE leave youth without positive role models of how to manage stigma  
3 effectively. Banning SOCE for minors is fully consistent with the ethical requirement that LMHP  
4 must base their work on the current literature that details how to be sensitive to cultural and  
5 familial influences on a youth's development and health (APA, 2012).

6 **CONCLUSION**

7 38. In summary, SB 1172 is a public health intervention aimed at harm reduction. It was  
8 founded on the fact that every major mental-health organization has a policy statement  
9 discouraging SOCE because of its lack of scientific merit, including the consensus that  
10 homosexuality is not a disorder of any kind that necessitates treatment. It is entirely reasonable  
11 for California to prohibit these types of interventions, particularly for minors, and encourage  
12 those in distress to seek services that are based on current knowledge of the psychology of sexual  
13 orientation, the psychology of gender, and the psychology of religion.

14 I declare under penalty of perjury pursuant to the laws of the State of California that the  
15 foregoing is true and correct.

16 Executed this 8th day of November, 2012, at Salt Lake City, Utah.

17  
18  
19 /s/ A. Lee Beckstead (original signature retained by attorney)  
20 A. LEE BECKSTEAD

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Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research and Practice, 33*, 249-259.

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---

### EDUCATION

- Ph.D. *Counseling Psychology. Department of Educational Psychology*  
University of Utah, Salt Lake City, (APA accredited). 2001.
- M.S. *Counseling Psychology. Department of Educational Psychology*  
University of Utah, Salt Lake City, (APA accredited). 1999.
- B.S. *Psychology. University of Utah, Salt Lake City. 1995.*  
Biology major, Salt Lake Community College, Salt Lake City. 1989-1991.
- 

### CLINICAL EXPERIENCE

- Oct 2010-  
Oct 2011 **Contract Provider**  
*Rape Recovery Center, Salt Lake City, Utah*
  - Provided individual psychotherapy to agency's male survivor clients
- June 2005-  
present **Co-facilitator, volunteer**  
*MaleSurvivor, Weekends of Recovery, www.malesurvivor.org*
  - Promote, interview/screen participants, & co-facilitate 3 to 5 weekend retreats yearly with 8-11 mental-health professionals in Utah, California, Atlanta, & Toronto for male survivors of sexual abuse (20-40 men per retreat). Weekends involve experiential exercises, small and large group processes of safety, mindfulness, self-expression, authentic movement, & community building
  - Participate in subcommittees focused on developing (a) protocol for participants with a sexual perpetration history; (b) research design to evaluate treatment effectiveness; (c) advanced-themed weekend protocol focused on relationships and intimacy, body empowerment, and recovery; and (d) protocol to evaluate whether transgender and intersex individuals can participate in the weekends and develop protocol to include their participation
  - Participate in monthly consultations regarding sexual abuse issues and interventions, including writing up the monthly notes of the meetings
  - Participate in annual staff retreat activities focused on self-care, identity, team-building, and integration of new members, policies, and planning
- April 2003- **Staff Associate. University Counseling Center, University of Utah**
  - Provide crisis coverage and training for the agency
- March 2003-  
present **Full-time Independent Practice. Aspen Grove Counseling;** work alongside Stephanie Bank, LCSW; Lindy Burton, LCSW; Mark Burton, PhD; Lisa Mountain, PhD; Brigg Noyes, PhD; & Angela Jette-Swanson, PhD.
  - Provide short- & long-term individual & couple's counseling for depression,

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- anxiety, eating disorders, substance abuse, relationship distress, HIV/AIDS, gender dysphoria, identity conflicts, career concerns, & grieving
- Facilitate a *Resolving Sexual, Social, and Spiritual Conflicts Therapy Group* & co-facilitated (w/ Jim Struve, LCSW) a *Men's Relationship Therapy Group*
- Participate in weekly case consultation meetings
- Process inquires for services and facilitate referrals within the community

July 2002-  
March 2003

**Certified Psychology Resident**

Supervisor: Kelly Lundberg, PhD

- Provided therapy for Dr. Lundberg's private practice clients
- Facilitated *Resolving Sexual, Social, and Spiritual Conflicts Therapy Group*
- Co-facilitated the State's *Interim Group* for individuals waiting to receive substance abuse/dependence treatment from County facilities
- Supervised 4 group co-facilitator practicum counselors

Aug 2002-  
Dec 2002

**Certified Psychology Resident**

*University of Utah Counseling Center*; Supervisor: Frances Harris, PhD

- Provided short-term individual counseling for students, staff, and faculty
- Co-facilitated *General Interpersonal Process Group* until August 2003
- Provided intake and crisis intervention services

Aug 2001-  
June 2002

**Postdoctoral Fellow. Counseling and Psychological Services; University of California, Berkeley**; Supervisors: Tom Merrifield, PhD, and Linda Zaruba, PhD

- Provided brief and long-term individual and couples counseling for students
- Conducted intake, career, and psychological assessments
- Provided 4 hours per week of crisis intervention services
- Supervised 1 predoctoral intern counselor
- Facilitated 7 voluntary and involuntary hospitalizations
- Collaborated in multidisciplinary team consultations in conjunction with psychiatry, medical services, nutrition, and social services

Aug 2000-  
Aug 2001

**Psychology Intern. University Counseling Center, University of Utah (APA accredited); Salt Lake City, Utah**

Supervisors: Richard Weigel, PhD, ABPP; and Mary Haas, PhD

- Provided brief and long-term individual and couples counseling for students, staff, and faculty
- Co-facilitated *Lesbian/Gay/Bisexual Therapy Group; Substance Abuse Therapy Group; Integrating Sexual, Social, and Spiritual Identities Therapy Group*; and a *General Interpersonal Process Group*
- Conducted career, psychological, and learning disability assessments
- Provided crisis intervention services during semester breaks
- Supervised 4 doctoral level practicum counselors
- Collaborated in multidisciplinary clinical team consultations and seminars

Jan-July  
2000

**Practicum Counselor. Centre for Addiction and Mental Health - Sexology and Forensic Units; Toronto, Ontario, Canada**

Supervisors: Ray Blanchard, PhD; James Cantor, PhD; Ken Zucker, PhD; and Maxine Petersen, M.A., Counseling Psychological Associate

- Provided intakes with clients managing gender dysphoria
- Administered neuropsychological assessments to sex offenders, clients with

- paraphilias, and men confused or conflicted about their sexual orientation
- Co-facilitated a *Gender Support Group* for clients managing gender identity dysphoria who were pre- and post surgical sex reassignment
- Contributed in weekly case conferences for children, adolescents, and adults

May-Dec  
1999

**Practicum Counselor.** *Valley Mental Health-Alcohol and Drug Treatment Unit; Salt Lake City, Utah*

Supervisors: Margaret Morris, PhD, and Mike Sheffield, PhD

- Provided individual counseling with clients on Medicaid/Medicare managing substance dependence and personality and affective disorders
- Conducted intakes, personality, and cognitive assessments
- Co-facilitated therapy groups: *Love and Logic (parenting)*; *Personality Development (clients with personality disorders)*; *Chemically Addicted Mentally Ill*; and *Family Substance Abuse Prevention Program*

May-Aug  
1999

**Practicum Counselor.** *Utah AIDS Foundation; Salt Lake City, Utah*

Supervisor: Doug Bruncker, LCSW

- Provided individual home/hospital counseling
- Co-facilitated *Therapy Group for Individuals Living With HIV/AIDS*

Aug 1998-  
Aug 1999

**Practicum Counselor.** *University Counseling Center; University of Utah Salt Lake City, Utah.* Supervisors: Susan L. Morrow, PhD; Ted Packard, PhD, A.B.P.P.; Lois Huebner, PhD; Laurie Wesley, M.S.; Craig Rooney, M.A.; and Troy Anderson, LCSW

- Conducted intakes and provided counseling for students, staff, and faculty
- Collaborated in multidisciplinary clinical team consultations and seminars

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## SUPERVISORY EXPERIENCE

April 2007-12 **Clinical Supervisor.** *Utah Pride Center; Salt Lake City, Utah*

- Provided supervision for 1 doctoral clinical psychology student who facilitated the Utah Pride Center's *Empowerment Workshops (2007-2009)*, *Lesbian/Bisexual Women's Support Group (2007-2009)*, and facilitated its *Adult Transgender Support Group (2009-2010)* and co-facilitated my *Resolving Sexual, Religious, and Social Conflicts Therapy Group (2007-2010)*
- Provided supervision to the above clinical psychology graduate student's supervision of a doctoral clinical psychology student's co-facilitation of the Utah Pride Center's *Empowerment Workshops (2009-2010)*
- Provided supervision for 1 master's counseling psychology student's (2009-present), 1 doctoral psychology student's co-facilitation of the *Empowerment Workshops (2009-2010)*, and 2 doctoral clinical psychology students who facilitated the Utah Pride Center's *Empowerment Workshops (2010-2012)*
- Provided group supervision for co-facilitators of the Utah Pride Center's *Empowerment Workshops (2009-2012)*
- Co-created and revised with each supervisee a yearlong series of 6-week community workshops on LGBTQ self-esteem, minority stress, gender identity, communication skills, coping skills, sexuality, and spirituality
- Engaged in formative written and oral evaluations

- July 2002-  
April 2003 **Clinical Supervisor.** Callister Foundation; Salt Lake City, Utah  
Supervisor: Kelly Lundberg, PhD
- Provided weekly and bimonthly supervision for 4 group co-facilitator (social work and counseling psychology) practicum counselors related to their substance-abuse group counseling
- Aug 2001-  
June 2002 **Clinical Supervisor.** *Counseling and Psychological Services, University of California, Berkeley*; Supervisors: Gloria Saito, PhD, and Tom Merrifield, PhD
- Provided weekly supervision for 1 predoctoral intern counselor
  - Reviewed audiotaped therapy sessions on weekly basis
  - Engaged in formative written and oral evaluations
- Aug 2000-  
May 2001 **Clinical Supervisor.** *University Counseling Center, University of Utah*  
Supervisors: Richard Weigel, PhD, ABPP.; Mary Haas, PhD; Glade Ellingson, PhD; Susan L. Morrow, PhD; and Ted Packard, PhD, ABPP
- Supervised 4 doctoral level practicum counselors (2 per semester)
  - Reviewed videotaped therapy sessions on weekly basis
  - Engaged in formative written and oral evaluations
- Fall 1999 **Practicum Supervisor.** *University Counseling Center, University of Utah*  
Supervisor: Lauren Weitzman, PhD
- Supervised 2 master's level (school and clinical) counselors
  - Reviewed videotaped therapy sessions on weekly basis
  - Engaged in formative written and oral evaluations

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## CURRICULUM DEVELOPED AND COURSES TAUGHT

- Summer 03 **Instructor.** *Department of Educational Psychology, University of Utah*  
**Counseling Sexual and Gender Minority Clients** (3 units)
- Topics: Contextual experiences of lesbian, gay, bisexual, questioning, transgender, transsexual, and intersex individuals and clinical interventions to manage the challenges they may face throughout the lifespan
- Fall 2002  
Fall 2000 **Instructor.** *Department of Educational Psychology, University of Utah*  
**Communication Skills** (half-semester)
- Topics: Awareness of self and others; styles of communication; and skills in speaking, listening, and resolving conflict
- Fall 2002,  
Summer 97-  
Spring 1999 **Instructor.** *Department of Educational Psychology, University of Utah*  
**Learning Skills/Strategies for College Success**  
(four full-quarter, four full-semester) Supervisor: Edith O. Kochenour, M.A.
- Collaborated in bimonthly staff meeting and in-service training
  - Topics: Values, goals, time management, concentration and memory, note taking, test taking, test anxiety, procrastination, critical and creative thinking, writing research papers, diversity, relationships, stress management, career process, and knowledge of campus resources

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- Spring 2001 **Co-instructor.** *Department of Educational Psychology, University of Utah*  
**Multicultural Issues: Understanding Self and Others (full semester)**  
Co-instructors: Brian Riedesel, PhD, and Danielle Oakley, M.A.
- **Topics:** Identity development; privilege/power; & panels on experiences of women, Native-Americans, African-Americans, Pacific-Islanders, Latino/as, Asian-American, Middle Easterners, lesbian/bisexual/gay individuals, people with disabilities, and people from diverse religious and spiritual backgrounds
- Spring 2001, Dec 1998 **Instructor.** *Department of Educational Psychology, University of Utah*  
**Career Development Workshop (one-day workshops)**
- **Topics:** The career decision process; exploring career values, interests, and abilities; and finding out more information on interested career fields
- Spring 2001 **Instructor.** *Department of Educational Psychology, University of Utah*  
**Examining the Impact of Gender and Sex Roles (half-semester)**
- **Topics:** Theories about gender; cross-cultural experiences; and how gender roles impact self, relationships, families, work, religion, and education
- Fall 2000 **Instructor.** *Department of Educational Psychology, University of Utah*  
**Career and Life Planning (half-semester)**
- **Topics:** Exploration of career interests, values, self-efficacy, decision-making skills, career fields, and resume writing and interviewing skills
- Fall 2000 **Instructor.** *Department of Educational Psychology, University of Utah*  
**Values and Relationships (half-semester)**
- **Topics:** Dating; partnership; commitment; sexuality; intimacy; conflict resolution; and family, workplace, and community relationships
- Fall 1999 **Co-Instructor.** *Department of Educational Psychology, University of Utah*  
**Interviewing & Counseling Skills (full-semester)**  
Supervisor: Robert D. Hill, PhD. Co-Instructor: Lynda Brzezinski, M.S.
- **Topics:** Basic counseling skills, with an emphasis on the therapeutic relationship, diverse theories, self-awareness, ethics, and multicultural issues
- Spring 1997 **Teachers' Assistant.** *Department of Psychology, University of Utah*  
**Psychology of Sexual Orientation (full-semester)**  
Instructors: Tom George, M.S., and Kelly Kinnish, M.S.
- **Topics:** Theories of etiology, identity development, gay youth, violence and prejudice, HIV/AIDS, gay/lesbian/bisexual parents, and legal issues

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## RESEARCH EXPERIENCE

- 2011- **Consultant;** MaleSurvivor.org
- Develop research design to evaluate effectiveness of weekend retreats
- 2011-12 **Dissertation Committee Member;** *School of Social Work, University of Utah*
- Douglas Crew: *Self-compassion with lesbian, gay, and bisexual persons*

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- 2010-2012 **Consultant; Utah State University, Renee Galliher, PhD, & Bill Bradshaw, PhD.**
- *Experiences of and resources for same-sex attracted Latter-day Saints*
- 2009-11 **Dissertation Committee Member; Psychology Department, University of Utah**
- Jordan Rullo: *Bisexuality: Beyond the central assumptions of male and female sexual orientation*
- 2006-07 **Dissertation Committee Member; College of Social Work, University of Utah**
- Mary E. Moran: *An examination of women's sexuality and spirituality: The effects of conversion therapy: A mixed method study*
- 2003- 2004 **Research Assistant. Counseling Psychology Program, University of Utah;**  
1996-1999 **Supervisor/co-researcher: Susan L. Morrow, PhD**
- Assisted in qualitative research on the visibility/invisibility of lesbian/bisexual women and the interaction between a sexual and career identity
- Oct 2000 **Doctoral Dissertation: *The process toward self-acceptance and self-identity of individuals who underwent sexual reorientation therapy***
- Collected and analyzed original qualitative data set based on the experiences of clients who underwent sexual reorientation therapy and reported harms and/or adopted a gay/lesbian/bisexual identity after therapy
  - Integrated data set with the thesis data to create one overarching theory
- Jan-July 2000 **Research Assistant. Centre for Addiction and Mental Health-Sexology and Forensic Units; Toronto, Ontario, Canada**  
**Supervisors: Ray Blanchard, PhD, and James Cantor, PhD**
- Administered and interpreted neuropsychological assessments to investigate the cognitive functioning of pedophiles and other sex offenders
- June 1999 **Master's Thesis: "*Gay is not me*": *Seeking congruence through sexual reorientation therapy***
- Collected and analyzed original qualitative data set (interviews, journal writings, focus groups) based on experiences of clients who underwent sexual reorientation therapy and report benefits/success of interventions
  - Created a theory based on data set to explain how and why individuals may report a change in their sexual orientation and identity after therapy
- 1996-1998 **Research Assistant. *Qualitative Research Group; University of Utah***  
**Supervisor: Susan L. Morrow, PhD**
- Participated in an ongoing group regarding qualitative research issues with a team of doctoral students and their research interests/goals
- 1995-1996 **Research Assistant. *Developmental Psychology Program, University of Utah***  
**Supervisor: Don Hartmann, PhD**
- Assisted in research involving friendship loss among children's peer groups
- 1995 **Research Assistant. *Social Psychology Program, University of Utah***  
**Supervisor: Carolyn Morf, PhD**
- Collected data in a quantitative study that measured self-regulation and affective responses to success and failure in narcissistic individuals

## PUBLICATIONS

Beckstead, A. L., & Glassgold, J. (book in preparation). *Options, not cures: A guidebook to resolve sexual orientation, religious, and social conflicts.*

Glassgold, J., & Beckstead, A. L. (article in preparation). Implementing the 2009 APA Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress.

Beckstead, A. L. (2012). *Can we change sexual orientation?* [Special issue on What is sexual orientation?]. *Archives of Sexual Behavior*, 41, 121-134. doi:10.1007/s10508-012-9922-x

Yarhouse, M. A., & Beckstead, A. L. (2011). Utilizing group therapy to navigate and resolve sexual orientation and religious conflicts. *Counseling and Values*, 56, 96-120.

Glassgold, J., Beckstead, A. L., Drescher, J., Greene, B., Miller, R. I., & Worthington, R. L. (2009). *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Washington, D.C.: American Psychological Association.

Glassgold, J., Beckstead, A. L., Drescher, J., Greene, B., Miller, R. I., & Worthington, R. L. (2009). *Resolution of the Appropriate Affirmative Therapeutic Responses to Sexual Orientation Distress and Change Efforts*. Washington, D.C.: American Psychological Association.

Beckstead, A. L., & Israel, T. (2007). Affirmative counseling and psychotherapy focused on issues related to sexual orientation conflicts. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2<sup>nd</sup> ed.) (pp. 221-244). Washington, D.C.: American Psychological Association.

Co-author from April 2004 to February 2005 of a mental-health advice column, *Sane Advice*, for the *Salt Lake Metro*, a LGBTQ biweekly community newspaper.

Beckstead, A. L., & Morrow, S. L. (2004). Mormon clients' experiences with conversion therapy: The need for a new treatment approach [Special issue]. *The Counseling Psychologist*, 32, 651-690.

Cantor, J. M., Blanchard, R., Christensen, B. K., Dickey, R., Klassen, P. E., Beckstead, A. L., Blak, T., & Kuban, M. E. (2004). Intelligence, memory, and handedness in pedophilia. *Neuropsychology*, 18(1), 3-14.

Morrow, S. L., & Beckstead, A. L. (2004). Conversion therapies for same-sex attracted clients in religious conflict: Context, predisposing factors, experiences, and implications for therapy [Special issue]. *The Counseling Psychologist*, 32, 641 - 650.

Morrow, S. L., Beckstead, A. L., Hayes, J. A., & Haldeman, D. C. (2004). Impossible dreams, impossible choices, and thoughts about depolarizing the debate [Special issue]. *The Counseling Psychologist*, 32, 778 - 78.

Beckstead, A. L. (2003). Understanding the self-reports of reparative therapy "successes" [Special issue] *Archives of Sexual Behavior*, 32, 421-423. Reprinted in J. Drescher & K. J.

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Zucker (Eds.), *Ex-gay research: Analyzing the Spitzer study and its relation to science, religion, politics, and culture* (pp. 75-81). Binghamton, NY: Haworth Press.

Beckstead, A. L. (2003, Spring). "We're approaching this too narrowly": The need for a broader based therapy for conflicted, same-sex attracted clients. *Division 44 Newsletter*, 19, 8-11.

Beckstead, A. L. (2001). Cures versus choices: Agendas in sexual reorientation therapy [Special issue]. *Journal of Gay and Lesbian Psychotherapy*, 5(3/4), 87-115. Reprinted in A. Shidlo, M. Schroeder, & J. Drescher (Eds.), *Sexual conversion therapy: Ethical, clinical, and research perspectives* (pp. 87-115). New York: Haworth Press.

Beckstead, A. L. (2001). The process toward self-acceptance and self-identity of individuals who underwent sexual reorientation therapy. (Doctoral dissertation, University of Utah, 2001). *Dissertation Abstracts International*, 62, 2475.

Beckstead, A. L. (1999). "Gay is not me": *Seeking congruence through sexual reorientation therapy*. Unpublished master's thesis, University of Utah, Salt Lake City.

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## AWARDS

2010 Dare to Dream Aware, *Male Survivor Organization*, given for "outstanding service to the Weekends of Recovery program."

2007 Fay Honey Knopp Award, *Male Survivor Organization*; Weekends of Recovery Facilitator Team: For "upholding the legacy that established and fostered national efforts to abolish male sexual victimization."

2005 Distinguished Major Contribution Award, *The Counseling Psychologist's* (APA-sponsored), which "recognizes top scholarship in the field of counseling psychology."

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## PROFESSIONAL CONFERENCE PRESENTATIONS

Glassgold, J., Beckstead, A. L., Drescher, J., Greene, B., Miller, R., & Worthington, R. (2009, August). *Report of the Task Force for Appropriate Therapeutic Response to Sexual Orientation*. Symposium conducted at the annual meeting of the American Psychological Association, Toronto.

Beckstead, A. L. (2007, August). Affirmative counseling and psychotherapy focused on issues related to sexual orientation conflicts. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Co-chairs), *Addressing intersecting identities when working with issues of sexual orientation*. Paper presented at the annual meeting of the American Psychological Association, San Francisco.

Yarhouse, M., & Beckstead, A. L. (Co-chairs) (2007, August). *Sexual identity therapy to address religious and spiritual conflicts*. Symposium conducted at the annual meeting of the American Psychological Association, San Francisco.

Yarhouse, M., & Beckstead, A. L. (2007, August). Sexual identity group therapy to navigate religious and spiritual conflicts. In M. Yarhouse & A. L. Beckstead (Co-chairs), *Sexual identity therapy to address religious and spiritual conflicts*. Paper presented at the annual meeting of the American Psychological Association, San Francisco.

Beckstead, A. L. (2004, July). Developmental and clinical factors for youth who struggle with sexual and religious conflicts. In M. Yarhouse (Chair), *Sexual identity confusion during adolescence: Religious, diversity, and professional issues*. Symposium conducted at the annual meeting of the American Psychological Association, Honolulu, HI.

Beckstead, A. L. (2004, June). *How lesbian and bisexual women identity development impacts with addiction*. Workshop presented at the annual meeting of the School on Alcoholism and Other Drug Dependencies, Salt Lake City, UT.

Beckstead, A. L., & Dennison, S. (2004, April). *Therapeutic and personal perspectives on transgender issues*. Paper presented at the annual meeting of the Generations Conference, Salt Lake City, UT.

Beckstead, A. L., & Dennison, S. (2003, November). *Clinical issues for youth raised by lesbian, gay, bisexual, and transgender parents*. Paper presented at the annual meeting of the Children's Behavioral Health Institute, Salt Lake City, UT.

Beckstead, A. L. (2003, July). *Understanding clients' experiences of sexual reorientation therapy: Implications for counseling and research*. Invited presenter at the annual meeting of the International Academy of Sex Research, Bloomington, IN.

Beckstead, A. L. (2002, November). *Clinical implications for college students dealing with sexual, social, and spiritual conflicts*. Paper presented at the annual meeting of the Utah University Counseling Center Conference, Salt Lake City, UT.

Beckstead, A. L. (2002, August). Let's wave the rainbow flag! In J. D. Robinson (Chair), *What about that intern?: Diversity issues in training settings*. Symposium conducted at the annual meeting of the American Psychological Association, Chicago.

Beckstead, A. L. (2001, August). Clients' experiences of conversion therapy: The process of seeking congruence. In S. L. Morrow (Chair), *Sexual reorientation: Client motivations and experiences, consequences, and alternatives*. Symposium conducted at the annual meeting of the American Psychological Association, San Francisco.

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Beckstead, A. L., & Morrow, S. L. (2001, March). *Treatment strategies for same-sex attracted clients in conflict*. Paper presented at the annual meeting of the Utah Chapter of the National Association of Social Workers, Salt Lake City, UT.

Anderson, L., & Beckstead, A. L. (1999, August). *Mentoring lesbian, gay, and bisexual students in psychology*. Co-chaired a roundtable discussion with lesbian/gay/bisexual mentors and students at the annual meeting of the American Psychological Association, Boston.

Beckstead, A. L. (1999, August). "*Gay is not me*": *Seeking congruence through sexual reorientation therapy*. Poster session presented at the annual meeting of the American Psychological Association, Boston.

American Psychological Association Graduate Students. (1999, August). *Academic climate for lesbian, gay, and bisexual students in psychology*. Co-chaired a roundtable discussion at the annual meeting of the American Psychological Association, Boston.

American Psychological Association Graduate Students. (1999, August). *Orientation to convention for lesbian, gay and bisexual students*. Co-chaired a roundtable discussion at the annual meeting of the American Psychological Association, Boston.

American Psychological Association Graduate Students. (1998, August). *Academic climate for lesbian, gay, and bisexual students in psychology*. Co-chaired a roundtable discussion at the annual meeting of the American Psychological Association, San Francisco.

Beckstead, A. L. (1998, August). *A qualitative study of individuals who seek sexual reorientation therapy*. Poster session presented at the annual meeting of the American Psychological Association, San Francisco.

## NON-PROFESSIONAL CONFERENCE PRESENTATIONS

Beckstead, A. L., & Hancock, H. (2012, November). *Building bridges and understanding between LGBTQ individuals and their LDS families*. Co-facilitated discussion/didactic at the annual meeting of Mormon Stories, Circling the Wagon Foundation, Salt Lake City, UT.

Beckstead, A. L. (2011, November). *What helps (and hurts) in resolving sexual, religious, and social conflicts*. Opening speech and presentation at the Mormon Stories conference for LGBTQ individuals and their families and allies. Salt Lake City, UT.

Beckstead, A. L. (2010, December). *Find your Man's G-Spot: A Gay Men's Sexual Satisfaction Workshop*. Facilitated discussion and provided information at the Queer Men's Sex Education Conference, co-sponsored by the Utah Pride Center and University of Utah's LGBTQ Resource Center, Salt Lake City, UT.

Beckstead, A. L. (2007, October). *The religious-homosexual identity dialectic: A developmental approach*. Panel discussant at the annual meeting of Sunstone Education Foundation, Salt Lake City, UT.

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Beckstead, A. L. (2007, February). *Resolving sexual, religious, and spiritual conflicts: Finding your path to harmony*. Workshop at the annual meeting of the Winterfest Conference, Salt Lake City, UT.

Beckstead, A. L. (2005, October). *Forgiveness of self and others: A path toward health and resolution*. Workshop at the annual meeting of the National Gay Men's Health Summit, Salt Lake City, UT.

Olaiz, H., Beckstead, A. L., Anderson, L. S., Holsinger, D., & Brubaker, J. (2005, July). *For the Strength of Mormon Gay Youth*. Symposium conducted at the annual meeting of Sunstone Education Foundation, Salt Lake City, UT.

Beckstead, A. L., & Struve, J. (2004, October). *Tenderhearted approaches to conflict resolution*. Workshop at the annual meeting of the National Association of Parents Families and Friends of Lesbian and Gays (PFLAG), Salt Lake City, UT.

Beckstead, A. L., & Struve, J. (2004, October). *Tenderhearted approaches to conflict resolution*. Workshop at the annual meeting of the Utah Chapter of the Gay Men's Health Summit, Salt Lake City, UT.

Beckstead, A. L., & Struve, J. (2003, October). *Healthy values for a healthy lifestyle: Finding and using your center*. Workshop at the annual meeting of the Gay Men's Health Summit, Salt Lake City, UT.

Beckstead, A. L. (2002, February). *Workshop for first-time presenters*. Workshop at the annual meeting of the University of California Lesbian/Gay/ Bisexual/Transgender/Intersex Association, Berkeley, CA.

Henderson, S., & Beckstead, A. L. (2002, February). *Forgiveness training: A new route toward health and resolution for LGBTIQQA individuals*. Workshop presented at the annual meeting of the Univ. of CA al. Lesbian/Gay/Bisexual/Transgender/Intersex Assn, Berkeley, CA.

Beckstead, A. L. (2001, June). *How conflicts with sexual orientation and religion affect marriage and family decisions*. Symposium conducted at the annual meeting of Family Fellowship, Salt Lake City, Utah.

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### INVITED SPEAKER

- 2003- *University Neuropsychiatric Institute, University of Utah*  
• Present yearly to interns on counseling LGBTQ clients
- 2003- *University Counseling Center, University of Utah*  
• Present yearly to interns on counseling LGBTQ clients

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- Nov 2012 *University of Utah's Educational Psychology Department, Salt Lake City, Utah*
- Presented "Increasing awareness, knowledge, and skills in working with LGBTQ clients with drug and alcohol addictions"
- Oct 2012 *LGBTQ-affirmative Psychotherapist Guild of Utah, Salt Lake City, Utah*
- Presented "Between a rock and a hard place: Helping clients who are conflicted with their sexual orientation"
- Sept 2012 *LGBTQ-affirmative Psychotherapist Guild of Utah, Salt Lake City, Utah*
- Panelist, "Reparative therapy is alive and well in Utah"
- May 2012 *Utah AIDS Foundation, Salt Lake City, Utah*
- Presented, "Finding your man's g-spot: A gay men's sexual satisfaction presentation"
- April 2012 *Southern Poverty Law Center, Provo, Salt Lake City, Utah*
- Panelist, "Why conversion therapy is an unethical attempt."
- 2009-11 *Clinical Psychology Department, University of Utah*
- Present on LGBT counseling for Multicultural Psychology graduate classes
- 2007-11 *Salt Lake Community College, Salt Lake City, Utah*
- Presented each semester to two Queer Studies classes on historical and current mental-health psychological concerns of sexual and gender minorities, specifically related to "coming out" and identity issues
- 2004-11 *Clinical Psychology Department, Gender Studies, University of Utah*
- Present yearly on conversion therapy to Psych of Love undergraduate class
- Sept 2011 *Utah AIDS Foundation, Salt Lake City, Utah*
- Presented, "What's love got to do with it? How to know when you're in love or just horny (or worse)"
- July 2011 *National Public Radio; Public Broadcast System; New York Times Magazine*
- Guest speaker on issues related to reparative therapy
- March 2011 *LGBTQ-affirmative Psychotherapist Guild of Utah, Association for Women in Psychology, & Women in Private Practice, Salt Lake City*
- Presented 6-hour ethics CEU workshop on resolving sexual, religious, and social conflicts, sponsored by Utah Psychological Association and Utah chapter of the National Association of Social Work
- January 2011 *LGBTQ-affirmative Psychotherapist Guild of Utah, Association for Women in Psychology, & Women in Private Practice, Salt Lake City*
- Presented on "Increasing Stigma Competence for Sexual/Gender Minorities"
- Dec 2010 *Utah AIDS Foundation, Salt Lake City*
- Panelist for World AIDS Day discussion on "Who's To Blame For AIDS?": Psychological reasons for and prevention of continual spread of HIV in Utah

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- Nov 2010 *KRCL Radio Active Talk Show, Salt Lake City*
- Guest speaker on issues of conversion/reparative therapy in Utah
- May 2010 *International Academy of Sex Research, Alberta, Canada*
- Presented on "Can we change sexual orientation? What we know, what we need to know, & why these questions are important" at an invited-only, 3-day workshop for top international sexologists titled, "The Puzzle of Sexual Orientation: What is it and How Does it Work?"
- Feb 2010 *Brigham Young University Counseling & Career Center, Provo, Utah*
- Presented 4-hour workshop on resolving sexual, religious, and social conflicts
- Oct 2009 *Brigham Young University Counseling & Career Center, Provo, Utah*
- Presented on strategies to resolve distress related to sexual orientation, religious, and social conflicts
- April 2009 *LGBT-affirmative Psychotherapist Guild of Utah, Salt Lake City*
- Facilitated a group discussion on the political, professional, therapeutic, and anti-therapeutic agendas regarding the diagnostic categories of gender dysphoria, paraphilias, and sexual orientation distress
- Feb 2009 *SJ Quinney College of Law, University of Utah*
- Panelist (with Senator Scott McCoy, Will Carlson, & Clifford J. Rosky) to debate "opposing" views regarding rights for LGBTQ individuals, *Resolved: The Utah State Legislature should pass the Common Ground Initiative.*
  - Presented scientific data regarding sexual orientation, gender identity, and the role of acceptance and affirmation of rights in facilitating mental health
- Feb 2009 *Affirmation (LGBT Mormons), Salt Lake City, Utah*
- Facilitated all-day workshop on *Understanding and Defining Who You Are Sexually, Emotionally, Relationally, Spiritually, and All the Other Important Aspects of You*
- 2006-09 *Counseling Psychology Department, University of Utah*
- Presented yearly on counseling sexual and gender minorities to Multicultural Counseling graduate class
- June 2008 *Family Fellowship, Salt Lake City, Utah*
- Presented on what helps and hurts individuals and families who are in conflict and distress with their sexual, religious, and social identities
- June 2008 *Ohio Psychological Association, Columbus, Ohio*
- Presented 6-hour CEU ethics workshop on resolving sexual, religious, and social conflicts
- Feb 2008 *Coloring Outside the Lines: Salt Lake Community College LGBT Student Union*
- Presented workshop on developing positive self-esteem and body image
- Feb 2008 *Regent University, Virginia Beach, Virginia*
- Presented on resolving sexual, religious, and social conflicts and dialogued

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with faculty and students about differences and similarities between gay-affirmative approaches and conservative religious approaches

- Nov 2007 *Affirmation (LGBT Mormons)*, Salt Lake City, Utah
- Presented on "honoring and integrating sexuality and spirituality into a coherent whole" using art therapy and group discussion
- Nov 2007 *Clinical Psychology Department*, University of Utah
- Presented on LGBT counseling issues
- Oct 2007 *Salt Lake Community College*, Salt Lake City, Utah
- Presented on transgender and transsexual counseling issues
- April 2007 *Greek Orthodox Church Family Fair*; Salt Lake City, Utah
- Presented on "Improving Self-esteem & Body Image and Understanding Eating Disorders"
- April 2007 *Educational Psychology Department*; Salt Lake City, Utah
- Presented on clinical issues of families with LGBT parents and/or children
- March 2007 *Utah Pride Center*; Salt Lake City, Utah
- Panelist on "Do I look fat?: Eating disorders, body image, & gay men"
- March 2007 *University of Utah Diversity & Social Justice Lecture Series*; Salt Lake City, Utah
- Panelist on "Queer theory: Genitals, clothing, pleasure, and shame"
- Sept 2006 *Weber State College Counseling Center*; Ogden, Utah
- Presented on resolving sexual, social, and religious conflicts
- March 2006 *Harvard Law School Lambda*; Boston
- Panelist on immutability of sexual orientation
- March 2006 *Primary Children's Hospital*; Salt Lake City, Utah
- Presented on LGBTQ youth issues for interns
- Feb 2006 *Straight Spouse Network*; Salt Lake City, Utah
- Described experiences of heterosexually married homosexuals/bisexuals
- Oct 2005 *North Valley Mental Health*, Salt Lake City, Utah
- Co-presented on conceptualizing and addressing LGBT mental-health issues
- Sept 2005 *Salt Lake Community College, Health & Wellness Services*, Salt Lake City, Utah
- Presented on sexual & religious identity development, conflicts, & resolution
- June 2005 *Damn These Heels: Salt Lake Queer Film Festival*
- Panelist on LGBT issues of mental health, oppression, identity, & spirituality
- March 2005 *Gay Family Home Evening Discussion Group*, Salt Lake City.
- Presented information on developing self-esteem and a positive self-identify for gay, lesbian, bisexual Mormon/LDS individuals

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- Sept 2004 *University Counseling Center, University of Utah*  
• Co-presented on conceptualizing, assessing, and treating eating disorders
- April 2004 *Lesbian, Gay, Bisexual, Transgender Resource Center, University of Utah*  
• Panelist on how a sexual minority identity intersects with cultural identities
- Feb 2004 *Mormon Studies Brown Bag Series, University of Utah*  
• Presented research on Mormon/LDS, same-sex attracted individuals
- Oct 2003 *Educational Psychology Dept., Strategies for College Success; University of Utah*  
• Presented information on critical thinking, diversity, and lesbian, gay, and bisexual issues to undergraduates
- Sept 2003 *Samaritan Counseling Center; Salt Lake City, Utah*  
• Presented information on managing sexual, social, and spiritual conflicts
- Aug 2003 *Women's Wellness Community Program; Salt Lake City, Utah*  
• Presented 3-hour workshop on managing sexual, social, and spiritual conflict
- July 2003 *Psychology Department; University of Utah*  
• Presented information on managing sexual, social, and spiritual conflicts
- May 2003 *Gamofite (Gay Mormon Fathers) Annual Conference; Lava Hot Springs, Idaho*  
• Co-facilitated discussion on beginning and maintaining relationships
- April 2003 *Colorado State University; Fort Collins, Colorado*  
• Provided Keynote Address on increasing self-worth and identity development, dealing with discrimination, and enhancing respect for diversity  
• Provided 3-hour workshop on managing sexual, social, and spiritual conflicts
- April 2003 *Psychology Department; University of Utah*  
• Presented information on managing sexual, social, and spiritual conflicts
- March 2003 *Social Work Department; University of Utah*  
• Presented information on managing sexual, social, and spiritual conflicts
- Feb 2003 *Take 2 Television Show, Utah*  
• Guest speaker on the issues of conversion/reparative therapy
- Nov 2002 *Lesbian, Gay, Bisexual, Transgender Resource Center, University of Utah*  
• Participated in panel discussion regarding "Can homosexuality be cured?"
- Oct 2002 *Family Fellowship; Provo, Utah*  
• Presented information on integrating sexual, social, and spiritual conflicts
- June 2002 *Counseling and Psychological Services; University of California, Berkeley*  
• Presented on clinical implications for sexual and social identity conflicts
- May 2002 *Counseling and Psychological Services; University of California, Berkeley*  
• Presented on facilitating clients' forgiveness toward self and others

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- June 2001 *University Counseling Center; University of Utah*  
• Presented information regarding transsexual and transgender issues
- April 2001 *Department of Educational Psychology; University of Utah*  
• Presented dissertation results as part of departmental seminar series
- April 2001 *Brigham Young University Counseling & Career Center; Provo, Utah*  
• Co-presented on issues for same-sex attracted/lesbian/gay/bisexual clients
- Feb 2001 *Learning Enhancement Program; University of Utah*  
• Presented on teaching sexual diversity in a college skills preparation class
- June 2000 *Centre for Addiction and Mental Health; Toronto, Ontario, Canada*  
• Presented dissertation results as part of Pride Celebration
- March 2000 *UMFM Radio Talk Show, University of Manitoba, Winnipeg, Canada*  
• Guest speaker on the issues of conversion/reparative therapy
- Feb 2000 *Centre for Addiction and Mental Health; Clinical Sexology-Children and Adolescent Unit; Toronto, Ontario, Canada*  
• Presented master's thesis results to practicum doctoral students
- Oct 1999 *Parents/Friends of Lesbian and Gays (PFLAG); Salt Lake City, Utah*  
• Presented master's thesis results
- Sept 1998 *Valley Mental Health; Salt Lake City, Utah*  
• Co-facilitated discussion with outpatients regarding sexual orientation issues
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### CONSULTATION AND OUTREACH

- March 2003 *Lesbian and Gay Student Union; University of Utah*  
• Presented information on how mental health affects physical health
- August 2002 *Resident Assistants; University of Utah*  
• Discussed potential problems that resident assistants may face, resources offered by university counseling services, and how to access services
- April 2001 *Queer & Asian; University of California, Berkeley*  
• Provided information and facilitated group discussion on "coming out."
- March 2002 *Incentive Awards Scholars; University of California, Berkeley*  
• Co-facilitated group discussion on embracing diversity on campus
- March 2002 *Cooperation Living; University of California, Berkeley*  
• Co-facilitated on-site debriefing, provided information on grieving, and discussed resources after the suicides of 3 students
- Feb 2002 *Health and Sexuality Peer Education Program; University of California, Berkeley*  
• Facilitated discussion on body image, self-esteem, sexuality, and condom use

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- Feb 2002 *Academic Probation: Reach for Success; University of California, Berkeley*  
• Co-taught two workshops on strategies to improve academic record
- Nov 2001 *Queer & Asian; University of California, Berkeley*  
• Provided information and facilitated discussion on relationship issues
- Nov 2001 *Residence Halls; University of California, Berkeley*  
• Co-facilitated discussion on time management skills
- Nov 2001 *Lesbian/Bisexual Women's Student Group; University of California, Berkeley*  
• Facilitated discussion on relationship issues and self-esteem
- Nov 2001 *Queer Catholic Student Group; University of California, Berkeley*  
• Co-facilitated discussion on stress management
- Oct 2001 *National Depression Screening Day; University of California, Berkeley*  
• Interpreted students' assessment results and made referrals accordingly
- Oct 2001 *National Coming Out Day; University of California, Berkeley*  
• Tabled and provided information about counseling center resources
- Sept 2001 *Cal Funds; University of California, Berkeley*  
• Provided crisis debriefing and facilitated discussion on stress management
- Sept 2001 *Residence Halls; University of California, Berkeley*  
• Provided crisis debriefing and facilitated discussion on stress management
- Spring 2000 *Greek System; University of Utah*  
• Provided information on grieving after a student's death
- Fall 2000 *College of Law; University of Utah*  
• Consulted with assistant dean and faculty on students' needs  
• Co-facilitated a student panel on stress management and study techniques
- Fall 2000 *Department of Modern Dance; University of Utah*  
• Co-presented information about services offered at the Counseling Center
- Nov 2000 *Lesbian and Gay Student Union; University of Utah*  
• Presented results from dissertation and discussed counseling services
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## ADMINISTRATIVE AND SERVICE EXPERIENCE

- Oct 2012- **Circling the Wagon Foundation, Advisory Board Member**
- Nov 2010- **Utah Psychological Association, Task Force Member**  
• Invited to submit information regarding the science and sociopolitical context regarding etiology, normality, and malleability of same-sex attractions  
• This information will be used to determine if UPA should take a stand on these issues and, if so, what kind of statement would be made to the public

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- 2008-09 *University of Utah, LGBT Resource Center, Advisory Board Member;*  
**Member of the Programming Committee**
- Work with the LGBT Resource Center Director to plan programs
  - Meet every other month with Programming Committee and every other month with Board to coordinate services with Fund Development/Outreach and Alumni committees
- 2007-09 *American Psychological Association, Task Force Member*
- Appointed to review and update the *Resolution on Appropriate Therapeutic Responses to Sexual Orientation* & evaluate and synthesize research on and recommendations for those highly conflicted with their sexual orientation
  - Co-authored the Task Force's Report and Resolution
  - Responded to political and media reactions during the process of the update
- 2003-06 *American Psychological Association, Division 12; Membership Committee*
- Reviewed applications and improved application process for new members
- Aug 2001-  
June 2002 *Counseling and Psychological Services; University of California, Berkeley*  
**Lesbian/Gay/Bisexual/Transgender/Intersex/Queer/Questioning/Allies (LGBTIQQA) Outreach Coordinator**
- Conducted outreach and developed connections between counseling center and LGBTIQQA student groups and the campus' Queer Resource Center
  - Co-developed peer training programs for "coming out" support groups and focus groups for gender/racial conflicts within the LGBTIQQA communities
- Programs Task Force Committee Member for University of California LGBTIQQA Annual Conference**
- Engaged in weekly planning meetings; recruited, selected, and organized scheduling of programs; coordinated contacts; and processed evaluations.
- Faculty Liaison for Gender Equity Center**
- Continued the contact and connections between the centers
- 2000-2001 *University Counseling Center; University of Utah*  
**Training Committee Member**
- Engaged in bimonthly review and resolution of training issues
- Selection Committee Member**
- Reviewed applications, interviewed applicants, & participated in the selection process for predoctoral internship positions
- Selection Committee Member**
- Interviewed applicants & participated in hiring a Tutoring Center Coordinator
- 1997-1999 *American Psychological Association for Graduate Students*  
**Committee member for Lesbian/Gay/Bisexual Concerns**
- Participated in meetings with the Committee Chair involving research, clinical, and professional issues for lesbian/gay/bisexual graduate students
- 1998, 1999 *Counseling Psychology Program; University of Utah*  
**Admissions Selection Committee Member**
- Reviewed and ranked applications for doctoral program positions
-

## PROFESSIONAL ASSOCIATIONS

- 2005-present ***LGBTQ-Affirmative Psychotherapist Guild of Utah***
- Cofounder of this grassroots organization & participate in monthly trainings
  - Co-designed and manage the group's website [www.lgbtqtherapists.com](http://www.lgbtqtherapists.com), which includes information for clients and consumers for finding a therapist, local/national resources, bibliographies, and calendar of community events
- 2004-present ***International Academy of Sex Research***; Associate Member
- 2004-2007 ***Healing the Great Divide***; Utah Psychological Association-sponsored, monthly group discussion on understanding and resolving discrimination in Utah
- 2000-present ***Utah Psychological Association***
- 1998-present ***American Psychological Association***
- Division 12 (Clinical Psychology)
  - Division 17 (Counseling Psychology)
  - Division 44 (Psychological Study of Lesbian, Gay, Bisexual, and Transgender Issues)

## REFERENCES

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**EXHIBIT D**



California LEGISLATIVE INFORMATION

SB-1172 Sexual orientation change efforts. (2011-2012)

Senate Bill No. 1172

CHAPTER 835

An act to add Article 15 (commencing with Section 865) to Chapter 1 of Division 2 of the Business and Professions Code, relating to healing arts.

[ Approved by Governor September 30, 2012. Filed Secretary of State September 30, 2012. ]

LEGISLATIVE COUNSEL'S DIGEST

SB 1172, Lieu. Sexual orientation change efforts.

Existing law provides for licensing and regulation of various professions in the healing arts, including physicians and surgeons, psychologists, marriage and family therapists, educational psychologists, clinical social workers, and licensed professional clinical counselors.

This bill would prohibit a mental health provider, as defined, from engaging in sexual orientation change efforts, as defined, with a patient under 18 years of age. The bill would provide that 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 the provider to discipline by the provider's licensing entity.

The bill would also declare the intent of the Legislature in this regard.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(a) Being lesbian, gay, or bisexual is not a disease, disorder, illness, deficiency, or shortcoming. The major professional associations of mental health practitioners and researchers in the United States have recognized this fact for nearly 40 years.

(b) The American Psychological Association convened a Task Force on Appropriate Therapeutic Responses to Sexual Orientation. The task force conducted a systematic review of peer-reviewed journal literature on sexual orientation change efforts, and issued a report in 2009. The task force concluded 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 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.

(c) The American Psychological Association issued a resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts in 2009, which states: "[T]he [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.”

(d) The American Psychiatric Association published a position statement in March of 2000 in which it stated:

“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, [the American Psychiatric Association] recommends that ethical practitioners refrain from attempts to change individuals’ sexual orientation, keeping in mind the medical dictum to first, do no harm.

The potential risks of reparative therapy are great, including 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 is not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed.

Therefore, 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.”

(e) The American School Counselor Association’s position statement on professional school counselors and lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) youth states: “It is not the role of the professional school counselor to attempt to change a student’s sexual orientation/gender identity but instead to provide support to LGBTQ students to promote student achievement and personal well-being. Recognizing that sexual orientation is not an illness and does not require treatment, professional school counselors may provide individual student planning or responsive services to LGBTQ students to promote self-acceptance, deal with social acceptance, understand issues related to coming out, including issues that families may face when a student goes through this process and identify appropriate community resources.”

(f) The American Academy of Pediatrics in 1993 published an article in its journal, Pediatrics, 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.”

(g) The American Medical Association Council on Scientific Affairs prepared a report in 1994 in which it stated: “Aversion therapy (a behavioral or medical intervention which pairs unwanted behavior, in this case, homosexual behavior, with unpleasant sensations or aversive consequences) is no longer recommended for gay men and lesbians. Through psychotherapy, gay men and lesbians can become comfortable with their sexual orientation and understand the societal response to it.”

(h) The National Association of Social Workers prepared a 1997 policy statement in which it stated: “Social stigmatization of lesbian, gay and bisexual people is widespread and is a primary motivating factor in leading some people to seek sexual orientation changes. Sexual orientation conversion therapies assume that homosexual orientation is both pathological and freely chosen. No data demonstrates that reparative or conversion therapies are effective, and, in fact, they may be harmful.”

(i) The American Counseling Association Governing Council issued a position statement in April of 1999, and in it the council states: “We oppose ‘the promotion of “reparative therapy” as a “cure” for individuals who are homosexual.”

(j) The American Psychoanalytic Association issued a position statement in June 2012 on attempts to change sexual orientation, gender, identity, or gender expression, and in it the association states: “As with any societal prejudice, bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice.

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

(k) The American Academy of Child and Adolescent Psychiatry in 2012 published an article in its journal, Journal of the American Academy of Child and Adolescent Psychiatry, stating: "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 empirical evidence 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, important protective factors against suicidal ideation and attempts. Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated."

(l) The Pan American Health Organization, a regional office of the World Health Organization, issued a statement in May of 2012 and in it the organization states: "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 reparative therapies "lack medical justification and represent a serious threat to the health and well-being of affected people."

(m) 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 higher 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.

(n) California has a compelling interest in protecting the physical and psychological well-being of minors, including lesbian, gay, bisexual, and transgender youth, and in protecting its minors against exposure to serious harms caused by sexual orientation change efforts.

(o) Nothing in this act is intended to prevent a minor who is 12 years of age or older from consenting to any mental health treatment or counseling services, consistent with Section 124260 of the Health and Safety Code, other than sexual orientation change efforts as defined in this act.

**SEC. 2.** Article 15 (commencing with Section 865) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

**Article 15. Sexual Orientation Change Efforts**

**865.** For the purposes of this article, the following terms shall have the following meanings:

(a) "Mental health provider" means a physician and surgeon specializing in the practice of psychiatry, a psychologist, a psychological assistant, intern, or trainee, a licensed marriage and family therapist, a registered marriage and family therapist, intern, or trainee, a licensed educational psychologist, a credentialed school psychologist, a licensed clinical social worker, an associate clinical social worker, a licensed professional clinical counselor, a registered clinical counselor, intern, or trainee, or any other person designated as a mental health professional under California law or regulation.

(b) (1) "Sexual orientation change efforts" means any practices by mental health providers that seek to change an individual's sexual orientation. This includes efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.

(2) "Sexual orientation change efforts" does not include psychotherapies that: (A) provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices; and (B) do not seek to change sexual orientation.

**865.1.** Under no circumstances shall a mental health provider engage in sexual orientation change efforts with a patient under 18 years of age.

**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.

