The World According to PFLAG: Why PFLAG and Children Don't Mix

By Linda Harvey
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An examination of the values of PFLAG (Parents, Families and Friends of Lesbians and Gays), a national group promoting the acceptance of gay, lesbian, bisexual and transgendered lifestyles for children and teens.

PFLAG is active on a local and national level attempting to infuse its radical ideas into schools, churches, youth organizations and into national and state public policy. There is growing support for the work of this organization, which is being received cordially by some schools and even corporations.

Yet behind its rhetoric of "rights" and "tolerance" is the sordid reality of what PFLAG actually supports. As their recommended literature reveals, the world according to PFLAG would encourage children to be self-indulgent and self-centered; to reject the wisdom of parents and other authorities if they wish, even at early ages; and to engage in just about any sexual behavior imaginable.

In this literature, there is even implied approval of sexual contact between adults with minors. It's a frequent, usually "positive" theme in many resources recommended by PFLAG. For a complete listing of these resources, consult the group's publications on its web site at www.pflag.org.

Warning: Graphic sexual content follows. The following are just a small sample of the situations, opinions and themes depicted in the PFLAG brochures and in books PFLAG recommends as "resources." The passages included here are mild compared to the obscene, self-destructive, abusive, and just plain weird material that predominates.

The sheer volume is grounds, we believe, for preventing this group from having any contact with minor children; nor should its ideas be adopted by teachers, counselors and parents. There is a dire need to expose this organization's roots. Schools and organizations that utilize PFLAG materials, list its web site or other contact points as resources, or allow PFLAG representatives to speak to children or other groups may find themselves ultimately exposed to criminal liability.

PFLAG's recommended literature encourages in sexual license for people of all ages. For children, this means that virtually any sexual activity as well as exposure to graphic sexual images and material, is not just permissible, but good for children, as part of the process of discovering their sexuality.

"I've been doing drag for about ten years, on and off....my fantasies were all about whipping. I started reading up on S/M, and it was making me interested in sex for the first time...I realized that, for what I was doing, I could be getting good money." (Interview with Minal, a young man who is a cross-dresser and works as a prostitute specializing in sado-masochism, in Revolutionary Voices, Ed. Amy Sonnie, Alyson Books, 2000, pp.171-172. Book recommended for youth by PFLAG in its brochure, "Be Yourself").

"... From a convenience store in a town thirty miles away that sold liquor to underage customers as well as porn paperbacks, I acquired a copy of a novel called Pretty Boys Must Die. It satisfied my curiosity about what homosexuals did....I was excited out of my mind....I also knew that somewhere out there, beyond Amethyst, someone had to be doing something remotely like what leather hustler Riley Jacks did to naïve young David (the "Pretty Boy")....

"I was ready.....But I had to wait. ...I gorged on new porn when I could get it...I was content to read for hours, and masturbate for hours..." (A man reminiscing about his youth, from Growing Up Gay/Growing Up Lesbian, ed. Bennett Singer, New Press, 1994, p.53. This book is part of recommended reading by PFLAG in its brochure for parents, "Our Daughters & Sons.")

"Except for her Adam's apple, it was hard to tell Christina was really a young male from the Philippines...My days were spent as a man and my nights as a woman...Christina introduced me to Breezy. She had started taking hormones when she was in her teens...

"During our physical lovemaking, Breezy was able to express her female and male energies at the same time...I was sad that our affair lasted only four days." (Memoir of transgendered youth Shu Wei Chen/ Andy, pp.179-180, in Bi Any Other Name, ed. Loraine Hutchins & Lani Kaahumanu, Alyson Books, 1991. Recommended in the PFLAG Bisexuality Resource Packet and in the PFLAG brochure for parents.)

In the novel Rainbow Boys (Alex Sanchez, Simon & Schuster, 2001), three 17-year old boys explore their homosexual attractions. Frequent themes include obtaining pornographic magazines (p.51) and movies (p.88), as well as graphic descriptions of masturbation (pp.51-52, 70, 89).

The book features several scenes of explicit heterosexual sex, and a scene where one of the teen boys has anal intercourse without a condom with a 29-year-old man he has just met via the Internet (p.148). This boy's mom is an officer of the local PFLAG chapter, and comes and goes to meetings throughout the book. Rainbow Boys is recommended by PFLAG in its brochure for youth, "Be Yourself."

"...I met this guy named Reggie, who was twenty-three. I met him hanging out in the subway station....He spent the night with me a few times..." (Memoir from 'D.B.', a 15 year-old runaway and school drop-out, in Two Teenagers in Twenty, Ed. Ann Heron, Alyson Books,1994, page 81. Book recommended by PFLAG in its brochure for youth.)

"...I joined this youth group called Positive Images; it's the Sonoma County gay/lesbian/bisexual youth group. I got a boyfriend instantly; he picked me up right away, right when I joined the group. He was older; he was twenty-five, I was sixteen...." (Todd Fay-Long, age 17, from In Your Face: Stories from the Lives of Queer Youth [cited above], p.58.)

"Slowly but surely, I came out to my priest. I was in shock when he said, 'That's fine...' He was the most supportive person I've ever met....My priest told me about this support group in Boston where there are a lot of kids like me...I'll never forget that first day at the Boston Alliance of Gay and Lesbian Youth (BAGLY)..." (Troix Reginald Bettencourt, age 18, Lowell, Massachusetts, looking back on his high school days, in Two Teenagers in Twenty [cited above], pp.158-159.)

PFLAG spreads false information about the Bible, religious faith, and restoration of heterosexuality through faith. This misinformation closes the door of change for many young people, and stirs up anti-Christian and anti-Jewish bias and hostility.

"In fact, the Bible says very little about homosexuality. Amidst the hundreds of thousands of other teachings, responsibilities, laws and prohibitions, there are only a handful of statements that might possibly apply to sex between men--and none that address lesbian sexuality." (Erroneous claim that ignores Romans 1:26 and many clear passages prohibiting homosexuality, from Free Your Mind: The Book for Gay, Lesbian, and Bisexual Youth--and Their Allies [cited above], p.279.)

"We were observant Jews--conservative...We were aware that ...the Old Testament prohibited ..gay relationships...However, w didn't have a problem reconciling these views because our kid always come first." (From PFLAG brochure, Faith in Ou Families, p.2).

"My parents found out I was a lesbian and sent me to a psychol ogist to be 'cured.' I am presently being cured, not of my sexua orientation, but of the way I accepted my parents' every word a gospel." (Joanne, age 18, in Two Teenagers in Twenty, [cite above], p.42)

"Later that week, Kyle arrived home from school to find his mon standing in the center of his bedroom...She barraged him wit questions like, Should she have done something different bring ing him up? or, What about the ex-gay groups that claime homosexuals could change? 'Mom,' he said, frustrated. 'You did n't do anything wrong and I can't change. Those groups are ful of fakes...'" (From novel *Rainbow Boys,* [cited above] p.103.)

ATTEND NARTH'S 2007 CONFERENCE IN DALLAS/FORT WORTH THIS OCTOBER

Register soon for NARTH's Annual Conference at the Dallas/Fort Worth Marriott Hotel from October 26-28, 2007. A registration form is available on the NARTH web site.

Our keynote speaker is Stanton Jones, Ph.D., co-author of *Homosexuality: The Use Of Scientific Research In The Church's Moral Debate.*

Dr. Douglas Abbott will discuss "The Role Of Free Will And Choice In Same-Sex Behavior."

Dr. Peet Botha will present a paper, "A Phenomenological Approach To Early Communities' Attitudes Toward Homosexuality."

NARTH Scientific Advisor Just Published In Journal

Abstract: Whitehead NE.
AN ANTI-BOY ANTIBODY? RE-EXAMINATION OF THE MATERNAL IMMUNE HYPOTHESIS.
J Biosoc Sci. 2007 Feb 22: 1-17

The maternal immune hypothesis (MIH) argues same-sex attraction (SSA) results from maternal immune attack on fetal male-specific brain structures and involves the previous biological influence of elder brothers. One of the surveys supporting this is shown to be based on an unsuitable sample and to contain some strong contrary evidence. The hypothesis relies on at least four speculative ideas and there is evidence against each:

(1) Likely immune response prevalence is too low compared with calculated SSA prevalence resulting from the fraternal birth order effect.

(2) Testis immune attack would be more likely than brain attack but is not known.

(3) Fetal brain structures are practically indistinguishable at birth and subsequent brain anatomical gender differentiation only occurs after birth when no attack is occurring.

(4) The hypothesis also predicts unfavorable biology for late birth-order males but in fact the reverse is generally true, and neurological effects are very minor. Studies show aborted fetuses caused by likely maternal immune attack are predominantly girls rather than boys, which also argues against the theory. Studies on identical twins show that common factors such as uterine environment are only a small influence on SSA and post-natal idiosyncratic reactions and non-shared environmental factors are much larger influences.

(Gender Identity Disorder, continued from page 24)

have been in the forefront of the discussion of human development for some time. Beginning with the work of Money (1957) it was asserted that although biological factors play a role in the development of a gender identity, sociological factors seem to play an even larger role. Diamond (1965) asserted that newborns were psychosexually "neutral" with regard to gender identity differentiation. Implicit in this hypothesis is that malleability in the short run implies adaptation in the long run. It has been demonstrated in the 40 years since that this is not the case- malleability does have a bearing on adaptation in the long run-- namely, that gender atypical behavior and identity is associated with a number of negative outcomes.

The notion of malleability perhaps naively informed physicians that psychosexual surgery, when properly applied, would have positive outcomes for ambiguously appearing children. Money's assertion, particularly with his most famous client, cannot be so simplistically understood and applied as he would wish. Zucker (2005), in his article, argues strongly that clinicians should engage in a formal assessment of children with ambiguous genitalia or gender atypical behavior or identity. The informed clinician (through psychometrics) can better assist other professionals, the parent and the child than merely relying on the assumption of malleability and adaptability.

There are several assumptions that one makes when using psychometrics to assess psychosexual differentiation, and Zucker wishes his reader to be aware of them. Psychometrics should be able to demonstrate differences between a normative and clinical population. These differences should be demonstrable in the three areas associated with:

- Males and females having a Gender Identity consistent with their gender.
- Males and females having a Gender Role consistent with typical gender behavior.
- Males and females being erotically attracted to their opposite gender.

A second assumption is that even animals on the evolutionary ladder below primates demonstrate that sociological factors play a significant role in the acquisition of gender-typical behaviors. This is used as justification for applying what others might assert are "transient, oppressive, cultural mores" as indicators of either typical or atypical gendered behavior. If animals socialize their young along certain patterns for the betterment and survival of the species, it is not oppressive, arbitrary or coercive to assess and encourage the socialization of children along those same lines.

A third assumption is that psychometric measures should be tied to cultural definitions of the two genders, unless the trait being measured is so demonstrably transient or arbitrary as to be meaningless.

Zucker then begins to list for the reader a variety of instruments which can either be administered to the child or to the parent which have moderate to large Effect Sizes. In this regard they are powerful (they properly reject the null hypothesis that there is no difference between gender-identity disordered children/physically intersex condition and normals). These measurements occur in all three areas of assessment: gender role, gender identity and temperament. This makes the assessment and validity of a GID diagnosis all the more powerful as it occurs in multiple measures across multiple attributes:

"...all of the measures listed in Table 1 met one or more of the following psychometric requirements: (1) there was evidence for a significant normative gender difference; (2) there was evidence for discriminant validity in comparing children with GID versus controls; (3) there was evidence for discriminant validity in comparing children with physical intersex conditions...versus same-sex controls."

The power of these assessment tools is all the more compelling when one looks closely at the statistical analyses used in these instruments. Each instrument demonstrates moderate to large Effect Sizes (.50 and larger). This is especially true of parent report measures. Even more importantly these effect sizes are larger for GID children than for CAH children (girls with congenital adrenal hyperplasia).

These moderate-to-large effect sizes are present in 11 studies of free play, such that normative children play with gender-typical toys at a much higher rate that either GID boy and girls or CAH girls. Free play that includes both gender typical toys and the opportunity for dress-up seems to be an even more useful tool at discriminating behaviors typical of girls and boys (Rekers and Yates, 1976).

The next question to be addressed in research is the assessment of adults and adolescents along the same three dimensional paradigm (gender identity, gender role, sexual orientation). The concept of how gender identity effects gender role and sexual orientation over time has not been operationally assessed. This leads clinicians to speak to parents, doctors and clients from a vacuum. Although there are a number of assessment tools which are said to address these factors in these age groups, they are inadequate by comparison to the precision of tools which exist to assess children.

Consequently, a lack of empirical data leads to much guessing and assertions based upon religion, politics and other subjective systems which may or may not serve the client. In this regard it leads me to the following set of questions:

- What percentage of GID diagnosed children later identify as homosexual in orientation?
- What percentage of GID diagnosed children later continue gender-atypical behavior, but identify with their gender role and do not identify with a homosexual orientation?
- What percentage of GID diagnosed children later report gender-typical behavior and identification with their gender role and report opposite-sex attraction?

- How does the ethical clinician navigate this process, not with only children who are GID, but with adults who later report symptoms consistent with a prior diagnosis of GID?

- Is gay affirmative therapy likely to help or harm (does it share some similarities to Money's poorly conceived malleability hypothesis)?

- Is reorientation therapy likely to help or harm (is emphasizing masculine interests and friends really sufficient in understanding and helping men who have gender atypical interests who wish to live as heterosexuals)?

IV. Zucker Defends the Diagnosis and Treatment of GID

The diagnosis of GID is under attack these days. In separate articles responding directly to critics, Zucker and Spitzer (2005) and Zucker (in press) address differing but related aspects of the controversy. Zucker and Spitzer respond to the accusation that GID was introduced into the DSM-III in 1980 as a backdoor method of replacing homosexuality as a diagnostic category, which had been deleted from the DSM-II in 1973. This claim has been based on the connection between GID in childhood and later homosexuality, as a homosexual sexual orientation without co-occurring GID is the most common outcome for children diagnosed with GID. The authors challenge the assertion of a homosexuality-GID diagnostic swap on a number of grounds, arguing that the GID diagnosis had shown clear clinical utility and met the test of expert consensus. Moreover, they assert that there was no need for another diagnosis to replace homosexuality, as the DSM-III contained the diagnosis of ego-dystonic homosexuality, and subsequent DSM versions have retained the residual diagnosis of sexual disorder not otherwise specified, which includes distress about homosexual orientation as one of its examples. For Zucker and Spitzer, GID is a credible and valid diagnosis that deserves further study rather than inaccurate historical characterizations.

In a separate response to an article by Langer and Martin (2004) in the Child and Adolescent Social Work Journal, Zucker (in press) defends the GID diagnosis against a slew of criticisms. Zucker begins by noting that since the mid-1970s he and his colleagues have assessed about 475 children and 300 adolescents referred for concerns about their gender-identity development. Zucker challenges the view of GID as simply a social construction, which has been asserted based on the higher referral rates for boys as opposed to girls. He contends instead that while social factors influence referral rates, one could equally argue that social factors result in a dismissal of gender conflict in girls, whereby greater tolerance for cross-gender behavior in girls results in parents and therapists not taking seriously the possibility of a girl experiencing substantial distress about her gender identity.

Elsewhere Zucker addresses the claim that the distress of the GID child is not inherent to the condition but rather a byproduct of social disapproval. He observes quite cogently that:

If one considers the developmental adolescent or adult "end-state" of GID, i.e., the strong desire to align the body via contra-sex hormones and sex-reassignment surgery....to the felt psychological state, it is difficulty to argue that cross-gender feelings and behaviors simply constitute normative variation or do not constitute an example of impairment. The required physical interventions are simply too radical to be though about otherwise. (p. 14).

Zucker also observed that research indicates children with GID have poorer social relations than controls and evidence a developmental lag in the acquisition of gender constancy. In response to the claim that the GID pathologizing of gender atypicality in boys is misogynistic and reinforces traditional male dominance over women, he questions why in an arguably patriarchal culture a boy would ever want to be a girl and adopt the identity of the oppressed female class. The sociopolitical model of patriarchical oppression should, if anything, predict a predominance of girls who want to be boys rather than the other way around. In addition, Zucker asserts, "There is considerable evidence for cross-cultural similarities in gender dysphoria, including its developmental history and concurrent phenomenology" (p. 17).

Perhaps of most interest to clinicians is Zucker's reply to the assertion that the diagnosis and treatment of GID is harmful to children. He affirms the notion that the diagnosis of GID is not what elicits stigmatization by others, but rather the behaviors that comprise the diagnosis. That is, the behaviors of the GID child are what lead to ostracization by peers, not the diagnostic label. In terms of treatment, Zucker views Langer and Martin's perspective as one of essentialism, meaning that children with GID are born that way and simply need to be left alone. While Zucker perceives gender identity and sexual orientation, especially among males, to become more fixed with age, he believes the data suggest a much greater plasticity in childhood. Consequently, he confesses, "As a result, many clinicians, and I am one of them, take the position that a trial of psychological treatment, including individual therapy and parent counseling, is warranted" (p. 22-23).

Overall, Zucker (in press) is very sympathetic for the need for continued research on the treatment of GID, acknowledging that clinicians at present have to rely primarily on accrued clinical wisdom rather than methodologically rigorous outcome studies. Of course, the ability to continue to study GID treatment is predicated upon its continued existence as a diagnostic condition, something that Zucker is obviously not taking for granted.

V. Girls with Gender Identity Disorder

Although gender-identity disorder (GID) is seen in the human population, it is not typical because most youth do not have it (Zucker, 2006). Clinically seen, children with GID present with a strong preference for sex-typed behaviors of the opposite sex and reject behaviors more characteristic of their own sex. It is best seen as a disorder because according to clinical and standardized assessment data it is subject to malleability with intervention. It is not a fixed state of human variance. Drummond's (2006) thesis supports this suggestion. The study based in Canada provided the data of 25 girls (ages 12 and younger) with

GID and found that, after follow up, only 12% were judged to have persistent GID in adulthood or later adolescence. In line with these findings, other outcome studies have shown that the majority of boys with GID are no longer gender dysphoric when they reach adulthood.

It was cited throughout the literature review that GID is highly correlated to psychosexual outcomes of transgenderism as well as homosexuality and bisexuality. In addition, GID is highly associated to high psychosocial comorbities such as: poor relationships, behavioral problems, DSM Axis I and Axis II disorders and self-injurious behaviors.

Conclusion

Zucker's research contradicts the notion that GID is a phantom disorder and that children diagnosed with GID present with no more distress than other children. To the contrary, his research suggests that these children do indeed have more psychological and behavioral problems than non-referred children. In response to an article in the Psychiatric News (July 18, 2003) suggesting that not only was GID a phantom disorder but it was the parents' distress, not the child's distress that was problematic, Zucker offered the following response: "Consider, for example, a 3-year-old girl who repeatedly states that she is a boy or that she wants to be a boy. Her parents reply by telling her that she is a girl, and the child's reaction is to cry and insist otherwise. Hill's interpretation of such distress is that it is merely the result of the parents' reaction, not the possibility that the child is also struggling with a complex feeling state. Of course, if the parents went along with the child's fantasy that she was a boy, there would be no overt distress, but it would hardly solve the underlying problem and would merely reinforce it." (Zucker, 2003).

Perhaps, the bigger issue is the rights of parents to oversee the development of their children. If GID is a risk factor for the later development of homosexuality, and GID is a treatable condition, do parents have the right to seek treatment for GID as a means of preventing a homosexual outcome?

Zucker's success in helping children with GID has excellent documented success. In their book, Gender Identity Disorder and Psychosexual Problems in Children and Adolescents, he and co-author Susan Bradley conclude: "It has been our experience that a sizeable number of children and their families achieve a great deal of change. In these cases, the GID resolves fully, and nothing in the children's behavior or fantasy suggest that gender identity issues remain problematic...All things considered, we take the position that in such cases a clinician should be optimistic, not nihilistic, about the possibility of helping the children to become more secure in their gender identity." In spite of the politically sensitive connection between childhood gender-identity disorder and later adult homosexuality, Zucker and Bradley believe treatment of childhood GID can be both "therapeutic and ethical." They base their case on several points, claiming treatment affords the following benefits:

- A reduction of social ostracism by peers.
- An opportunity to relieve the psychopathology which has been documented to be associated with GID, both in the child and within the family.
- The prevention of later transsexualism;
- The prevention of homosexuality in adulthood.

On this controversial point, Zucker believes that treatment is justified for social reasons--but he is doubtful about their being justification to prevent homosexuality for religious reasons.

And if a secure gender identity prevents the development of later homosexuality, as Zucker acknowledges as a possibility, parents should be informed of the research on the relationship between the two. Zucker's priority is "helping these kids be happily male or female," but he also acknowledges that the treatment process does, in some cases, apparently avert homosexual development.

And in support of parents' rights to avert a homosexual outcome for their children, Zucker cites a persuasive quote from Richard Green: "The right of parents to oversee the development of children is a long-established principle. Who is to dictate that parents may not try to raise their children in a manner that maximizes the possibility of a heterosexual outcome? It that prerogative is denied, should parents also be denied the right to raise their children as atheists? Or as priests?"

This review was prepared by the Scientific Advisory Committee of NARTH, A. Dean Byrd, Ph. D., MBA, MPH Chair. Contributing members include: Ned Stringham, Ph.D., Philip M. Sutton, Ph.D., David Blakeslee, Psy. D., Christopher Rosik, Ph.D. and James E. Phelan, MSW, Psy. D.

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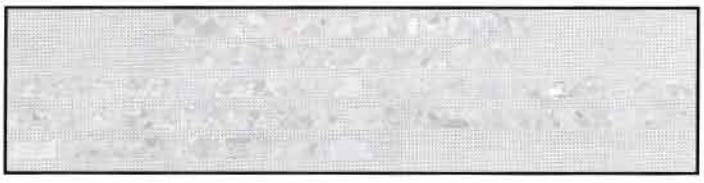

NYU Students Find Accepting Campus For Transsexuals

Brooke Donatone is a licensed clinical social worker at the NYU Student Health Center. She notes: "Few things fit into neat boxes and gender is one of them." Donatone believes that Gender Identity Disorder should be removed from the psychiatric manual. "I don't see the purpose of pathologizing gender identity."

Andrew Fanelli is a cross-dressing NYU student who wears women's clothing but does not wish to have a sex change operation. According to Fanelli, "I'm a straight man who wears women's clothing. I refuse to let who I am and how I feel comfortable being become repressed."

NYU Professor Carolyn Dinshaw, chair of the social and cultural analysis department is former director of the Center for Gender and Sexuality Studies. She observes: "I think that the match between body morphology and gender identification doesn't have to be perfect. There can be a disjunction." NYU has a nondiscrimination employment policy that welcomes transgendered employees.

Christopher Rosik, Ph.D., a member of the NARTH Scientific Advisory Committee, has observed: "While transgendered students are clearly in need of our compassion, I suspect that simply affirming their disjuncted gender identity does them a disservice. A preferable first response would be to determine if any help can be provided to lessen the disjunction for these individuals.

"Follow up studies of transsexuals have suggested that, while interventions such as sex change surgery reduced distress due to the perceived gender incongruity, their relational, vocational and emotional difficulties continued unabated. The collusion of NYU officials with these students' psychological reality to the apparent exclusion of encouraging them to seek help is therefore ill advised."

'Transmen' Come Out At Women's Colleges

"When She Graduates As He," published by the *Boston Globe* describes a growing trend and women's colleges in dealing with so-called transmen, women who are undergoing sex change operation to become men. The article describes the journey of Isaiah Bartlett, who is a 20-year-old psychology major, and is undergoing a transformation from a "butch lesbian" to a male.

This individual's real name is Allison Bartlett. She enrolled in Mt. Holyoke College in the fall of 2005, shaved her head into a Mohawk and began wearing boxer shorts. She also started binding her breasts before going out to classes.

Bartlett says she began to understand her desire to be a male after hearing a talk by Kevin Murphy, a woman who has decided to live as a man. Murphy came out as a lesbian in high school but eventually paid for a double mastectomy and started taking hormones. Murphy was still "Caitlin" when she enrolled at Mt. Holyoke College in 2003.

Globe writer Adrian Brune notes that "From a medical point of view, Isaiah Bartlett's story reflects the classic traits of gender identity disorder as defined in the 'Diagnostic and Statistical Manual of Mental Disorders,' the bible of the mental health profession. At the same time, while no one knows exactly how common it is, advocates and many professionals who work with the trans population believe transgender people should be reclassified, because gender variation is normal across the human spectrum."

Brune quotes transgender family therapist Arlene Istar Lev, a professor of social welfare at the State University of New York at Albany. Lev notes: "We know that a certain percentage of the population is transgender, and we know the research on transitioning and age. At this point, we have no evidence of any young people regretting these decisions [to have sex change operations]." Not mentioned in Brune's article is the fact that she is a long-time writer for gay and lesbian publications, including the *Advocate, Washington Blade, Houston Voice, New York Blade* and other publications with a gay political perspective.

APA Establishes Task Force On Appropriate Therapeutic Responses To Sexual Orientation

In March 2007, the American Psychological Association established the Task Force on Appropriate Therapeutic Responses To Sexual Orientation. Membership will be approved by the APA Committee on Lesbian, Gay, Bisexual and Transgender Concerns. The Task Force is expected to generate a report that will address the following issues:

(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 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
(c) The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation
(d) Education, training, and research issues as they pertain to such therapeutic interventions
(e) 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.

See next page for appeal from PFOX to the APA to be fair in the assembling of its task force.